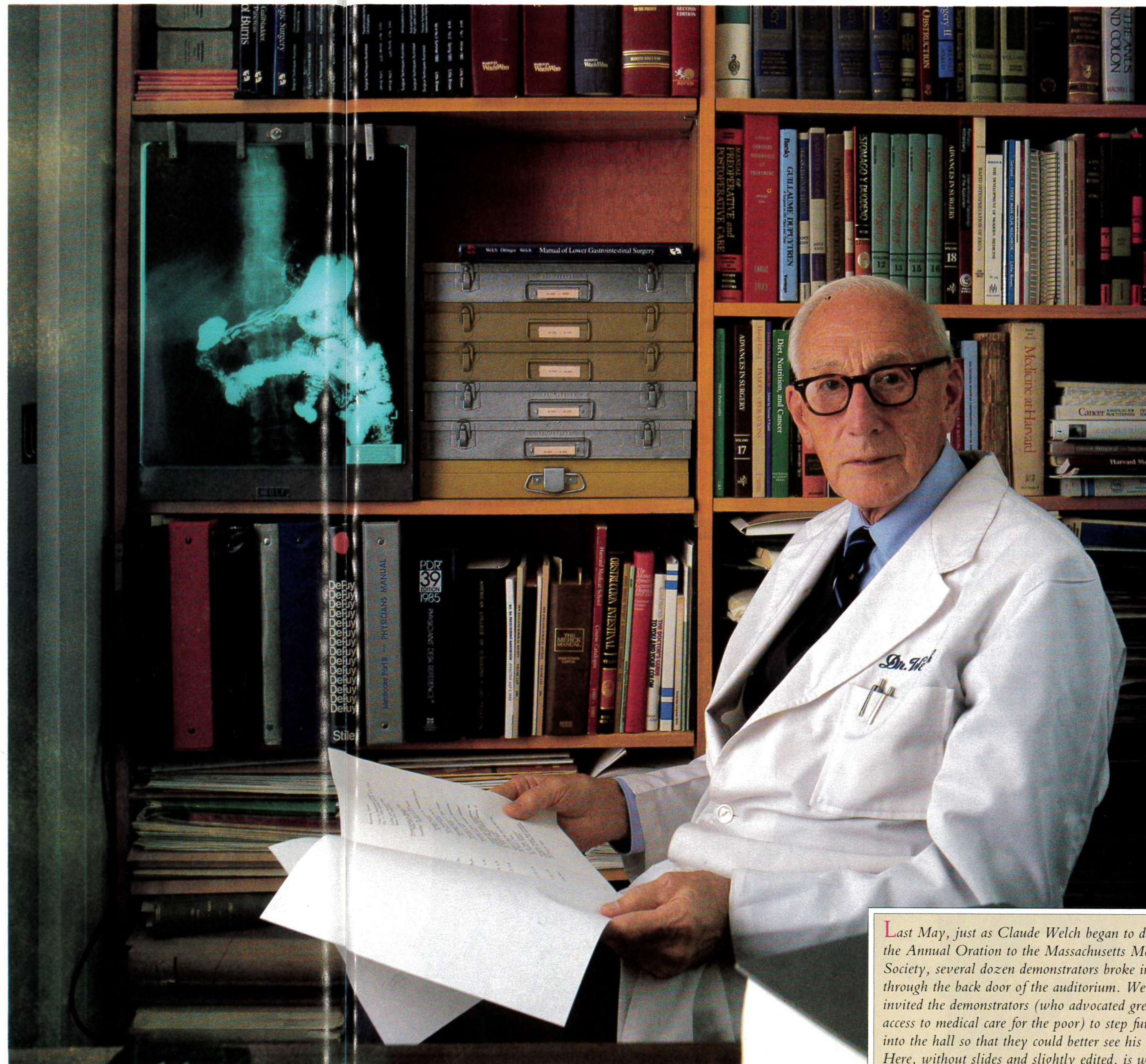
ANNUAL ORATION

AESCULAPIUS, CAN WE LEARN FROM YOUR EXAMPLE?



