Honorary Fellow – C. Everett Koop's Global Vision for Health Care:
A Chest 2000 Reunion with Allen Goldberg

Al Lever: I am Al Lever and I am the CEO of the College and I want to welcome you to Chest 2000 and to our Honor Lecture. I am indeed greatly honored myself to have this opportunity to do the introduction for this session. Last year, Dr. Allen Goldberg who was then our president, wanted to have his mentor, C. Everett Koop, give the keynote address – he wanted this to happen because Allen is a pediatric anesthesiologist by training, and he has worked at the CHOP, the Children's Hospital of Philadelphia, with the eminent and innovative pediatric surgeon, Dr. C. Everett Koop. As many mentors do, Dr. Koop said to Allen, "I want you to have the honor of doing your own presidential address," and that started another dialogue. The idea that they came up with was that since we were doing a major track on tele-education, was to really do a fireside chat that would have Dr. Koop being satellited into Chicago and for Allen Goldberg to be present on the podium. Last year in doing that, and working through a prepared program, they covered topics such as the impact of managed care, the physician patient relationship, tele-communication and education, alternative and complimentary medicine, chronic disease and disability, ethical issues (particularly as it related to end of life), and on top of that a global vision. So, it is indeed my pleasure now to be able to introduce both Dr. Koop and Dr. Goldberg in really what we will call a reunion of Allen and Chick at Chest 2000. So welcome Dr. Koop and Dr. Goldberg! Please give them a round of applause and welcome them to this session.

Dr. Koop: Here we are again.

Dr. Goldberg: Yes, a year has past. This year the American College of Chest Physicians is an organization all around the world with 15,500 members located in over 90 countries. I was interested to see that you were asked to speak at the U.N. Summit on the Future of Health. As it happens, the ACCP really focuses on globalization. I am really interested in what you think of globalization and how you handled that assignment.

Dr. Koop: Well, I was very interested that they connected health with happiness in this Globalization Conference. I think, Allen, we all thought that globalization would happen because we believe it should happen. And then, when the Berlin Wall came down and the cold war was over, we expected that it really could happen. But it didn't, and as a matter of fact, if you look at what has happened since those days, instead of having things globalized, they have become more particularized. We once again "Balkanize the Balkans" and that's happened in other places in Europe and Asia. The strife that has been going on in Africa and Latin American has not abated in any way and it just seems that globalization, even though there is a tremendous global commerce going on, we have

not really developed what you could call a global marketplace. And, I think there is only one thing that we have really truly globalized. What we have globalized is the spread of disease.

Dr. Goldberg: Could you explain that a little more in what obligation that is?

Dr. Koop: Well, I will give you the obligation first. If we have globalized disease, we absolutely have the obligation to globalize health because it has happened because of who we are and the way we live and the way we work, and it means that if we're going to globalize health, then we have to globalize prevention and treatment in order to achieve health, and knowing me, you probably understand that I think this is going to have to be a public private partnership. I would remind you that disease has never known geographic boundaries and perhaps the very first example of that we had was in the 14th century with what we now call the plague. And then, when the colonization and exploration of the North American Continent took place, we lost actually millions and millions of Native Americans to disease that they had never before been exposed to. And then, the flu of 1918 and 1919 is a more modern global pandemic. Finally, the one we are concerned about today most is AIDS. AIDS apparently came from Africa on an aisle seat on an airplane. So, we're in a situation now where I think we have to remember that communication and transportation has aided and abetted the spread of disease. Virus's that couldn't survive a transatlantic oceanic crossing from LeHarve to New York, can now make it very well from Heathrow to O'Hare and we have an International Conference here, just think of all the virus's that our international guests brought with them and think of the colds they will take from San Francisco back to their homeland. So, there is no way we can escape what has happened and what is happening, except to counter-act it.

Dr. Goldberg: I think there are people who think that globalization has really happened to a much greater degree. I am always learning from my children who have recently given me a book by Thomas Freedman, about how to understand globalization and it's called the *Lexis and the Olive Tree*. And really, what he says is that we now have a dominant international system that he does claim has occurred since the fall of the Berlin Wall that replaced the cold war – He sees it has affected everything, politics, environment, geo-politics, economics in every country and it's due really to things you've already stated, that we have new Internet working of information technologies, and broader communication, so we now have the capacity to reach everybody at much lower costs. And we continue to integrate markets, we integrate nations, we integrate these technologies so that even individuals are empowered, corporations are empowered and nation states are empowered, they can reach all around the world faster and cheaper than ever before. He claims we have really changed in the whole way we work in the world because of these technological innovations. We've actually democratized three things he says, there's technology that's democratized, so that it affects how we communicate so that we all could be producers. It affects finance, how we invest money, we can all, as individuals, be investors. It can affect information, how we learn, how we can all be learners and education seekers. And as you suggested, we also have this problem with the forces against it. There are cultural forces, we're attacking cultures,

there are economic forces where people feel threatened that their jobs are at stake or their businesses are at stake and there are social forces where people think there is loss of control of society. So I am really interested in you talking about health and disease, where do you put all of this? Is it going to be politics that is going to be globalized? Is it going to be economics that is going to be globalized? What are the priorities as you see it?

