Volume 41

Diseases of the
COLON & RECTUM

Number 11

NOVEMBER 1998

PRESIDENTIAL ADDRESS

Who Nurtured Cock Robin?

By Ira J. Kodner, M.D.

St. Louis, Missouri

INTRODUCTION

At a recent meeting of one of our most prestigious surgical societies, the presidential address was delivered by a prominent surgeon and directed toward young surgeons who might be interested in becoming academic surgical scientists.[1] During the speech, he explained to the audience the importance of focusing on the advancement of the individual academic career, without allowing such intrusions as administrative responsibility, teaching, intense clinical load, and even time spent with community and family. He cited an article by Carl Dragstedt, the brother of renowned surgeon, Lester Dragstedt, written in 1964.[2] The article entitled "Who Killed Cock Robin?" was a parody on the famous children's rhyme dealing with the ultimate death of Cock Robin for which no one would take the blame. The article by Dragstedt was interpreted as illustrating the failure of a young scientist who made a potentially important discovery in the laboratory, but never progressed to acquire his fame as a scientist because his early work was recognized, and his fame quickly diverted him to community, family, humanitarian, and educational issues. The point of the article is that no one who lured him into all of these activities took blame for his demise; but in fact, he was looked on as a failure for never developing his initial potential.

Ira J. Kodner, M.D.

The question I ask today is "Was he a failure?" I believe it is a flaw to counsel a young surgeon to look only at the benefit to his or her own personal career and accomplishment. If we evaluate Cock Robin, how many may have benefited from his diversion, even though he did not get the Nobel Prize? What gratification did he personally derive by diversifying and making contributions in many areas? Most important, what is our obligation, as physicians and surgeons, to our patients, our students, our families, and to hu-

Read at the meeting of The American Society of Colon and Rectal Surgeons, San Antonio, Texas, May 2 to 7, 1998.
Address reprint requests to Dr. Kodner: Section of Colon and Rectal Surgery, Barnes-Jewish Hospital, 216 South Kingshighway, St. Louis, Missouri 63110.

manity? What should we as members of a small specialty do to nurture our young for the good of all; and critically, what is the risk if we fail to do so?

WHO NURTURED THIS PARTICULAR COCK ROBIN?

As I reflect on my own career, I have to recognize those who nurtured me, helping me achieve a position that has enabled me to enjoy a productive and, so far, I think, successful career. There were, of course, my parents, my mother being a gentle, sensitive, loving person from Paducah, Kentucky. Her emphasis when I was growing up was on honesty, with no exception, and a concept of sharing. My father, on the other hand, was from Russia, having come to the United States as an immigrant from the Ukraine. His emphasis was on learning and hard work. My father was an outspoken, determined, and often inflexible individual. Fortunately, I am sure, I have inherited none of his traits.

I have encountered many teachers along the way to whom I owe a debt of gratitude. I have experienced the benefit of many college and medical school professors and am especially indebted to Dr. Edward Griffith, a senior scientist at Monsanto, in whose laboratory I worked for several years and with whom I experienced many scientific adventures. His principles have stood me in good stead for negotiating through the academic world. I am also indebted to Dr. J. J. Thomas, a surgeon whom I met when I was in undergraduate school. I had to bring him his lunch at the local drugstore where I worked as a clerk, because he was not allowed to sit at the counter and eat with white people. Although he was a great surgeon and respected in the community, he still had to eat lunch in the stock room. His advice was invaluable and guided me through the early years of medical school. I have had great mentors along the way, including Dr. Arthur Baue, who made it possible for me to train at the Cleveland Clinic in colon and rectal surgery. I was offered my first practice opportunity, from which the seeds were sown to build our current academic program, by Dr. Stanley London, who was in the private practice of surgery in St. Louis and was one of the early surgical mentors to whom I am forever grateful. As time went on, there were many other people who contributed to my career, especially Dr. Robert Fry, my friend and partner for many years.

I have had the benefit of having two older brothers and two sisters-in-law with whom I have become ever closer over the years. My truest friend and inspiration, of course, is my wife, Barbara, to whom I will soon have been married for 35 years, assuming all of us get through this week. We have been together since early undergraduate school, and I feel that we have shared everything good and not so good. We have grown up together. In so doing, I have received the unending support of her parents, John and Elva Bottchen, who are here today. They always seemed to be there when we needed help, which, in the early days, occurred with some frequency. As time went on, Barbara and I had our children, who have been and continue to be a daily inspiration. They have been enormously patient, first of all, to have to confess to their friends that their father was a colon and rectal surgeon, much less to be supportive and to allow me to devote time to the specialty that was probably better intended to be for them.

