A Conversation Between Drs. Koop and Goldberg—1999

Allen I. Goldberg, MD, FCCP, 1999 President of the American College of Chest Physicians, held a conversation with his teacher and mentor, former Surgeon General of the United States, C. Everett Koop, MD, by way of satellite technology.

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AL LEVER: Good morning. I'm Al Lever, the Executive Vice President of the American College of Chest Physicians and the Chest Foundation. And on behalf of the President, the Officers, the Board of Regents, the Governors of both the American College of Chest Physicians and the Chest Foundation, I'd like to welcome you to Chest 1999 and the 65th anniversary of the American College of Chest Physicians.

Traditionally, it is the opportunity of the scientific program chair to make this introduction. Dr. Udaya Prakash has asked me to welcome you to this meeting and that he has recently undergone corrective surgery for pericarditis and I could report to you that he's recovering very well and that he has expressed his personal pleasure of welcoming you all here. And I know tomorrow in his tele-education program that we're doing cooperatively with the Mayo Clinic, he will also welcome you all to this program.

I'd also like to thank all of the program committee who have really put together an outstanding program for all of you during this week. We are doing things to make a difference, and some of the things at this program are done differently, and some of the things are different. A couple of things that we will be doing is a women's health track, women's health/nation's wealth, a track on the collaborative efforts to improve the care of inner-city asthmatics, as well as the tele-education and tele-medicine tracks.

This program today, too, is different. And I'd like to take a moment to introduce two people who all of you know: Dr. Allen Goldberg, the President for the past year of the American College of Chest Physicians; a pediatric critical care and with a particular interest in home care. He's developed the home care section here at the college to be another very meaningful activity that we are addressing to take care of the patient.

In addition, we have one other person that you will be shortly introduced to: Dr. C. Everett Koop. Most of you know him as the icon who has stood as the past Surgeon General and has fought together with us in the wars against tobacco.

But today, I'd like to do a little bit of a different introduction of the two of them. Over the past year, I've had two opportunities to spend afternoons with both Dr. Koop and Dr. Goldberg discussing from the time that Allen was a pediatric anesthesiologist resident at the CHOP—that's Children's Hospital of Philadelphia—under the tutelage of Dr. C. Everett Koop, the very famous innovative pediatric surgeon. The time that we spent together really demonstrated, number one, how mentorship works but more importantly, how it transforms from one person being a mentor to two people not only becoming colleagues but friends looking at the direction and the future of medicine.

This presentation today, more like the fireside chat, is the continuation of that dialogue that they have had since they worked together at CHOP. And it is my pleasure to introduce a little bit different, more like sitting back and watching a movie with Andre, really Allen and Chick continuing that dialogue that's gone all these years. And if we could give a welcome to our President, Immediate Past President, Dr. Allen Goldberg.

DR. GOLDBERG: Good morning and welcome. This is no ordinary congress. This is no ordinary convention. This is going to be different. And to make that demonstration to you today, we are using technology which I think will be part of our lives, part of our practice, and certainly something that we're going to need to understand. And we're going to demonstrate the value of having a mentor.

Dr. Koop, good morning. I can't hear you. Can we bring up the audio? I'm going to ask you the first question to get started.

Dr. Koop, you have been always discussing with me over the years, from pediatric surgery years through your time in government and afterwards, you've been guiding me. You've been trying to help me understand how to prepare for my career. As we approach the new century, what is the most important concern that you have?

DR. KOOP: The most important concern that I have, Allen, is the vexing problem of managed care. But before I say anything more about that, let me just get two other problems that might even be bigger than that. They are so big that we have no foreseeable future solution for them. The first of these is what we're going to do with the burgeoning elderly population and the chronic health care problems that they present to us. The second is how do we handle the tremendous amount of information that is exploding in genetics, especially genome, and how can we take the proper steps to protect the privacy and confidentiality of genetic material so that people do not have their lives ruined by that knowledge.

Now let me get back to managed care. I think that there are several things about managed care that we all understand. Older managed care was not the way it is today. They really were very concerned about prevention. This is 30 years ago I'm talking about now. They maintained health. They were truly health maintenance organizations, and they only did necessary and effective treatment interventions.