Dr. Koop: Well, I can't tell you what the "pecking" order is going to be, but I am absolutely convinced that we can't have political or economic globalization until we have a healthy planet on which to live.

Dr. Goldberg: That sounds like a huge, huge, challenge.

Dr. Koop: Well, there's no doubt it's a huge challenge, but things change tremendously. For example, when I was your chief delegate to WHO, we despaired many times of ever being able to take to the continent of Africa a "health system" because they didn't have any kind of infrastructure, and with nothing to build on, how could you possibly afford what you needed? Then all of a sudden, new technology just leap-frogged over the necessity for an infrastructure and with wireless cells and with the computer we now have an information transfer system that is just as good as we ever hoped we'd have in Africa and it works remarkably well, and right now, this information system enables us to instantaneously transfer health information from San Francisco to Addis Abba or Kinshasa and back again. So, we've done it in spite of the fact that we didn't have the tools with which to do it.

Dr. Goldberg: So, what I'm hearing you say is that the globalization of health really is possible due to these advances in telecommunications.

Dr. Koop: Exactly, Exactly.

Dr. Goldberg: Even if it doesn't necessarily require the high technology and the high costs of putting in an infrastructure because low technology will also work well. And what you're also saying is the economic progress that we need won't happen unless we have this global health. So, it not only will happen, can happen, it must happen for us to have a global economy. Because without global health, you just cannot develop a successful global economy.

Dr. Koop: Let me give you an example, from not too far from here there is a tribe of Indians, the Teraskins, in Southwest Mexico, and the *National Geographic Magazine* says they haven't changed their culture in 400 years in spite of the fact that they are surrounded by industrial Mexico. Well, I provided the healthcare for that tribe almost single-handedly for about 10 years, and when I started, my professional friends in medicine in Mexico City said, "you're going to find the Teraskins are lazy, they don't want to do a good days' work, and are not interested in a better and expanding Mexico. When I got there, they seemed to fit that same description. But here's what I found out. Every one of them had at least two intestinal parasites. They all had peripheral ulcers,

they all were anemic, their nutrition was atrocious, tortillas and beans and if you had a good providing father, he might boil a fish head in water once a week and give the broth to his children. Those that lived around the lakes had malaria because of the mosquitoes. But those that lived in the high altitudes, no mosquitoes, no malaria, but they had syphilis. So these people weren't lazy, they weren't people who couldn't work for a day, they weren't people who were disinterested in Mexico, they were just plain sick and the sad thing about it is, these people had something to offer because they were all skilled in woodcraft. Some of them were true artists in carving and in lacquer work and all that it took to make them into a productive economic force was health. And that health was just a few bureaucratic steps away in Mexico City.

Dr. Goldberg: I think you made your point.

Dr. Koop: I think I have. But I have to tell you Allen, when you said globalization, you have to remember, you can also globalize things within a given country. The global view in a given country, I think, is going to become more and more a part of our common language. The word that I use and that people are starting to use is "prospective medicine," and what it really is, is applying public health principles, but it is delivered to individuals. The domestic applications are necessary I believe, if we're going to deliver what I think is global health to all people and we must do that and somehow or other, we have to globally understand that the health of all people is indeed the responsibility of all people. And we have to work not only as individuals focusing on individuals but we have to consider global health in a community. Let me give you an example of what I mean. In South Africa, after Apartheid went away, they brought in the first African government and they had a brand new ministry of health and Dr. Dumar was the Minister of Health, a capable lady, and she found that in Southern South Africa the incidence of HIV was 1 in 5. She also found that the employees of her own Public Health Department didn't really understand the transmission of Aids. One year later, the incidence had changed from 1 in 5 to 1 in 3. Now, that is not only a terrible tragedy for South Africa, but I think it could be prevented by thinking globally. Do you remember Lauderbach, the guy that was such a linguist in Africa; his goal was "literacy for the entire continent"? And he had a little motto, " Each one teach one." Suppose that in South Africa, each person who understood the transmission of Aids had said to somebody, this is how it's done, each one teaching one, and that person teaching another. I don't think you would have gone from 1 in 5 to 1 in 3 and that would have avoided a tremendous public health tragedy for that country.