The time spent at the Cleveland Clinic was the true formative aspect of my career as a colon and rectal surgeon. Under the tutelage of Dr. Rupert Turnbull and Dr. Frank Weakley, I think I obtained the finest training possible in our specialty. I had the opportunity to be fellows with Ian Lavery, David Jagelman, and Peter Wilk. Through the opportunity at Cleveland Clinic, I met such great people in colon and rectal surgery as Drs. Brian Brook, John Galligher, Aubrey York-Mason, Norma Gill, E. S. R. Hughes, Vic Fazio, and many, many others.

WHAT I HAVE BEEN ABLE TO DO?

I had the opportunity to establish a colon and rectal surgery program where none existed in St. Louis, first in private practice and then on the medical school faculty, which I think is now one of the best full-time academic programs in colon and rectal surgery, as is clearly evident by our current faculty of Drs. Jim Fleshman, Elisa Birnbaum, and Tom Read. Along with our surgeons, I think we have the very finest of nurses and staff. The glorious array of clinical and research fellows has of course enriched my career beyond belief, *usually*! I would be remiss, of course, not to mention the honor which I have had to care for thousands of patients with colon and rectal diseases.

WHAT IS THE RISK OF NOT NURTURING OUR YOUTH?

As we confront the current enormous challenges to the practice of medicine and surgery, we must be reminded of the fact that we have just recognized,

certainly not celebrated, the 50th anniversary of the Nuremberg Physicians Trials.[3] We must ask: What led some of the physicians of Europe to participate in the commission of atrocities under the Nazis? Were they monsters looking for a means of doing evil, or were they physicians like us, faced with political and economic intrusions into the care of sick human beings, as we are experiencing today?

THE NUREMBERG PHYSICIANS TRIAL AND THE STATUS OF PHYSICIANS AND MEDICINE IN EUROPE (1933–1939)

Medicine in Germany in the 1930s became a state-regulated profession. Physicians were asked to practice such that their success was determined by their contributions toward the improvement of the health of the "people as a whole."[3] Confidentiality was declared optional, with priority being given to the public welfare. Interestingly, of all German occupational groups, physicians had the highest proportion of members of the Nazi Party.[3, 4] Physicians found themselves clamoring to respond to the needs of the state rather than to the individual.[5] This, unfortunately, is not the history of a few madmen on the fringe, but rather a revelation of the depths to which the leading medical establishment of the time could sink. How big is the leap from a mission of protecting the "people as a whole" and preserving the scarce financial resources of the time to participating in medically sanctioned mass destruction of government-determined unworthy human beings?[6]

It is to the everlasting honor of the medical profession of the Netherlands that they recognized the earliest and most subtle phases of this attempt and rejected it.[7] The initial request was simple: the duty to return people to a functional state of health as a *public* task. Although, on the surface, the new demands appeared not too grossly unacceptable, the Dutch physicians astutely decided that it is the first, although slight, step away from principle that is the most important one. They had the foresight to resist before the first step was taken, they acted unanimously, and they won out in the end, even at the cost of some of their own lives.[7] As we stand on the doorstep of the 21st century armed with new genetics, confronted by pressure of cost control, encountering increasing participation of the state in physician-patient relationships, and challenged by new debates over euthanasia and physician-assisted suicide, we must wonder if it could happen to us.

DESCRIPTION OF THE CURRENT SOCIAL AND ECONOMIC PRESSURES IN AMERICAN MEDICINE

In a recent article in *Pharos*, the journal of the medical honorary society, ΑΩΑ, Dr. Denton Cooley described the past, present, and future of American medical practice.[8] He pointed out that, 50 years ago, surgeons had only conceived of one-tenth of the operations we now do routinely. Operations that would have been thought of as impossible have become commonplace. These technical and surgical advances come with a price: sacrifice of the physician-patient relationship. Physicians began to concentrate more on identifying and treating patients ailments than on establishing personalized, compassionate connections with patients. The very technology that had been designed to aid both the physician and the patient caused a rift to form between its benefactors. Patients began to resent the high cost and increasingly impersonal nature of medical treatment. The public often now sees physicians as indifferent technicians interested more in buying new cars than in listening to the patient's problem.[9]

The proposed "protection" of the public from unscrupulous physicians and the "runaway" cost of medical care is the "marching order" of managed care. Physicians with managed-care contracts are given incentives to lower costs by reducing care, often with the threat of having their own salaries reduced. Primary care physicians, or "gatekeepers," may delay referring their patients for specialized treatment, sometimes with serious or even fatal consequences.[10] Even worse than the denial of specialized care may be the preeminence of administrators in making decisions which have a direct impact on patient care. They make these decisions from a business and economic background, without the capability or concern for the effect they may have on sick human beings. To quote Dr. Cooley: "Perhaps laws should be enacted to hold the administrators of health care organizations accountable for such undercare of patients."[8]

The cost of medical care has become a concern, because we cannot seem to control it. As a result, everyone points to health care costs as being in a state of crisis. When employers, unions, government, and insurance companies decide that we have a crisis, a crisis exists.