Today, I think the perception of most Americans, both doctors and patients alike, is that the present HMOs, the present managed care people, are interested, first of all, in controlling costs and very secondarily in maintaining health. I do not believe that market forces alone can possibly take care of all of the things that you and I are concerned about for patients.

The greatest concern I have is that managed care encourages physicians to actually withhold treatment because it's to the benefit of the stockholders of the company that

governs their medical care. This, I hope, is a very temporary aberration in the way of practiced medicine in this country for a long, long time.

DR. GOLDBERG: Dr. Koop, is there any way that physicians can make a difference in this situation?

DR. KOOP: Oh, I think physicians are the key to the situation. I think that some of the things that we may be able to discuss later about the Internet can show that doctors with a new educational process can fill in many of the gaps that managed care has left in the minds of our patients about quality of care.

Now, one of the things that I think that we want to do, Allen, is not get bogged down in any one subject. And let me move on to another one besides managed care now and ask you if that's my number one issue, what should be my number two or perhaps is your number one? What do you think is the most pivotal problem we face today?

DR. GOLDBERG: I think it relates to the managed care issue. It's what has happened to the physician-patient relationship. I see a great loss of respect by patients of their physicians. Part of this is due to the time constraints, the paperwork, and attention to other things than good communication and, in fact, what I think has been poor communication.

There also, I think, is a loss of something that's tradition; a tradition that I saw in my role models. Perhaps we don't have those role models anymore, those persons who can mentor the way you and other key people in my life have mentored me.

There's also a change, I think, in what the patient is becoming. The patient is becoming more self-aware, educated, empowered with knowledge. We ourselves as physicians I think have to change the way we relate to our patients, more like a partner, like an educator, to encourage that empowerment. And this is not something we have the time or necessarily a model that we were trained to do. So as times change, some of these traditions have to change, and the ways we relate to our patients have to change to regain that respect.

DR. KOOP: One tradition I'd like us to go back to, Allen, is the professionalism that you and I were raised with. I think if we had return to the professionalism that was the heart and soul of our practice of medicine, we would have much more satisfactory relationships with our patients. And I would remind you that the hallmark of the professional is that he always puts the needs of his patient, his student, above his own. And managed care will either buy this hallowed hallmark of our profession or, if we take the proper steps, if we police ourselves, if we give back to society some of the things they gave us, I think we can actually get back to the old doctor-patient relationship. And, of course, the new forms of communication will do a tremendous amount to help us.

DR. GOLDBERG: I remember many years ago, you and I talked about education and getting to people very early. In fact, you wanted to get to people before medical school.

One of the visions that you had many years ago was to have a new approach to education. In fact, you've created at Dartmouth the C. Everett Koop Institute. I wonder what you're doing there that's innovative that has helped to have physicians change their relationships to patient? How have you helped to foster this professionalism in this opportunity that has now become a reality to you?

DR. KOOP: Well, as I talk to the public, they tell me the things that you hinted at a little earlier. They don't trust us the way they used to. They think we're always overly busy. And if you say, "What bothers you most about your doctor," it's always the same answer: "He doesn't listen to me." And you say, "Well, what bothers you after that?" And he says, "Well, if he talks to me, I don't understand him." So we as physicians who think we are great communicators really fall down not only in listening but also in explaining.

DR. GOLDBERG: Are there ways that you will be able to encourage the physicians in your training program to be able to deal differently with patients to be more professional?

DR. KOOP: Well, the thing that we did that I think has been most effective is we have put first- and second-year students team teaching grade-school kids. And that helps everybody. The pupil in grade school benefits. The teacher is empowered by the medical student. The medical student learns how to teach children.

But that's not why I did the program. I did the program to make those young men and women communicators. And the instructors in the third and fourth years tell me that they know which students took our elective courses in communication by working in grade schools because they are at home with patients, they're not embarrassed, they ask the right questions. But most of all, they listen, and they listen, and they listen.

DR. GOLDBERG: I agree with the communication problem. As you know, we started together home care at the Children's Hospital of Philadelphia. And you've stated in previous writings that you've done that you learn more in one house call than you can by having ten visits to an office. The liberty even now to do house calls, the time constraints that puts on people, what a tension that time constraint is to foster this communication.

I mean things are changing, Dr. Koop. You've been alive most of this century. We have new realities. Can we maintain these traditions, or should we change some of the ways we do the new professionalism?