Last May, just as Claude Welch began to deliver the Annual Oration to the Massachusetts Medical Society, several dozen demonstrators broke in through the back door of the auditorium. Welch invited the demonstrators (who advocated greater access to medical care for the poor) to step further into the hall so that they could better see his slides. Here, without slides and slightly edited, is what he said.

The first annual oration of the Massachusetts Medical Society was given in 1804, and with a few exceptions it has been delivered regularly for 180 years. The subject matter of many of the early orations would be appropriate today: such topics as "On the Excessive Use of Ardent Spirits" (1824) or "On the Manner of Detecting Deep-seated Matter" (1827), which could serve as a modern introduction for radiologists on needle drainage of abdominal abscesses, are illustrations. On the other hand, the Civil War passed unnoticed and there are bare traces of the World Wars. The socioeconomics of medicine were ignored in early years, but no one can doubt their overwhelming importance now, for we are on the threshold of a revolution in medical care.

In this period of rapid social change there is danger that advances medicine has achieved in the past may be lost, and it is imperative that we analyze the fabric of our profession and consider methods to preserve it. To that end, I will present some opinions drawn from mythol-

CLAUDE E. WELCH

ogy and history. Each of the four individuals whom I will mention was preeminent in his time, and each was followed by a period of retrogression out of which medicine rose again to even greater heights. There is every reason to expect that present regressions will be followed by even greater triumphs, provided that we keep our priorities straight. It is the identification of these priorities and the achievement of their respective goals to which the MMS must devote its energies.

Let's turn to the first of our giants: Aesculapius, the Greek god of medicine who epitomized the medical wisdom of the ancient Greeks and who, like the MMS, had to survive many cataclysms. His history furnishes an interesting parallel to that of the present day. (No stranger to the MMS, Aesculapius' figure has graced every medallion of the Society from 1804 to the present and is reproduced in our publications many times a year.)

Aesculapius was sired by Apollo, the sun god, but was born a mortal. Aesculapian fame and power became so great that temples were erected in his honor in many sites; the island of Cos and the town of Epidaurus were two of the major locations. Great masses of the ill were attracted to these temples and left what gifts (such as gold or a cock) they could afford. Those who had no wealth to offer were treated nonetheless. Typical of the great healing temples of today — our hospitals — patients were put to bed and cures often followed. Some highly excited persons were placed in dark, snake-filled rooms beneath the temples, establishing, if you will, the ancient version of shock therapy. (This method was successful enough that the snake continued as the emblem of healing.)

But tragedy followed. Aesculapius incurred the wrath of Pluto, the powerful god of the underworld, because Aesculapius' healing temples decreased the number of corpses delivered to Hades. Pluto complained to Zeus, persuading him that Aesculapius' healing powers were making all men immortal and thereby equivalent to the few Olympian gods. Zeus, a redoubtable individual, took immediate action. He appeared in the form of a huge cloud and dispatched Aesculapius with a thunderbolt. Zeus, however, rued his hasty action, and rehabilitated Aesculapius, making him immortal and a true god.

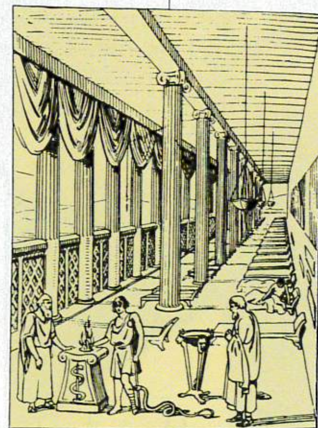
As the centuries passed, the care of the ill in western Europe passed into the hands of priests, and a long period of dark ages followed. Out of this darkness emerged our second medical giant, Maimonides, who stood out in an era of mediocrity. This famous Jewish physician, who lived in Cordoba, Spain, also later attained a position of preeminence as a philosopher. When the Jews were driven from Spain, he went to Cairo, where he pursued his medical and philosophical interests until his death. Again there followed a long period of stagnation, a time during which little differentiated physicians from quacks and when the attempted cure of a disease was often more hazardous than the disease itself.