We do spend more money per capita on health care than any other country in the world, yet our poor, unemployed, and underinsured continue to have lim-

ited access to medical care. It is critical to note when calculating the cost of medicine in the United States, however, that huge expenditures which are allocated to *social welfare* in other countries are charged to medicine in the United States. These include the overwhelming cost of alcohol and drug abuse, teenage pregnancy, and penetrating trauma, seemingly insoluble social problems for which we are held accountable. The initial solution to this dilemma was to ration by *access* rather than by restricting the excellent care available to those who had enough insurance to make such care possible. Under managed care, we are now confronting the other horn of the dilemma. More people have access to the system, but the thrust is to ration the potential excellence of care.[11] This is occurring, of course, in a situation where *access* is still rationed, but in a more surreptitious manner: easy access for the well, difficult access for the sick and elderly.

All of this has led to deterioration of the patient-physician relationship. People are encouraged to believe that physicians and institutions are interchangeable, and that anyone can manage a patient from Diagnosis A to Outcome B. Patients now spend more time seeing paramedical personnel and completing paperwork than actually seeing their physicians. In fact, patients are no longer called patients. They are now called "clients" or "consumers".[12] No wonder there is a growing dissatisfaction with the system. We, as surgeons, must be especially troubled by this depersonalization, because our work is that of individual physicians responsible for our own patients. Society has decided that it was the physicians who were the cause of the increasing health care costs and that we had to be managed, controlled, and restricted. Because our patients were no longer our allies and because medicine had no clear, respected, and unanimous voice of its own, no effective defense could be expected against the bureaucratic regulations being imposed on physicians and patients.

I believe there is an even greater risk to medicine than the deterioration of the cherished patient-physician relationship, and that is the endangerment of our personal and professional integrity. When physicians are offered financial incentives to minimize the expensive care, competing forces tug at us. It is untenable to see physicians, who by law and ethics must be the advocate of their patients, placed in a situation where, to maintain a reasonable income and perhaps their very jobs, they must ration the amount of money to be spent on an individual patient.

Some of us refuse to compromise and tirelessly advocate for our patients. In so doing, we often run ourselves ragged dealing with bureaucratic obstacles. Others of us take the same advocacy position but eventually become frustrated, exhausted, and financially threatened to the point where we retire early or leave practice for some other position. Unfortunately, for some of us, financial considerations erode our ethical and humanitarian principles and the very oath of dedication to our patients. We even eventually convince ourselves that the low-cost care we are providing is of high quality, when, in fact, it is substandard. These are the physicians to worry about, because this corruption of their integrity undermines their professionalism and threatens the quality of their care. "For profit" managed care makes no bones about its intention to capture, as soon as possible, potential customers through comprehensive arrangements, including rationing of specialized physician services, and to market this concept to American business.[13]

What was the role of physicians under Nazism and how could they have let such horrible things happen? Are there parallels for us today? What lessons must we learn from our colleagues of only 60 years ago? German physicians were told by the party that their only responsibility was conformity with the specified doctrine, not truth, not decency, not humanitarianism, not patient care, not human rights.[14] They had to compromise values for expediency. Even the great academic medical community of Germany fell prey to the system. In his 1991 description of a lecture by the historian, Dr. William Siedelman, my son, Dr. Charles Kodner, explained that our own American medical educational and academic system was modeled after the powerful figures in German medical research.[15] They were well published in respected journals, invited to speak at scientific meetings, and looked on as leaders in their fields. Even the experiments they performed in concentration camps were seen to be critical in pursuit of their personal academic goals. Seen in this light, these physicians provide examples of the evil inherent in scientific and economic endeavors that do not recognize the value of human life above the usefulness of results.[16]

The analogy between what was asked of the physicians in Germany from the Nazis and what is being asked of us, and forced on us, today should be of the greatest concern. As the funding of health care is curtailed further, at what point do we cross the line from reasonable concession to choices that jeopardize

our long-held professional standards. Dr. Jerome Kassirer of the *New England Journal of Medicine* raised the following questions in his recent editorial[17]: Should we remain silent if dialysis is denied to the elderly? Are we prepared to accept the reality of a two-tiered system in which the wealthy receive care and the poor are denied? Should we continue to comply with the for-profit health care systems that make a millionaire per month out of venture capitalists and simultaneously drain money away from patient care and medical research? At what point is collective action by the profession warranted to preserve our integrity? Will the profession ever unify in opposition to market values as the foundation of our health care system?