DR. KOOP: Well, let me put it in a different light. I don't think the most visionary person sitting before you in that audience has any concept of the tremendous changes that are going to take place in the practice of medicine because of the communication possibilities of the Internet. It is the communication of the future, and it combines our three present forms of communication: television, telephone, and the computer.

DR. GOLDBERG: Well, I agree with you. The American College of Chest Physicians is monitoring this very closely as we change from a format of education to the electronic age. Information such as 34% of U.S. adults are now using the Net, and they're using it to

search for information about health. That's in 1998, 22 million Americans searched for information.

Of interest, these are the persons over the age of 50. You suggested before that the burgeoning number of elderly is going to be an issue. These older persons are going to become savvy; and with the simpler technology, the telephone access, for example, to the Internet, they will be getting this information.

Also, doctors are starting to use the Internet more and more. The surveys that I've read said that 85 percent of doctors now are on line. 63 percent of them use e-mail daily. About half of those are for communicating with patients. These statistics show this is a real trend to be dealt with.

I guess the question I have for you, Dr. Koop, is when they use this, how do they know the information they're getting is reliable?

DR. KOOP: Well, that's the sad thing. There are, of course, now almost 20,000 health sites on the Internet. And because right information, wrong information glows with the same intensity on the television screen, the poor consumer, unless he is really smart about medicine, doesn't have much to help him.

And so what we have decided the answer is branding. You have brands in television. You have brands in cars. And I think that branding of web sites on television that have to do with health are extremely important.

It's no secret that I have gotten deeply into this field with drkoop.com. And I just received word last night that the number of people that visited our web site in the month of September was 14.2 million. That is almost inconceivable just six months ago.

But by doing that, Allen, we can not only become the educator of the problems that the physician hasn't got time to talk about, but in the process, we empower the patient to make decisions in tandem with his physician about diagnostic and therapeutic procedures. And I think that's what's going to change outcomes in the future. And the cultural change has to be that we as physicians recognize that the time constraints of managed care force us to use some other health educator to close the gap.

DR. GOLDBERG: This is an extraordinarily important point. The use of this for communication, will this be satisfying the patients, if we send e-mails to them, the way we used to when we had face to face? How are we going to integrate this information technology so that we can practice medicine and still feel that we're partners with our patients? We must make this change as the world is changing, and this has become a prominent part of our life.

DR. KOOP: It takes a little time for a community of physicians to become familiar with and comfortable with the Internet. Here at Dartmouth, we have a small college of 5,000

students, faculty of about 1,200, and a small town to support it; but every day, we send 250,000 e-mails.

Now, that means patients are communicating with doctors. And this is one place, Allen, where high technology is not going to separate doctor from patient; it's going to bring them closer.

And you refer to the elderly. You know, in the trade, they call these the Wired Retired. And they are really burgeoning in number, and they're becoming very familiar with the ability to ask a question of a doctor that they didn't ask when they were with him in the office.

You know how things are with doctors and patients ordinarily. The patient's always a little bit awesome. She's scared about the relationship. Now, the managed care time clock is ticking so fast that she doesn't want to disturb the doctor who seems to be so overly busy. But what happens? She goes home and says, "I'm going to call the doctor and ask that question I forgot." So they play telephone tag for two or three days or he never calls back. Suppose she just takes 30 seconds and asks the question on e-mail. He can answer it in 90 seconds, add a word of comfort. She can download it, read it ten times that day if she wants to. It certainly is the thing of the future.

DR. GOLDBERG: It seems to me that this is a trend, and we have to look at a trend like this, and we have to make very basic changes. What I like about what you said is it reflects on another value I know we've discussed over the years: the importance of self-help, the importance of empowering patients and educating them so they can become our care partners. This is an important adjunct and something that I know that you've always believed is a major part of your practice of surgery.

DR. KOOP: Well, I agree with everything you said. But what's going to take the place of the old self-help groups are the chat rooms on television. We run on drkoop.com 40 chat rooms right now, and we have people there who are knowledgeable and resource people. I think that this is the thing that provides the complement to the good practice of medicine between doctor and patient.

DR. GOLDBERG: What are some of the things that people are concerned about? What are some of the things that they're looking at the Internet for that they can't get?