About 200 years ago, during the French Revolution, a third extraordinary man appeared. He was the French surgeon Guillaume Dupuytren, who, with his enormous energy, converted the old Hôtel Dieu from a charnel house into what at that time was a modern hospital. He saw 10,000 patients a year. He was an important teacher and was often pursued by some 300 people during his morning rounds. Although Dupuytren died a wealthy man, he was a great friend of the poor and treated anyone who came to his office.

Our fourth figure, William Osler, was the greatest physician of his time a century ago. Osler was one of the founders of the Johns Hopkins School of Medicine, the first of the modern institutions in our country devoted not only to care of the sick and teaching, but also to the development of research.

Aesculapius and his important successors emphasized the individual care of patients, teaching, and education. All of them treated the poor and the rich alike. And all of them, except Maimonides, built temples of medicine. In addition, Osler stressed research, completing the tripod upon which modern medicine exists — patient care, education, and research.

In these times of turmoil, we would do well to study the actions of these great healers and to emulate what they have done. These four persons, all gods in the medical universe, identified in their days three fundamental considerations that we must support to prevent any deterioration in the current level of practice of American medicine. They are, in brief, maintenance of the doctor–patient relationship; support of the temples of medicine as centers for patient care, education, and research; and care for all of humanity, the poor as well as the rich. Let us now examine each of these considerations in more detail, because action by all members of this Society will be necessary to maintain American medicine as the best in the world.



The practicing doctor's relationship with a patient must always be on an individual basis. In the past, this has been the bastion of so-called Aesculapian authority, which assumed that the physician always knew what was best for his or her patient and that the patient should blindly follow the physician's advice. This attitude has been subject to caricature frequently in the past two centuries; the satire was particularly biting at a time when medicine actually had little to offer besides authoritarian statements, leeches, bloodletting, and enemas.

Today, the concept of Aesculapian authority is likewise under attack, but for different reasons. It is assailed by social scientists, envied by many groups, and weakened by a spirit of cynicism that pervades the country.

Today's Aesculapians are bewildered by the rapid progression of changing and often contradictory events. We feel we are reduced to gleaning the few grains of wheat left by an army of clerks and bureaucrats. "Natural foods" and daily jogging are considered prescriptions for a long life — a life in which doctors are an expensive and unnecessary luxury. Advocates of patients' rights abound. The practitioner today is constrained by regulations that change by the hour, and by groups that tend to diminish the authority of individual physicians. These constraints include a "gatekeeper" (a primary-care physician who must authorize a hospital admission or a visit to a specialist); a professional review organization, which unilaterally forms lists of patients unacceptable for hospital admission; the demand for second opinions for many operative procedures; and some lawyers who thrive on malpractice actions and sow doubts in the minds of patients rather than the hope and trust that is the essence of the true doctor–patient relationship.