Sooner or later, we must face these threatening issues. Most leaders of American medicine are busy now just coping: trying to preserve the membership of their societies, struggling to increase their share of the market, striving to save their research and training missions, and conspiring to survive in the intensely competitive marketplace. Many acknowledge their deep concern about the system privately, but publicly they remain silent.

Market-driven health care creates conflicts that threaten our profession. Physicians will be forced to choose between the best interests of their patients and their own economic survival. I suspect this was the same choice thrust on our colleagues in Germany following the upheaval of World War I and the economic depression of the late 1920s. The incentive to remain employed is so strong that many of us today in a capitated system may not provide all of the services we should, may not always be the patient's advocate, and may be reluctant to challenge the rules governing which services are appropriate. Physicians forced into such excruciating quandaries may find themselves conforming to the restrictions and deceiving themselves into believing that what they are doing is best for their patients. At what point do we stand, as did the Dutch physicians, and say: "Not here! Not us!"

WHAT IS THE SOLUTION?

We are experiencing a corporate approach to health care that is an outgrowth of the business orientation of our society. Our professionalism, which remains essential to our overall mission, must adapt to these overwhelming forces.

Elie Wiesel, Nobel Laureate, Holocaust survivor, and Nuremberg Trial witness, questioned how educated physicians from prestigious universities could have participated in the Holocaust. He, too, cited the emphasis on abstraction and dehumanization as central elements on that shameful path.[18]

Well, I hope that during the past few minutes I have led you to the correct diagnosis. But look around you. We are surgeons. Making the diagnosis is just the beginning. Assuming we can get on the schedule, what operation needs to be done to save this "patient?" As surgeons, we must have the courage to make the difficult, ethical decision that will positively affect our patients' lives. When we deal with all of the outside, nonmedical, controlling factors that have an impact on our patient care, we must emphatically remind them of several critical factors.

The "managers" can set up clinics, provide information, buy practices, bill patients, and carry clipboards; but they cannot *deliver* care. Only physicians and nurses actually can care for sick people.[19] As I often tenderly explain to arrogant administrators: "You eat because I work!" We must constantly remind them that in the words of Pellegrini: the fundamental difference between a business and a profession is that at some point in the professional relationship, when a difficult decision is to be made, you can depend on the one who is a true professional to relinquish his own self-interest. Respect and trust are not given in perpetuity, but must be earned each day of our lives.[20]

A more specific plan of action has been suggested by Dr. David Himmelstein, representing the Ad Hoc Committee to Defend Health Care.[21] He explains that for the public who are mostly healthy and use little care, awareness of the degradation of medicine builds slowly; it is mainly those who are extensively ill that encounter the dark side of market-driven health care. He warns that the changes afoot push nursing and medicine further from caring, fairness, and efficiency. Although we may disagree among ourselves on many aspects of reform, we should be able to stand in unity on the following common ground:[21]

1. Medicine and nursing must not be diverted from their primary tasks: the relief of suffering, the prevention and treatment of illness, and the promotion of health.
2. Pursuit of corporate profit and personal fortune has no place in caregiving.
3. Potent financial incentives that reward overcare or undercare weaken the patient-physician bonds and should be prohibited. Similarly, busi-

ness arrangements to allow corporations and employers to control the care of patients should be proscribed, and I would add that Congress should pass legislation permitting members of health care plans to sue the plans directly for harm caused by the wrongful acts committed at the direction of the plan.

4. A patient's right to a physician of choice must not be curtailed.
5. Access to health care must be the right of all.

We physicians and the public must join in a dialogue to protect the future of American health care. The headlong rush to profit-driven care has occurred without the assent of patients or practitioners, through a mechanism largely hidden from public scrutiny and above citizen participation. This must be replaced by an open and inclusive process that is not dominated by the loudest voices, those amplified by money and political influence.[21]

Himmelstein reminds us that America's history is filled with examples of powerful social movements kindled by initially unimposing moral voices, such as the Boston Tea Party, abolitionism, appeals for civil rights, and nuclear disarmament, to mention only a few. Only a comparable public outcry can reclaim medicine. Our profession's voices can gain extraordinary resonance when we speak selflessly in our patient's interests.