Dr. Goldberg: Well, I think you make your point and why public health and looking at the health of the community is very, very important to us who take care of individuals and families. I think however, to continue on we should move on.

Dr. Koop: I agree.

Dr. Goldberg: Last year at Chest 1999, we raised a lot of issues that we really didn't talk about much; we talked about our concern for the number of people, the 90 million Americans with chronic disease and disability - the need for chronic care in our quick fix

society. And, you mentioned some of your concerns about the number of people, the 1 in 4 Americans taking care of them. I think it's important we discuss certain things that we need to deal with. What do you think?

Dr. Koop: Yes, before I leave globalization, let me tell you, you're going to get just as sick of hearing about globalization next year as you did hearing about the millennium last year. But, I am glad you brought that up Allen, because we talked last year about things we didn't have a chance to finish, which is one of the good things about these dialogs, to say that we might be able to come back next year and do it again. And we raise concern about, I think it was 90 million Americans we talked about that had chronic disease or disability and needed some kind of chronic care in our quick fix society that wasn't yet quite adept to doing that very thing. And, we also talked about the 1 in 4 of our population that currently is involved in taking care of them and I have to ask you a question because you have been so interested in this - "What do physicians need to understand if we are to have a greater impact on chronic disease in this country?"

Dr. Goldberg: I think we have to appreciate that people who have chronic disease in their families want to stay home. Interesting today, in today's *U.S. Today,* I was noticing that HMO's are finally getting to look at the elderly, having people stay home and the economic impact on that. People want to stay home because of the impact of several things that happen in homecare. Homecare represents a culture change. And in that culture change, the person is in the center - the person directs care and they start to learn about their own self-management of care – and that has an enormous impact on their health. The family has an impact and the community has an impact, it provides a support and a safety net that is extremely important to people, as they get older. And the Involvement has an impact. You think about people who are at home are comfortable because they know the environment, pets for example are very important to people and they can maintain those relationships, and certain practices they may have, including their spiritual practices which are difficult when they leave home are still possible and these have an impact. As we developed homecare, we have to realize that we've done this in an environment in public policy that has discouraged home care because of the payment policies. As a result, a lot of the care of the elderly and other persons with chronic disability and chronic diseases, is being done by unpaid care providers, if you will, we call these informal care givers and they really need assistance and relief. The numbers are staggering, about, over 25 million Americans, many of these people have jobs and children are providing 80% of the home for ailing and vulnerable people. Some of it just a few hours, but some of it up to 40 hrs. or more a week! It almost affects a quarter of U. S. households. I saw that information from the AARP in the National Lines of Care Giving and some of the information, again, is enormously staggering if we want to consider this as part of the healthcare reform.

First of all, 73% of the care providers are females. These are, 2/3's of them are married, they are in their mid-forties, they are taking care of children at home, they don't make a lot of money, the mean income of the homes are not great and yet their expenditures are great; 64% of these women are working while they do this and they are taking care of relatives, many of whom are old (mean age of these relatives is 77 yrs. old). They're

very long term situations – some of them, the mean time, is 4_ yrs, and some of them can last 6, 7, 8 years. I think more and more people are realizing that this is happening that more hours per week are necessary by these informal caregivers. But you want to think of the big picture of what's happening in health care costs. The market value of this unpaid care is over $190 billion dollars. Part of it's out of pocket, but $1.5 billion dollars is paid for this. I think people, doctors have to realize that this is going on and I don't think they know that.

Dr. Koop: Well, it is a tremendous problem and it's going to be compounded as the present baby boomer generation gets to the age where they go from caregiver to the person who has to be cared for. Now, I am reminded when I was a kid there was a joke that went, "who takes care of the care of the care taker's daughter while the care taker is busy taking care"? Now, it's not really funny because, while I think that speaks to, is the tremendous drain on energy that this whole thing you are describing brings, and it means that we've gotta think very, very carefully about the fatigue and the burnout and how we can provide respite care for these people who need it so badly.

Dr. Goldberg: Absolutely, and in this regard, as you know, we are both interested in E-health; I see a role for E-health that might help, at least provide some support for these people. E-health can provide tele-education, it can give them information that they need because a lot of those hours, having experienced this in my own family, are spent searching for information. It also can provide tele-care by helping to do remote diagnosis and remote monitoring and it can also provide tele-support. The years that I have known you, I know you are an advocate of self-help as am I. This gives you a chance to electronically, to link up either by e-mail or some of the chat rooms and get some support, or just by having the family members be able to contact each other through electronics. This will be some help and some diversion for some of the families.