DR. KOOP: Well, first of all, they approach it in different ways. Some people have symptoms. They can find what that's all about. Other people have been given a diagnosis by their doctor that they don't understand. But they also can approach it by looking at women's health, men's health, sports health, travel health, children's health, immunization, and so on. And then we have things like drug chapters. So if your gynecologist gives you one medication and your internist another, are they compatible, or am I taking a chance with drug reactions?

The interesting thing to me, Allen, is that a great many of the people who surf the web are looking for alternatives. And I think that should lead us into our next subject because a lot of the stuff you find about medicine on the Internet really has to do with alternative or complementary medicine. And I'd like to ask you what you think lies ahead in the field of alternative medicine as it refers to orthodox physicians such as you and I?

DR. GOLDBERG: Well, as I thought about this subject and as we are now investigating this at Loyola University of Chicago where I work, I realize that this alternative, for many of the people, it really is not an alternative. Eighty percent of the world is using what we would consider non-traditional medicine instead of what we would consider more traditional primary care.

But what's astounding is here in our country, the statistics that are being reported in our peer-review journals—The New England Journal of Medicine and JAMA; for example, a recent JAMA issue in November totally dedicated. It showed that of the American public, 34% of them or a third of adults were looking for this as an alternative to what they were getting in their therapy. And the increase is astounding, both in numbers, in visits to the practitioners, and what they're spending. In 1997, they're spending already $27 million out of pocket.

I mean we have a trend here we have to analyze. The insurance companies, the managed care companies are starting to recognize that something's happening here; that the outcomes of people who use it are improved. And as a result, they are starting to give that option to their patients.

DR. KOOP: Let's talk about how we should face this issue. Orthodox medicine is sort of at odds with alternative medicine. So let's start in medical school. What do you think medical schools ought to be doing about alternative medicine?

DR. GOLDBERG: I think one thing for sure, we have to find out if there is any evidence. We're in an era right now where we want to use evidence-based medicine. The challenge is can we use the scientific approach for research the way we have learned in the century when we went to medical school as a model.

I'm not so sure it's going to be easy to understand the mechanisms of these various alternatives or those things that would complement that we can integrate into our medicine. We may have to start looking at the evidence in the form of outcome. If patients perceive that there is a benefit, and if they are healthy, that to them is evidence of a result. We may have to broaden our scope of what we're looking for. If the evidence is improved health, that's the perception of the patient, then we can show that, we have to start thinking very realistically of introducing this into our education.

We run the fear, Dr. Koop, a fear that concerns me because we are starting to do this at the side of our education at Loyola. We're starting to bring in alternative therapists just to teach those of us who are interested. Some of the things I'm hearing really concern me. We shouldn't even touch these things unless we understand them because their use with

traditional medicine or their use alone requires a knowledge base that we don't have. So we must have education. We must become aware of it. We must know how it will interact with what we're doing traditionally. How will it interact with the lab tests, how we can interpret it. We know that patients—yes?

DR. KOOP: I think we're on the same track. I think the least medical schools can do is to inform their students about their general knowledge so that if a patient does come and talk to them and say, "I'm taking St. John's Wort," they ought to at least know what the public thinks St. John's Wort does.

One of the sad things about all this, Allen, you mentioned that figure of 34% of our population that is already using at least one form of alternative care. The second statistic that goes with that which is frightening is that 70% of those folks do not share that information with their orthodox physician when they talk to him. So you have the opportunity for drug reactions and all sorts of things.

Suppose that you were given the opportunity to be the chief of the new section at NIH that is looking into alternative and complementary medicine. How would you spend your budget? What would you want to do with it?

DR. GOLDBERG: What's of interest, and you raised that, is the fact that we have a center at the NIH which shows that we're taking this very seriously. And that center has gone from $2 million to $15 million this year. The increase is astounding, of the budget.

I think my answer to the question would be I would like to try to determine a process by which evidence can be validated, data can be presented to physicians. Because what we have here is a major cultural conflict. We as physicians are taught to believe certain things, to value certain things, and to do certain things in a certain way. And we need evidence and we need data to be able to embrace enthusiastically things.