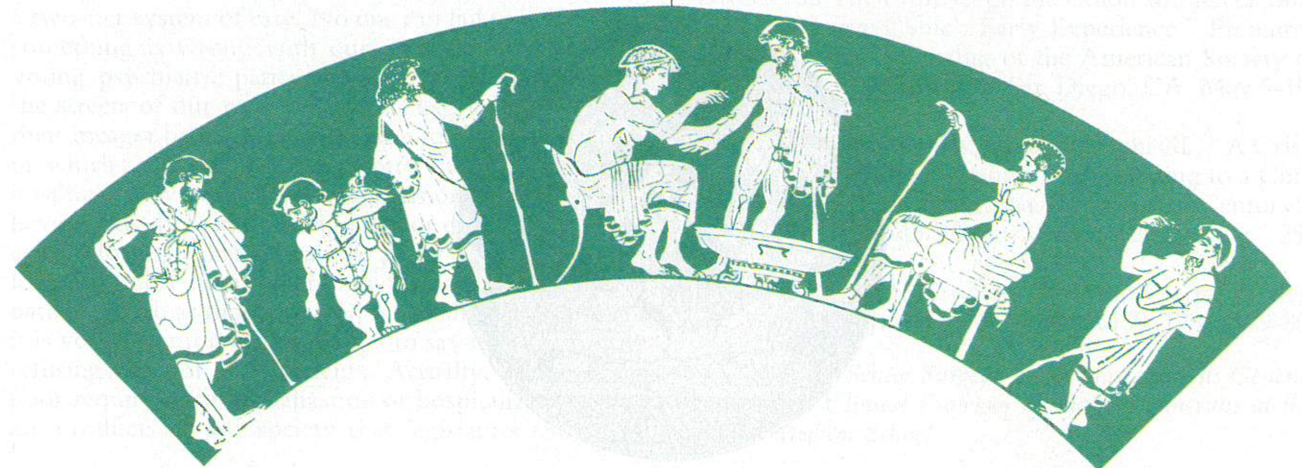
In addition, two other enormous barriers are arrayed against this intimate relationship between doctor and patient. The first is that of machines. A visit to a diagnostic center, for example, could mean two days of tests and finally a fifteen-minute visit with a physician who summarizes the data and rather coldly presents his advice concerning treatment. This dependence on laboratory tests and machines clearly is in the best interests of many patients; but overuse has depersonalized medical care and has led to many of the huge increases in the costs of medicine.

The overuse of ancillary services in this state has been the subject of very active investigation by the Massachusetts Hospital Association and Blue Cross. Essentially every new machine or technique has automatically led to a substantial overuse. For example, cardiac pacemakers, endoscopic examination of the intestinal tract and joints, and vascular intervention or hip replacements are examples in which serious overuse has occurred. Fortunately, the tyranny of machines will be reduced by prepayment plans that require that doctors choose between the costs of excessive laboratory tests and funds retained by the physician.

The second major barrier threatening the doctor–patient relationship is the government as a third-party payer and its Draconian imposition of standardized lengths of hospital stay.

Physicians sometimes can cure, but frequently all they can do is show compassion, and nowhere is the dichotomy between government reimbursement and the aims of physicians more obvious than in the issue of length of hospital stay. It is exemplified by the dying patient who, because he or she has exhausted the predetermined length of stay and has no more hospital benefits, is required to leave the hospital to die a few days later under very unhappy circumstances at home. Compassion is a virtue to physicians. Government regulations often make no provisions for it.

Ultimately, we ought to spend our energies attempting to reverse some of these unhappy situations. I am particularly troubled about prepayment plans that allow family care physicians to dictate all referrals and choice of specialists — a bizarre resurrection of Aesculapian authority by which the primary-care physician assume



THE BETTMANN ARCHIVE

the god's mantle. It is entirely possible that the benefits of receiving care from specialists, who are so widely available and highly regarded by many patients, could become a casualty of the gatekeeper system.

Practicing physicians should have some influence in determining a patient's length of hospital stay. It is comforting to note that various professional groups are alerted again to make definite recommendations in this regard. It is also refreshing to learn that the Federal Trade Commission has given the Health Care Financing Administration authority to set fees. HCFA, in turn, is again considering the reestablishment of relative-value scales for reimbursement for physicians. It is essential in this era of cost containment that compassion be placed somewhere in the balance and allowance made for increased lengths of stay and reimbursement.

Another problem that demands attention is that of professional liability. I am dubious that any method will be accepted that will eliminate nuisance suits and the payment of adequate compensation to injured patients. However, there is now some evidence that the public is beginning to recognize the magnitude of the problem. The economist Professor Eli Ginzberg estimates the costs of "defensive medicine" (excessive protective tests, insurance, and awards) have added 10 to 15 percent to the nation's health-care bill. The American Medical Association estimates that $15 billion is spent yearly for defensive medicine.