Dr. Koop: There is so much more to it than that isn't there?

Dr. Goldberg: Absolutely, really what tele-healthcare really means is, tele-medicine means you can do health care anywhere, anytime, for any reason, wherever you want it, where ever you need it. We can integrate for example, chronic disease types of guidelines through these protocols, through this mixology, we can provide the kinds of information that people need and the support they need. But I think more to it is how we do it. We now can use multiple technologies and they don't all have to be expensive. Some of them can be very simple, you can just do it through a telephone and now telephones are combined with the Internet or through TV, through Web TV. A lot of the elderly are using Web TV that has large font to make it easy. They also can be done, of course, through computer and now the use of hand-held devices. And the multiple ways we can do it. We can do it through wireless, telephone through cable, and satellite.

What I think is interesting about this, we've always thought of the health care system as having 4 basic needs: Tele-health and E-health can give them access - access to both health care delivery and information. But also, if we hopefully scrutinize it well, with health care research and outcomes research, and affect the costs by doing it with less cost,

we can improve the quality and also from the preliminary studies that some of our colleagues have done, a great satisfaction of all those involved. So it looks like E-health might be of a great deal of support for the person at home with chronic disease and disability. Now Dr. Koop, I know that you have created Dr.Koop.com and a lot of people would like to hear you talk about that, I know –

Dr. Koop: Are you sure?

Dr. Goldberg: I am sure. I think so. I know why you did it because I've known you a long time. You really wanted to provide patients with access to information. You wanted to give them a portal, you wanted to empower people with health self-management, you wanted to encourage an informed dialog with physicians and patients as partners in care. But we all know that you have had some difficulties, commercially with Dr.Koop.com. What I would like to know, if you can discuss some of the conceptual problems that you can identify with your original idea.

Dr. Koop: Well, the first thing I would like to say is that the Internet is still the best way that I know of communicating the two life-worn messages I've had for patients whether they were one on one or the entire country when I was surgeon general. The first of those is take charge of your own health. The second is there is no prescription I can give you that is more valuable than knowledge. Now, Wall Street to the contrary, I think that the Internet, eventually, when things come to rest, will change the way that medicine is practiced and I think it will change it for the better, and I think one of the things that it will do and I would like to show it to you if we had more time, and that is giving people a better understanding of public health. Any time you can get the public to understand public health, that is really a plus for them and specifically I can say this, that I have learned, I'm not sure everybody has learned this, but I have learned that you cannot support a health Website by advertising alone. And I think the failure of so many health Websites is a tragedy on the one hand but if you look at the way these companies were managed, including my own, I think you could pick out what went wrong and what could have been done differently.

First of all, I think they all shared one thing in common. A profligacy in the way they handled money. They handled money as though there was no end to the cash and as a result, the burn rate, as they call it in the trade, was excessively high and suddenly the burn rate exceeded the income and that's why so many companies did fail. But the dot.com's also were riding on the tail of a very high market of technology stocks. And, this is a very highly volatile market, it was a psychological market, and I don't think that many times that many of those stocks; there was a real connection between the price of the stock and the value that the company had to our society. But the other thing is, it was all free, and, I don't know how long the American people will expect to get accurate debt information about health without paying for it. They are willing to pay for any other kind of advice, but health, they would like to have free on the Internet. But just suppose, right now Dr.Koop.com was within a just short distance of having 3 million registered users, that means they have shared some of their health problems with us, we know their zip codes, we know their diagnoses, but no other things that would let anybody disturb their

privacy, and these folks get an e-mail letter from us once a week on the problems they have and it's a valuable service. But suppose that those 3 million people paid us just $5.00 a month - $15 million dollars a month would enable a company like ours to make a Website for health that is beyond the wildest imagination of people who use these things. But, having said all of that, which is sort of past history, as I look to the future, there is one major thing, if I could do just one thing, I would bring about the cultural change that we need for medical doctors to get themselves in the loop and refer their patients to the Internet. Because the well informed patient is not only empowered to make decisions in tandem with his or her physician but it establishes with the doctor a higher level of communication and understanding and they can talk at the graduate school level instead of kindergarten level and the doctor doesn't have to start talking to a patient with coronary heart disease about the heart being a pump, having 2 valves in it, these vessels on the outside, he can step right into the field and geography of angioplasty and this patient is able to follow him right along that way.

Dr. Goldberg: So you see the biggest problem now is getting the doctors and patients to work together in tandem. That, however, I think is going to require quite a physician cultural change whatever we call this MD/patient relationship that we're so concerned about having lost. How do you think we'll do that?