The challenge I would see is part methodological. By what method can we look at this phenomenon to have evidence that makes sense that at least would start to bring into our telescope and our microscope the possibility that this is something we should do? I don't think we are going to get mechanism-type research. I think that's far off. But does it work? Why does it work?

We also have to broaden our telescope in another way. As I've reviewed this phenomenon, there are different ways that the physicians or the therapists use this. The way you do it, where you do it—I mean, you know I do home care. I think the home setting and the environment is a factor here.

I also think in a lot of these things, there's a cultural element. Various people from certain parts of the world have certain beliefs and certain ways of looking at things, certain perceptions that in their way, their demonstration is clear. So I think we even have to start looking at behavioral research and methodological research that will start giving us evidence that will convince us to use this.

DR. KOOP: You're absolutely right. You know, I look back on my father-in-law, who was an old-time family doctor. And when he died, he had in his vest pocket a little leather book that had his favorite prescriptions in it as well as those of his colleagues. And I went through that, looked at every prescription, and I found six pharmaceuticals that you and I would say have a beneficial effect upon a patient. And yet, he was remarkably effective as a physician, and his patients got well. They loved him, and they trusted him. So there is with alternative medicine this other opportunity that physicians have to return to the art of medicine.

You talked about mentors a minute ago. I remember that when I first went to medical school, we had some real gray-beards who had not even seen or heard of penicillin. Not sulfonamides. But they practiced good medicine. And what they said was use every single thing that is in the patient's own armamentarium, and you will be able to heal that patient. So it includes not only the alternative medicines that we've been talking about, but it includes mind-body medicine. It includes spirituality.

I remember an old doctor saying if a patient has faith, help them rely on that faith. If they believe in prayer, encourage them to pray. Pray with them if you have to.

I think we have a great opportunity not to just be ridiculing alternative medicine but try to marry the good parts of it, separate the wheat from the chaff.

DR. GOLDBERG: I totally agree with that. I think you raised the question before, Dr. Koop, about the elderly and the number of people elderly that we will be dealing with as a percentage of the population.

As you know, when we worked at the Children's Hospital of Philadelphia together, the patients that I first sent home that were your patients, the results of your advances in pediatric surgery had chronic problems. They were there for months and years. I'm concerned that we have another issue to take into the new century and that is we're going to have to come to grips that people will live longer, but they will also have many chronic conditions.

And this is not just the elderly. As we know in pediatrics, as both of us are pediatric physicians and surgeons, chronic disease and disability represents a very prominent issue in infants and children. Our modern medicine is geared up for acute episodic care. Our system is just not geared for the kinds of health promotion and chronic disease prevention and management. A lot of the cost escalation is due to this.

We need to come to a different model for that. Where do we get these care models, and how do we bring this into our education of our young people so that they can deal with what will become a much more prominent part of their exposure?

DR. KOOP: Well, first of all, I think we have to understand the scope of the problem and the difference between children and adults. Most children who have chronic illness, as

you and I well know, they don't remember anything other than chronic illness. And so they grow up thinking, "This is the norm for me." Fortunately, most children with chronic illness don't have the terrible problem of chronic pain that adult patients have toward the end of life.

So they're two different groups that present some of the same problems, but their numbers to me are staggering. Already, as far as the elderly chronic ill are concerned, we have 99 million such people in our country. And those who keep prophetic records of these things say that by the year 2050, we will have 170 million chronically ill people to take care of.

Already, 1 in 4 Americans is devoting a large part of his life to the chronic care of a member of his family or his extended family. And most of the things that are happening that are good are family centered and community based. And I don't think our government has wakened to the fact what you just said about the huge numbers ahead and the fact that it's getting worse and worse.

Where do we go from here? Do you think it's in the realm of home care such as you've talked about? Does it mean we have to have patients' rights bills as are being discussed in Congress now? Do we have to get involved with government in being certain that people who want to give pain medication are not pursued by the DEA? What do you think?

DR. GOLDBERG: Well, I think that we clearly need a reform of what we're doing because we're focused on the wrong thing. I think one of the most exciting things that has happened in chronic disease management is the creation of what are called community health networks. We have one in Chicago, the Chicago Asthma Consortium. We're actually going to spend a whole two days at this meeting discussing community health networks of that type.