In Massachusetts, Himmelstein's group has pledged the following initial steps and implored them to expand into other communities:[21]

1. They have petitioned the Governor, legislature, and Attorney General for a moratorium on for-profit takeovers of any health care organization until comprehensive state and national regulatory policies are in place.
2. Open meetings are being called by physicians and nurses to inform the public of the deterioration of care and to ask them to join in the securing of future health policies guided by service and compassion rather than greed.
3. They launched an ongoing series of local educational programs for nurses and physicians and have asked that every health institution throughout the nation devote a major conference, such as Grand Rounds, to the moral crisis facing our profession.

I urge all of us in this audience and especially the current and future leadership of our society to seek an inclusive and empowering dialogue with patients, legislators, and the public to formulate a caring vision true to the community roots and samaritan traditions of American medicine and nursing.

We gave up too easily. We must make another serious attempt to formulate a national health policy that will provide health care to all. To quote Dr. Kassirer: "After all, what oath, promise, or pledge did we ever make, either as individuals or as a professional, that obligates us to restrict care? We pledged, instead, to provide care".[22]

Compromising care to control cost is a vexing social issue in which the integrity of the profession is at stake, and medicine must have a clear, strong voice in these public decisions. Before we face more odious choices, we must come to grips with these difficult tradeoffs. So far, except for a few voices in this country, the air is filled with a strained silence.[17]

I hope that we, as colon and rectal surgeons and as members of the American Society of Colon and Rectal Surgeons, will nurture our young, as I have been nurtured by so many wonderful people, so that they may proudly enter the appropriate arenas and stand the difficult ground. The more senior and secure among us must stand *now* to establish the precedent for speaking loudly and clearly for what is right by absolute ethical, moral, and medical standards.

It has been my honor and privilege to have served our specialty in so many ways during the past years, especially this past year as your President. I want to thank all of you who have made this possible. Have no doubt; this "Cock Robin" lives!

REFERENCES

1. Wells SA Jr. The surgical scientist. Ann Surg 1996;224: 239–54.
2. Dragstedt CA. Who killed Cock Robin? Perspect Biol Med 1962;224:364–76.
3. Seidelman WE. The path to Nuremberg in the pages of *JAMA*, 1933–1939. JAMA 1966;276:1693–6.
4. Garver KL. Nazi medicine, the Nuremberg Code and their relevance today. Genetics in Practice. Pittsburgh: Allegheny University Health Sciences, 1997:5–7.
5. Shuster E. Fifty years later: the significance of the Nuremberg Code. N Engl J Med 1997;337:1436–40.
6. Grodin MA, Annas GJ. Legacies of Nuremberg: medical ethics and human rights [editorial]. JAMA 1996;276: 1682–3.
7. Alexander L. Medical science under dictatorship. N Engl J Med 1949;241:39–47.
8. Cooley DA. Medical practice: past, present, future. Pharos 1997;60:13–6.

9. Annas GJ. A national bill of patients' rights. N Engl J Med 1998;338:695–9.
10. Fox BC. Medical-legal aspects of curbside consultation [letter]. JAMA 1996;276:1635.
11. Asch DA, Ubel PA. Rationing by any other name [sounding board]. N Engl J Med 1997;336:1668–71.
12. Porter DD. Trouble in paradise: physicians in the managed care era. Pharos 1997;60:2–6.
13. Guze SB. The "industrialization" vs. the professionalism of medicine, part II. Mo Med 1986;83:259–61.
14. Panush RS. Upon finding a Nazi anatomy atlas: the lessons of Nazi medicine. Pharos 1996;(Fall)1:8–22.
15. Kodner C. Review: medical grand rounds 4/9/91: "Villains and victims: medicine's Nazi heritage" by Seidelman WE. Washington University School of Medicine Newsletter, St. Louis, Missouri.
16. Barondess JA. Medicine against society: lessons from the Third Reich. JAMA 1996;276:1657–61.
17. Kassirer JP. Our endangered integrity - it can only get worse [editorial]. N Engl J Med 1997;336:1666–7.
18. Annas GJ, Grodin MA. The Nazi doctors and the Nuremberg Code: relevance for modern medical research [conference report]. Med War 1990;6:120–3.
19. Jonsen AR. Fighting in the fortress of medicine: surgical competence in the era of managed care. J Gastrointest Surg 1997;1:101–5.
20. Leffall LD. Medical ethics in today's society. ACS Bulletin 1994;79:7–11.
21. Himmelstein DU. A call to action against market medicine. JAMA 1977;278:1733–4.
22. Kassirer JP. Managed care and the morality of the marketplace. N Engl J Med 1995;333:50–2.