Dr. Koop: Well, you and I have been teaching people for years, and you know as well as I, that it's much easier to teach a layman than it is to teach a doctor. But, let me put it to you this way. I have to use my hands to describe it. Suppose that you ask me "what are the things you do as a doctor?" Well, I take histories, I do physical exams, I am a scientific and medical resource, I'm a compassionate friend, and I am also a health educator. These four are inextricably tied together in that mystical thing we call the doctor/patient relationship. But this one out here, health education, is not really part of that. So, I can't give up any of these, but I can give that one up. And so, if we can teach the doctor that by giving up his function as a health educator, he would have more time to be a better doctor, more time to have a better relationship with his patient, and these days when we have the constraints of managed care, that's really the only thing I can think of that the physician can give up and not loose a tremendous amount to us going out into the world. And doctors have to accept the Internet and they have to accept it in the same way I think that the public has accepted it, and when they do, I think we'll have a system that is really unbeatable. And, physician-guided use of the Internet, by patients, works. I know it from the kind of e-mail we get from our patients who use the Internet. And, when doctors really understand this, I think that they will be willing to give up their health education role and move into this thing. And if they can accept that, we will have much more time to spend with our patients if we have turned over the health education function to the Internet.

Dr. Goldberg: Do you think that the doctors who might have been part of the problem now that they have this cultural change and understand that this is reliable information like an educational prescription, and the doctors can now be part of the solution. Now this is a very great concern for us at the American College of Chest Physician's because we as many other associations have very high expectations for integrating and using the

Internet for physician education for our post graduate CME education and also hopefully have physicians integrate this for patient care. This just doesn't seem to have happened and right now the American College of Chest Physicians is undergoing a major re-thinking of our strategy including our e-strategy. But what I'd like to know is what you think of the current status, future projection is for the use of the Internet for the use of these educational purposes. What barriers kept them from happening? And what benefits are there for using the Internet in physician practice and physician education?

Dr. Koop: Well, I think all of us who have been through this turmoil, that is involved the health space so much on the Internet agree on one thing and that is if we could anchor the Internet enterprise to a bricks and mortar enterprise we would have a much more stable company, we won't have to rely on the Internet alone. And, you can draw a lot of scenarios that we practice today in medicine that could be improved. For example, your mother goes to see the physician and she comes home and says, "oh, I forgot to ask him the most important question," and what does she usually do? She telephones, she gets the nurse or receptionist and "I'll have the doctor call you back," so she stays home for 3 days, he may play telephone tag with her, he may not, maybe he never calls. If you have a group of physicians who have become very comfortable with e-mail and you have patients who are also very comfortable with e-mail, it makes a whole new scenario. Your mother can just type in "I forgot to ask you this doctor," he can answer that question immediately, he can add a word of comfort such as "I never saw you looking better Mrs. Goldberg," and she can take that and read it all day if she wants to. I come from a community at Dartmouth, where we have been steeped in the Internet for years and years and that's the way many patients communicate with their doctors. I do this for my wife and me every morning if we've got a problem and at our age we have many problems.

Dr. Goldberg: And they might even say some things that they wouldn't say verbally.

Dr. Koop: Well, there is a certain amount of privacy that you can say, for example, I went to the study a couple of years ago on the things patients don't like to talk about and found that all of them are willing to put it down in e-mail such as "I'm incontinent" or for a man to say " I dribble and wet my pants."

Dr. Goldberg: I really wonder though as I see my own colleagues, some of them have embraced this Internet with such a quick speed, and others are absolutely holding back. I think there is a great issue here that the systems do not understand all of their users, these are technology driven systems. They are not necessarily user or need driven systems, and we have to develop these based on understanding. The culture of the physician, we have to understand how to do change management. And I wonder, what has been the success that you've seen? You've talked often about Dartmouth and the Dartmouth community. What do we do to make this happen for those that don't, that hold back and many of them are an authority, they are in charge of some of the programs we go to, trying to get the programs underway.

Dr. Koop: I can tell you right off the top of my head that you'd think that all the things you learn about dealing with patients would teach you how to deal with doctors, that's

not true. They're a different breed, some are very uncomfortable with the Internet, some are uncomfortable with change but the place that I learned this Allen, was in the messages we gave about smoking. The health effects of smoking are the same on everybody. But the message about how that is delivered cannot be the same to everybody, and unless you attune a message culturally to the people who are going to hear it doesn't work. Now, when I say something like that, I think what comes to mind are people "oh, an African Tribe or Native American Tribe, or people in Indonesia or people in Australia, actually, if you make a pronouncemento in a city like Philadelphia, that's going to be absorbed differently in 27 different ghettos that have long standing European cultural ties to a kind of medicine that maybe you and I don't even understand.