The beauty of a community health network is that you get the perspectives from all of the people who should be there. Patients and people in the community, community agencies, voluntary organizations have good ideas, but we haven't brought them into the understanding of ways of changing the system and listen to those ideas. I would even say the managed care and payor community, if they could become partners in some kind of, if you will, a patient, a payor, a provider partnership. We can create a large community of activity respecting the perspective of people and completely change the system.

It gets back to the question of complementary or alternative medicine. What we have are the needs to alter the paradigms, alter the systems, the way we do things. We have to appreciate the statistics you just talked about, the statistics of the increased numbers. We don't have the models that we are traditionally using inadequate models to be able to make this transformation; new way of working together.

What I'm finding in the excitement of being involved in these community health networks is that when you ask people, they have the answers. But we haven't asked people. The whole idea of realizing the importance of empowering patients that you

talked about and taught me and self-help, this is an enormous leap into a new paradigm. Bring them to the table. Create these systems. It's an entirely different way of working, and I'm not sure how it would fit into the kinds of managed care issues we talked about early in the hour.

DR. KOOP: I think one of the things we've got to deal with, Allen, is—and you talk about new ways of doing things. I think the public in general believes that the kind of patient you and I are talking about, the chronically ill patient, this 90 million, they think of them as being institutionalized or hospitalized and that somebody is taking care of them. That's not true. Most of our elderly chronically ill are not institutionalized.

The reason that we have to think about that carefully is that there are so many unmet needs for chronically ill people who are living in their homes. And by unmet needs, I mean help in getting out of bed, help in going to the store, help in getting out of a chair, help in going down stairs.

Those little things, when they are not given as aids to chronically ill patients, result in chronic illness beyond what they have and in accidents which give them broken bones and other things. And that does institutionalize them, and it does hospitalize them. And that not only separates them from their family caregivers, but it increases tremendously the cost that the taxpayer has to worry about as this number of people increases over the next couple of decades.

My point, I think, is that the rest of us have to recognize that 1 out of 4 of us is already spending a lot of his time doing this. We ought to help them.

DR. GOLDBERG: But being in home care, realizing that the home is the setting that a person when they have a chronic illness or disability prefer, and certainly when you're older you prefer, I see a tremendous need. I'm concerned about recent public policy which has made it much more difficult for those providers of home care to provide home care.

One of the last things we need to talk about, since you've guided me with such an ethical foundation for all you've done, is what kinds of ways can we make the change into the new millennium with an ethical foundation? The books you wrote when you were in your earlier years as a pediatric surgeon later on show that you're very definitely directed by very serious ethical concerns. What are those concerns that we now have to deal with? You mentioned some of them to me in our previous discussions.

DR. KOOP: Well, I think what you just mentioned, this is a wonderful segue from the care of the chronically ill to the next issue because the care of the chronically ill is primarily an ethical problem. And when you get a large chronically ill group of patients, they are getting closer and closer to death.

One of the things that doctors do not do well—and you and I know this better than anybody. They don't talk about the thing that's on the patient's mind most; namely, "How

long am I going to live?" We're great at talking about chemotherapy and how much radiation they ought to have. But what they want to talk about is, "Will I be comfortable? Is the end coming closer? And how can we work together to make that the best for me?"

So I think the number one ethical problem that physicians will face at the end of this century and into the next one is the decisions that physicians and patients together have to make at the end of life.

DR. GOLDBERG: We appreciate that here at the college. In fact, we have a whole program, I think was given yesterday, on the end of life: the AMA EPEC Program. We have not brought into our education until recently this attention to the end of life management. And it concerns me a great deal, as many of the issues now with physician-assisted suicide have now become probably the hottest and most heavily-debated subject in all of the areas of our society, the Congress, and the Supreme Court.

The physician doesn't know what to do. They're between being concerned of being told by using palliative management and pain management—there's a very fine edge; not only in the toxicity of the drugs and the use of the drugs but in the concerns of society whether or not they're committing criminal acts versus compassionate care

This is an enormous problem that I think we have to address in public policy and we have to address early on in medical school so we can treat the dying patient with great more dignity and great more opportunity for a better way to end one's life.

DR. KOOP: Well, you and I have talked about this a lot and that is that we have not been well-trained as physicians in the management of pain. We say to patients, "I will see that you don't have pain," but then we don't really follow through and keep our promise about that.