Nearly a quarter of all malpractice suits in the Commonwealth are based on the plea that inadequate consent for operation was obtained. To counter this complaint, Dr. Lyndon Lee in 1973 persuaded the Veterans Administration to change the "operative permit" form to a "request for administration of anesthesia and for performance of operations and other procedures." As Weaver has said, this method correctly defines the doctor–patient relationship. The patient should play an active rather than a passive role in a doctor–patient partnership. This idea merits further investigation.

Many other options should be adopted if the tort system is to be maintained. Rules on expert witnesses need revision; some self-styled witnesses are senile and detract from the dignity of the medical profession when they appear on the witness stand. At present in Massachusetts, if any physician states in a case before a tribunal that malpractice might be involved, a judge is likely to send the matter to trial. Such action treats every physician as an expert — something that is manifestly untrue. Recently in Texas a practical nurse was deemed qualified to give an expert opinion on a medical malpractice action. Surely, "experts" must be peers in their own profession and specialty.

The suggestions discussed above and others now before the Legislature by the Society will require strong public support if they are to become laws. Therefore, it is the duty of every physician to shore up his own personal contacts. Telephone calls from patients cannot be ignored, delegated to an office nurse, or refused at night. Doctors must be on call or leave adequate coverage. Other problems, such as delays in waiting rooms, considered by physicians as a petty annoyance, loom large in the opinion of patients.

If physicians wish to regain some of the Aesculapian authority characteristic of their predecessors they must recognize that nothing will diminish the reputation of a doctor in a patient's eyes more than a lack of knowledge and an inability to make a decision. For example, after a doctor has given a patient all the controversial evidence concerning the treatment of breast cancer, the patient frequently asks for a recommendation and the proper choice of therapy. For the doctor to say that he or she will do anything the patient wants is a complete abdication of responsibility. Patients, of course, make the final decisions, but many of them want and need solid advice.

Next, let us consider the temples of medicine. Those of Aesculapius were the greatest in the world for more than 2,000 years, but now they lie in ruins. Osler, nearly a century ago, spoke of the immortal spirit of Aesculapius and of the promise of American medicine: "Give me the temples, give me the priests, give me the true worship, the old Hippocratic service of the art and the science of ministering to man. Where the clouds of incense rise highest, there must my chief temple be and to it from all quarters will the faithful flock, as it was in Greece, in Alexandria, in Rome, in Northern Italy, in France, so it is now in Germany, and so it may be in the New World I long to see."

As Osler predicted, America has its share of temples. They are our great hospitals, medical schools, and research laboratories. But they are not immortal; all are under serious attack today. It is the hospitals, in particular, that bear the brunt of criticism directed toward American medicine. Something seems to have gone wrong. We may have become so interested in the extremely costly preservation of individuals who are beyond salvage that we may unwittingly play out our own modern version of Zeus and Aesculapius. Our task is to preserve our temples of medicine — the hospitals and research facilities. Unfortunately, as governmental agencies assess the nation's health-care expenditures, they see that by far the largest percentage is due to hospital care. This item in 1983 accounted for more than 41 percent of the $355 billion that went to health-care expenditures in the United States. It is only natural, therefore, that in any attempt to cut expenses attention should be focused particularly on this segment. Hospitals systematically are being weakened by many factors, including "unbundling" of services; the shift to ambulatory care facilities, many of which exist entirely outside of hospitals; the reduction in funds devoted to teaching programs; and at present the imposition of reimbursement based on diagnosis-related groups.