Dr. Goldberg: So, you see the importance of pervasiveness of culture not only as physicians, who represent a culture in the way we think, but also the kind of ethnic background we might have.

Dr. Koop: Well, we have got to study what doctors think about this more than we have and we've got to cater to the individual user who is a physician, and we've got to ask him what he wants us to tell them.

Dr. Goldberg: Do you think that some of the younger physicians who are embracing this can help out some of us who take a long time to adapt? In other words, do you think some of the technical barriers can be overcome by some of our peers teaching each other?

Dr. Koop: Oh, I think there's no question about it. You can almost divide the medical population into thirds, those who have most recently graduated from medical school, they grew up on video games, they know more about this than you or I will ever learn or forget. There's a group at Dartmouth called the Dartmouth Co-op and it's composed of about 350 physicians from Maine, New Hampshire and Vermont; most of them in family practice, most of them in some kind of primary care like pediatrics and we surveyed them a couple of years ago and they fit into 3 categories: 1.) Those who are really facile with the computer and knew their way around the Internet; 2.) Those who wish they could; 3.) and those who didn't want you to speak to them about it again. But what happened at that meeting was that those who were facile said, just what Lauderbach said in Africa, "why don't we have each one teach one?" and so those who knew the most took those by the hand who didn't want to hear about it and taught them step by step, how to feel comfortable with the computer and how to access the Internet.

Dr. Goldberg: This idea of peer support, I think resonates on a theme we've been talking about the importance of mentoring – this is a way we can mentor each other – don't you thing?

Dr. Koop: Exactly. And, I have also found that physicians who have not been very anxious to get involved with the Internet, you might say they were dragged into this medium kicking and screaming; once they master it, they really acknowledge "how did I ever get along without it before "?

Dr. Goldberg: It's interesting to see the difference with the consumers - last year you mentioned in our chat that the #1 application of the Internet, all around the world, is the consumer looking for health information. And the Internet has worked for that for getting to the consumer – and I wonder why that worked? What was the reason that the Internet worked for them?

Dr. Koop: I think maybe would it be overcoming technical barriers because you're working with your peers? I don't know.

Dr. Goldberg: Well, it seems like they really start, they've identified a need, truly identified a need, and they get some very different targeting. I remember some of our discussions during the year you mentioned that they were targeting the female baby boomer. The female baby boomer is the decision maker who is concerned about both her health, her children's health, and the person who is elderly in the home, her husband's health, her parent's health, so they have done some very, very interesting things - they seem to be more comfortable with the comfortable with the computer than physicians are so I think your idea of peer support as a means of mentoring maybe a solution that we need to add to good marketing and good need identification.

Dr. Koop: I'm glad you mentioned the female baby boomer because we as physicians who try to communicate with a group of people should never underestimate how powerful that lady is, because as you said, she provides the health decisions for herself, her spouse, his parents, her parents and their children. So, except for kids between say 18 and 28, she makes all the medical decisions in the country!

Dr. Goldberg: Maybe one of the solutions would be if we targeted the physicians with the same understanding of their needs, their culture and instead of pushing technology upon them, look to put those needs and what their user capabilities were, maybe we would get more physicians (cross talk here)

Dr. Koop: I come back to what I said earlier Allen, we don't know as much about physicians as we do about baby boomers and I think they are more private people and I think there is a sense in which when the physician finally is out of practice, he is overcome tremendous number of preparatory territory hurdles, and now, you and I come along and say "hey, here's something new, you've got to do it differently."

Dr. Goldberg: Last year we talked about our concerns, the big issues, and Al Lever a few moments ago summarized them. I think #1 was the issue of the impact of managed care, #2 was the physician/patient relationship and our poor communication in what we thought might be the future. We discussed last year the importance of having a vision and we discussed the importance of physicians in leadership. Taking on leadership roles, that physicians could effect and determine the future of the practice of medicine. You know, we had the text of our talk on the Internet and it's still there on www.chestnet.org and we made a session – a videotape that's now been produced and hopefully will be distributed to the ACCP membership and maybe to the public. I've used this. I've used this for medical students, I've used it for residents and it's amazing, it totally stops them,

there's total silence as we now have in this audience and the people say, "Yes! What can I do to get involved? What's next?" What should we tell them?