You know that Congress is now discussing a pain control act—

DR. GOLDBERG: Yes.

DR. KOOP: —to try to draw the line between assisted suicide on the one hand and yet not pursuing a doctor who is using, in the minds of the DEA, too many narcotics to keep his patient free of pain.

But I think there's another thing that you and I have discussed that's worth bringing out. It isn't just the pharmaceuticals that we give people. I have studied very carefully what's happened in the last 10 years in reference to euthanasia in the land of my ancestors in Holland. And I think that what happens is this: It may sound overly simplified. But when a patient gets to that point of despair at the end of life, it's because she picks up from her family and from her doctor that they have come to the conclusion that she has a life that now, in their eyes, is not worth living.

We forget that tremendous problem that they have because of our attitude, and we also forget that most patients who say, "Oh, I wish this were over. Won't you help me out of this life," are severely depressed people. And if we treat that depression, their attitude toward life and how it should be ended changes dramatically.

DR. GOLDBERG: I think this subject and others that we've worked with as we focused on chronic disease and disability makes a very key point. We've always gone back to our patients—persons with disabilities. We've said, "Let's partner with you. Let's learn from you." This has been part of our work in self-help. This has been part of our work with the community of persons with disabilities.

We have to hear their concerns because some of them have some very, very good ideas how we can alter the way we communicate, the way we understand their perspective, and the way we can treat those kind of situations. We have to listen. Which gets back, I think, to the issue that you raised early on; that physicians do not listen enough to really understand. We're in situations that I know other than in home care, where I have the time to sit around a little bit longer around the coffee table to see things and understand things in the environment in which a person is to really truly understand where I really get the picture.

I don't know how we're going to change all that, but I think we're getting close to—I mean today is the first day of November 1999. It's just two months when we're going into a very, very new opportunity we call the new millennium. I mean we have to start having some kind of a vision for the future understanding some of these trends that we talked about and many others to be able to help in whatever way you can in a leadership way.

I believe the members of the American College of Chest Physicians are all leaders. They may be leaders just in their communities. They may be leaders just in their practices. We all can make a difference.

I'm interested—you've lived most of this century. You've been a pioneer in pediatric surgery this century. You've been a major figure in public policy in the world public health. I mean there's not very many people I can ask this question to, obviously, that I can talk to the way I can with you.

What do you think would be the future—put on your prophetic hat. As you see the future, what kinds of a future do you propose?

DR. KOOP: Well, it's not what I propose, Allen; it's what I think will happen. And let me confine my remarks not to the Internet, not to communication, but to what probably is going to happen policy-wise.

We've discussed professionalism. We've discussed patients' rights. We've discussed the new things with alternative medicine and so on. I think we are going down a pathway that has a fork in the road ahead of us.

If we read the handwriting on the wall properly, if we help physicians to regain control of their profession and take it out of the hands of the business world, if it truly becomes a medical profession and not a medical industry, I think we'll find our way into the next century with the best things that we've learned about cost containment in managed care with some of the older things that you and I know were so precious to patients in the days of fees for service medicine.

If we can combine those and we can take care of some of the problems of patient concern and doctors' concern about each other, we could have a health care system in the early years of the next century that would work. And we'd look back on the '90s and say, "Boy, it was a tough time, and we almost lost it. But we pulled it together at just the right time. And what we have isn't perfect, but it's sure better than it could have been."

Now, my other great concern is the other path. And it has to do with something we haven't even mentioned and that is when Mr. Clinton ran the first time for president, he talked about the 34 million people who had no insurance. When he ran the second time, he talked about the 43 million who had no insurance. And if you extrapolate 34 and 43 out into the future, you find in about 2002, there might be 60 million Americans who are uninsured.

I think that mass will become so critical that neither they, nor we who have insurance, can tolerate it any longer. So if we don't find a way out of managed care to our benefit, the best of both systems, something like this can happen in the year, say, 2005. Some president will say, "Look, you economic medical pundits. You always told us that if we let market forces take control, you'd give us better efficiency, higher quality, and lower cost. We gave you that opportunity in Labor Day of 1993. And all these years have gone by, and you have failed us. And in addition to that, we have 60 million uninsured people that we cannot tolerate. Therefore, we are taking over as a government, and we are going into a single payor system."