Some effects of DRGs are now becoming apparent. A recent report from the Ochsner Clinic, one of the largest hospitals in the South, has revealed that in a study of DRGs related to colorectal disease, payments by the government for those diagnoses of relatively trivial diseases have been in the hospital's favor and have allowed the hospital to save money in that group. However, the hospital has experienced an enormous revenue loss with the group of patients with more severe disease, and particularly those who require acute care. The net result is an overall revenue loss associated with treating all patients with colorectal disease under the DRG system. Furthermore, unless the rules are changed, this loss promises to be exaggerated as the years go by because of the payment mechanisms that are envisioned as specified in the law.

It is hard to escape the impression that a very deliberate attempt is being made to destroy our present temples of American medicine. They are our workshops. We physicians will thrive or sink with hospitals. We must support them.

Finally, the medical profession ought to regard all persons, rich or poor, as eligible for medical care. There is no question that we are in danger of again reinstituting a two-tier system of care. No one can fail to believe that something is wrong with our priorities when we see young psychiatric patients wandering aimlessly about the streets of our major cities or "bag ladies" carrying their meager belongings with them to find some cranny in which to sleep. We must decry the fact that many hospitals now restrict their admissions to those who have relatively lucrative diagnoses or can pay for excess costs. Hospitals that are run for profit certainly will not look favorably upon potentially unprofitable groups of patients, such as those covered by Medicaid. At present it is very common for legislators to say that doctors are refusing care for such patients. Actually, many of the poor require institutionalization or hospitalization; they are products of our society that legislators should be sworn to protect.

To put it succinctly, today's Aesculapians are in need of a tonic.

In conclusion, no one doubts that storm clouds are gathering over American medicine today, just as they did over Aesculapius. Many of them could be dispelled by a redirection of federal policy. The arms race drains sorely needed funds and emphasizes death rather than life. The conscience of mankind has been numbed by genocide — the Holocaust stands as one of the most horrible examples. It is as if Zeus were listening to Pluto rather than Aesculapius.

Though the future is still cloudy, in these hectic days there are three major matters with which we, as members of the MMS, must be deeply concerned. Outstanding physicians, giants of their times, have shown us that the care of patients as individuals, maintenance of the temples of medicine, and care of the poor as well as the rich are essential. There are numerous practical considerations that loom very large these days to make it difficult to achieve these simple though admittedly expensive goals. To me, as I'm sure they are to you, these goals are worth fighting for. They mean an entire rearrangement of national priorities, but let us not forget that Aesculapius became a true god because of his promotion of health for all pilgrims to his temples.

David Rogers recently phrased our priorities more bluntly when he said, "Over time, society tends to reward groups that aspire to noble goals like improving the human condition. That is what spawned physicians in the first place. They should hang on to that high ground." If we do, and if we meet these challenges, Aesculapian ideals will reign again. If the concept of Aesculapian authority fares well, so does the Massachusetts Medical Society. □

1. Ginzberg E. "American Medicine: The Power Shift." *Bulletin of the American College of Surgeons* 70(4) (1985): 2-6.

2. American Medical Association Special Task Force on Professional Liability and Insurance 1984-85. Professional Liability Report 1. Chicago: American Medical Association, 1984, p. 16.

3. Osler W. "Vienna after Thirty-four Years." *Journal of the American Medical Association* 50 (1908):1523-5.

4. Hicks TC, Ferrari BT, Ray JE, Gathright JB Jr. "DRG's and Their Impact on the Colon and Rectal Surgeon — A Large Clinic's Early Experience." Presented at the 84th annual meeting of the American Society of Colon and Rectal Surgeons, San Diego, CA, May 5-10, 1985.

5. Warren JV, Plumb DN, Trzebiatowski GL. "A Crisis in Medical Education: Thoughts on Listening to a Conference on Medical Education for the 21st Century." *Journal of the American Medical Association* 253 (1985):2404-7.

6. Weaver JP. "The Problem with the Operative Permit." *Surgery, Gynecology & Obstetrics* 159 (1984):579-80.

Dr. Welch is Senior Surgeon at the Massachusetts General Hospital and Clinical Professor of Surgery Emeritus at the Harvard Medical School.