Dr Koop: Well, your experience is exactly the same as mine. The current talk I give to medical students is the ten issues in American medicine that will form the backdrop against which you will practice. And, of course it arouses a great number of questions, and they always say, "What can I do now so I can prevent the problem that my father's in?" Well, I have to make a confession to you and tell you that when I was early on in the practice of medicine, I thought that politics in general was dirty. After I became Surgeon General, I KNEW that politics was dirty! But, I think that the mistake I made was to assume that medical politics would be like national or state politics and it is different. And, I think the great mistake that I made in my career, was not to be part of the medical political process. Sure, I belong to the AMA, I belong to the County Medical Society, I belong to the State Medical Society, and I occasionally even went to meetings, but I never did anything active, I never went to lobby anybody, I never went to the state capitol to try to be a part of a committee to change things. So, the first thing I say to a medical student is "join a medical student organization because you cannot change the future of medicine from the outside but you might be able to change it from the inside." So that's the first thing I would do and I think if we had, all of us, taken a bigger and better interest in medical politics, we never would have lost control of the doctor/patient relationship. If we had been more interested in these things and I know it's a tough job for physicians, we spend a 1/3 of our lives preparing ourselves to be patient advocates. And actually, we're so busy doing that, once we have the ability to do that we don't like to get mixed up in the politics of medicine. But I think we're going to have to make a compromise because if we continue to let other people run our business, we will become journeymen and we cannot afford that we have got to stay the professionals that we are. So, if we are going to get involved with healthcare policies, we have got to do it as early on as we can and I look forward to the day, Allen, when medical school organization will have chapters in various medical schools that the American Urological Society would have a chapter in a medical school. And, we've talked about this a little bit before, but, if we could establish medicine as the "guild" that it used to be in the United Kingdom, and if the young medical student when he said finally "I'm going to be a doctor, I'm a pre-medical student at college and I'm going to medical school", we have the obligation to put a collegial arm around that youngster and say "welcome to the guild," this is the thing you've got to think about. These are our major problems now, some ethical, some political, some are financial but we'll work them out together.

Dr. Goldberg: What I hear you talking about is the theme of mentoring, something that you've done, I know personally, and that I have tried to do for other people. So, very important to have a mentor to go through this, but also, I hear something, I recall you made a visit to me when I was in my previous employment sitting in my office and you called me up and realized I was struggling with things trying to get them to happen, in a way outside of organization – and I will never forget the day you came walking down the hall, I don't think the people in the hall will forget it either, because when the Surgeon General walks down the hall unexpectedly, it's quite a scene. And you came to me and you said, "you're never going to get it done this way, you've got to stop what you're

doing it and get involved with organizations," and personally, that is one of the reasons I got involved with the American College of Chest Physicians. I saw an organization that could make a difference by the collective work that we do that would improve people's understanding. And I found my working associations, and my encouragement now and my residents and my medical students to get involved with those associations - has given them now an outlet for their energies – they are starting to realize that the problem is on their future, environmental screening and getting involved with organizations and taking on the role of leadership is something we've got to do as mentors and I appreciate you having done that with me.

Dr. Koop: As Surgeon General, I automatically sat on the House of Delegates of the AMA and I really fairly enjoyed those years, they were very good years. And the thing that stands out in my mind most, is the fact that many of the things that I cherish that the AMA stands for was introduced to the House of Delegates by the Student American Medical Association.

Dr. Goldberg: I sense that energy and enthusiasm of young people right now and they do have the ideas, but they don't realize that they can make a difference. You know, last year again, you felt, you gave a lot of people anxiety by the way, who read those texts and saw those films, the time was very limited before health care reform would be literally done to us, would be imposed upon us in the United States if our current market and regulatory approach continues to fail. You said at that time the number one indicator you were concerned about was the rise in the number of uninsured working Americans, not poor people, but working Americans which eventually would be your projections reaching a number so high that it would be absolutely intolerable, intolerable for us to be part of the global economy. And you said at that point, this would limit us, that would be imposed upon. Now, you've brought up politics and I am going to bring up politics. Everyone knows that we are about to approach a very critical decision that is going to affect the future of health policy in America, the 2000 Presidential Election. I don't want to ask you who you think is the better candidate or what the better platform is, I don't think that would be appropriate. But I would like to say a question, I think, for members of the College would love you to say the following: If you could give timeless advice, timeless advice to each presidential candidate if you could have that access to them, what do you think they should think is the main health issues for this discussion?