Now, that may be beneficial for those 60 million, but it's interesting that we would come to that at a time in history when every other country that has tried the single payor system has weighed it in the balances and found it lacking economically, ethically, and morally. So we have a tremendous opportunity in the next 5 to 7 years to shape up and fly right. But part of it has to do with professionals remaining professional, teaching all those who follow us to be as professional as their ancestors were, to remember all the opportunities that communication brings us, and see if we can forge a medical system that suits both patient and the doctor alike.

DR. GOLDBERG: Well, I certainly think your vision for the future gives us a variety of paths we can go. And I certainly think there's one thing we will agree on: There will be a future. There will be a future. It's going to happen. And what we have to do is to have some kind of a vision; a vision that we can try to create a future that we want to happen.

The only way we can do that, I think, is by understanding the trends. We have tried this morning to look at a few trends that we see growing. We have to widen our telescope and

look at the trends that are going on, not just limited to health care but the world: the world of economics, the world of social issues, the cultural aspects. We have to have a much broader view. And in that broad view, we have to have perhaps a total shift in the way we think and perceive and do things.

What you're saying is we are going to have to reform things and that these things we've tried haven't worked. And I agree. I think part of the complementary medicine discussion we said is health care reform. People are walking away from one system to another, walking with their feet making that reform.

That reform has to have a new focus, though. I think it needs a whole approach that's on global focus, and I think this global focus works in other countries besides the United States. We certainly have to focus more on health and not just on illness. We have to focus more on the continuity of what we do than just on the episodic on what we do. We have to think in terms that the long-term and the chronic conditions are going to become the most prominent thing that we are going to have to deal with now that we've had such successes in acute medicine.

There are going to be many other things we have to think about just besides the medical issue. The effect of culture on health, Linpair's book, talking about 3 or 4 different countries that in each one of them, it's different in the way they look at health; the effect of a community, the effect of the environment. We have to bring those kinds of components into making this paradigm.

I think we have to realize that if we're going to make global health a new focus, we have to work on the level of the person, the level of the family, and now get to the level of the community. Because we're never going to solve some of those problems unless we look at the community issues, some of which are economic and social, to make a difference.

These are a whole new way of thinking, a new professional role for the physician. I agree we must change, but I'm not sure that the professional traditional role of the last century is what we need. Our physicians have to be partners with our patients. We have to listen, but we have to realize that empowered with the knowledge that they're going to get with the Internet, they are going to be informed, and we have to be partners. We have to be teachers. We have to be facilitators in our community in a new kind of leadership, not just a dominate leadership but bringing to the table what we can perceive of.

I think it's a whole new way of thinking. This is what our future must bring for us as physicians if we're going to be active participants. And also at the same time, we have to understand we need to integrate good management principles, good financial management. We have to be part of the solution for making it economically possible.

I think it can be done, but it requires, I think, two concepts. One is understanding other people. I call it cultural understanding. People who come from different education, from a different way of looking at things. We have to accept that there are going to be cultural misunderstandings. We have to manage them.

The second thing is we have to understand change management. The future will bring change, and we have to learn how to do that kind of change.

You know, as we're getting close to the time we have, I just want to say that you and I have always wanted to have an hour together. When you proposed that we do this, we got 8 hours together, and I'm really grateful for that. It's been fantastic.

I remember still being in your office once, and you said that I could come and sit by the fireplace and put our feet up. I look forward to the next chat we have, whether it be here in Chicago or perhaps in New Hampshire where you are, that we have that opportunity and we can continue this for many years to come.

DR. KOOP: Let me say one thing in closing, Allen. I've always told you privately that you're the most caring physician I know. And today, what you've said I think proves my point. Thank you.

DR. GOLDBERG: Thank you, Dr. Koop, and God bless you.

AL LEVER: I, too, would like to thank Dr. Goldberg and Dr. Koop for this outstanding presentation. I also want to thank not only the scientific program committee but our industry sponsors and AstraZeneca, who provided an unrestricted educational grant for this program.

I encourage all of you to attend not only the sessions but take part in every other part of the program: the exhibit hall, the high-tech learning lab, the poster presentations, and most of all, have a meaningful, thoughtful, and continue the dialogue that you heard today. Let's produce a vision for the future.