Dr. Koop: Well, I've been through this in the last debates. In the 3 debates, I watched those and I really got frustrated and furious because they were talking about things, (a) as though they could fix them, and (b) they were talking about promises they could never keep. And the thing that bothers me most about the situation in this country, I will put to you in the form of a question. Don't answer it. "What does every industrialized nation in this world have that we don't have and what does almost every other nation have that we don't have?" We have not got a Minister of Health, a Secretary of Health, who is a physician and devotes all of his time to that. We have for as long as I can remember shared the tremendous profession of medicine at the cabinet level with education, with welfare, with human services. We need a president who understands that is the wrong way to go, that we need a cabinet officer who is a physician and remember that whatever

the government wants to do administratively, if they do not have the doctors, the nurses, and other health care professionals with them, they never will be able to succeed. But you put in the cabinet a doctor who understands what you and I are talking about today and who understands that medicine has to be part of our foreign policy and that we have to have something that does indeed globalize health, then you will have the people in this country rally around that foreign policy about health and that president will be successful.

Dr. Goldberg: We've found something with this person in this new position something we'd like to have, we finally have something that disturbs us. Also, that we do not have which is really a health policy. We get a feeling that the financial decisions of our managed care organizations, our insurance organizations and some of the regulatory decisions of Medicaid and Medicare create a health policy and you're looking at it very differently, issues-based, needs-based, truly on global health which is the issue as you say we are going to be hearing a great deal about now that we have passed the millennium.

Now due to the response of our first fireside chat, which was absolutely incredible, I was very grateful to Dr. Richard Irwin and Dr. Susan Pingleton to give us another chance to have a reunion today. We hope that others can enjoy the transcripts of last year and the one that will be created for this year and the videos I told you that have been produced, not yet distributed, we hope they will soon be available for distribution to our ACCP organization and probably beyond. As you know, having you as my mentor all these years through my professional lifetime has meant a great deal to me. You've taught me the importance of mentoring and hopefully I have done what you have asked me to do which is to find other young people and mentor them. And I am very, very grateful now as my mentor that you've shown a willingness to work with me over the next year. I just want to talk a moment about that.

We're going to try to work together as I understand, to create some more of these thought provoking discussions and maybe some multi-media educational products that will really highlight those kinds of key issues that we're facing as physicians and that the public is facing. The global leads that really now have to be looked at make things right in our so-called system of healthcare. Because I think as we demonstrate the importance of mentoring which I think should be obvious to you in the audience has been a major part of our relationship, I think we can really start to re-invigorate physicians as leaders to promote the health of their patients their families, with the emphasis on globality of their communities, a major theme of the American College of Chest Physicians and The Chest Foundation (ACCP's philanthropic arm) as you know. We also hope to encourage more health –promoting partnerships between physicians and their patients. I think what we need to make sure is everyone who is a physician maybe frustrated with what we are dealing with right now, but we can understand that if we do work together, we can make a difference.

Dr. Koop: There's no question in my mind about that Allen. The thing that bothers me when I talk to young doctors and students as we have been talking now, is they go away pessimistic, and that's never my intent. I tend to be a pessimist about my problems but an optimist about yours. And, I think that medicine is just too wonderful a profession to

let anything happen to it. And I think if we as a profession realize that whatever it is that we do, whether we're fighting cancer or working for this wonderful fellowship, it's going to be against a backdrop that never has probably been as severe as it has at this time. We heard Mr. Richard "Dickie" Scruggs talk about managed care and its problems, which we all understand fully well. I think, but we also have the loss of professionalism that we talked about last year and that makes it difficult to be the kind of doctors that we would like to be. We have seen mergers of all kinds of medical institutions that haven't fulfilled our high expectations and now they're un-merging and there's a sense of pessimism that we tried one more thing and it didn't really work. Academic medicine itself is fighting for its very life and if something doesn't happen in Congress to change the legislation that is now set for the future in the Balanced Budget Act, academic medicine as you and I were raised in it will become a thing of the past. And, we can't let that happen. And, so, I guess my closing remarks are a plea for all of the people in this organization for all physicians to get involved in the political process where they will have a say in how we can move toward the optimistic future that everyone of us has the right to believe in. And, I used the word "journeymen" before and I would just close with this one thought; if we let the Congress and the courts make us as professionals into what appears to be journeymen, journeymen we will become.

Dr. Goldberg: I thank you for today as I always have and for your wisdom and encouragement. The last years I have known you have been difficult years for all of us watching what we believed in and what we saw, literally being destroyed by others and I hope that physician leadership, working with our patients, that partnership is powerful – can really make an impact on some of the changes that are about to occur during the time limits that we have. We truly believe this in the American College of Chest Physicians and we're trying to get our members to take that activity.

Dr. Koop: If I didn't think we could win, Allen, I wouldn't be here.

Dr. Goldberg: We thank you for coming in person this year, and I look forward so much to working with you this year. Thank you for coming.