

Commencement Address # 6 –June 13, 1988

Ethical Imperatives and the New Physician:
VI. Responding to the Patients of Tomorrow

Commencement Address
By
C. Everett Koop, MD, ScD
Surgeon General
Of the
U.S. Public Health Service
U.S. Department of Health and Human Services

Presented at the Commencement Exercises of the
University of Health Sciences/The Chicago Medical School
Chicago, Illinois
June 13, 1988

I started by thanking the Trustees, the faculty, and the Class of 1988 for inviting me to take part in their commencement exercises and, especially for the honor they had conferred upon me.

I started by expressing a regret that I had often felt in the seven years I had been Surgeon General and that was I had often wished that – somehow, earlier in my career as a physician -- I could have had a turn at public service. I said that because I felt I could have truly benefited from a year or two even more of being forced to think about issues in medicine and public health in terms of their relevance to an entire people and not just to the patients in my own particular practice.

I could say parenthetically that in the academic field of pediatric surgery, and being a pioneer in starting that new specialty, a lot of the things I did -- one-on-one -- to patients, did become protocol, established well enough to be used in medicine in general and public health in particular. So, my career wasn't totally devoid of the things I wished I had more of, it was just a matter of deficient quantity. My wish for this class was that they might have such an opportunity while they still had the enthusiasm and energy of youth.

That was my first challenge. My second one was to begin – as soon as they could – to put their own ethical house in order, to understand it, to be comfortable with it, and be prepared to rely on it very much in the years ahead. I didn't say it then, but I say it now – and defend it -- I reminded them that ethics is a subject of great moment to millions of people in business, industry, law, politics, science, and virtually every field of human endeavor. These people, by the way, are age peers of the graduating class – their fellow citizens and neighbors – and soon perhaps also their patients. That's why I tried to focus on the need for a system of personal and professional ethics to guide and support each graduate as they stepped into the world of patient care.

One of the things they would wrestle with ethically was the continuing tension between our aspirations and our resources, or to say it another way, the tension between what we want to accomplish and what we can afford to accomplish. Every major decision would reflect that tension: the integrity of the Medicare program, improved medical care for the handicapped, the impact of the rise in numbers of older Americans, and the challenge of specific diseases, such as AIDS.

Then there was the explosion of new knowledge in science and technology. We know how, but do we know why and why not to use it. There are tragic choices ahead out there, such as the one Oregon faced the year before, when it had to choose between 30 organ transplantations or prenatal care for 1,500 expectant mothers. The mothers won and it was the beginning of what everyone called the first experiment in rationing health care. That, of course, was an incorrect statement, because we had been rationing health care for years. Another ethical dilemma arises when we hear from many sources that old people who are sick – especially those terminally ill – ought to be allowed to or even encouraged to die as quickly as possible. By hastening death, society can save more money and other resources become available to pay for health and medical care of younger people. The question about who would make that decision about life or death is frequently answered by folks suggesting the government, or some quasi-government agency. When that happens, I usually suggest the U.S. Postal Service, which tends to dampen the argument just a bit.

That led to the slow introduction of the idea of patients, themselves, determining when they die and then ask their physicians to help them do so. We have to be careful that we do not unwittingly allow economics to determine what our ethics will be. That's backwards and I don't like it. Ethics should determine our economics.

Having said that, I had to confess that demographics were not on our side. The tax base to support each person over the age of 65 indicates, ideally, that 5 younger tax-paying wage earners are needed to pay for that one person's Medicare coverage. As I write this introduction, there are only three tax-paying wage earners so doing. I noted that many of those present would be called upon to help make these decisions officially and reminded them that it would not be an easy task. Back to the question of technology! We seem to be back again in the type of period in history of history that comes in grand cycles – a period where science, law, and religion all intersect and overlap.

This is what shapes the present-day ethos of medical practice. The very technologies that raise the most serious ethical, moral, and legal issues are indeed technologies for conditions that are quite rare or are technologies for choices that the great majority of people don't want to make.

It is interesting that I said then, in 1988, that although not minimizing the significance of the esoteric technologies, that to reverse infertility, the popular preferences for dealing with this problem are still adoption, routine drug therapies, and resignation. Those were truly the public's preferences and the physicians as well. It's fifteen years since I prepared these remarks and even in that short time, that statement is quite obsolete.

I then introduced something medical students don't hear much about –namely patient's complaints that are called "conditions without illness". These are patients in relatively in good physical and mental health, but don't believe it. What they want from their physician is some display of reassurance, understanding, solace, or sympathy, or perhaps what Shakespeare called the "milk of human kindness".

To put things in perspective, many of that graduating class, I thought would never face the ethical challenge of prescribing a liver transplant for a middle-aged ex-alcoholic. On the other hand, I said that they would each very well be likely to be asked to respond to a variety of non-medical, but very human complaints, such as these "conditions without sickness".

I recounted that just the previous year, I had conducted Pediatric Grand Rounds in one of the nation's top medical schools and after hearing four interesting cases, I discussed them to the best of my ability, but when I finished, I felt compelled to note that all four cases were not so much examples of medical problems as they were of social problems. Which also reminded me that at a conference in the Netherlands on handicapped children, just a month before this talk, we introduced ourselves around the table and one Dutch physician called himself a "social pediatrician". I added a word of caution here that physicians must guard against society's tendency to seek medical answers to all of societies social problems. We don't have that kind of magic.

I closed by urging the class to know and understand as much as possible about their own ethical approach to life and health care and to be strong enough to remain true to it not only for their sake, but also for the sake of their patients. I asked if each one was willing, if able, to enrich – as well as to save – the lives of others through his or her own ethical conduct as a practicing physician. If their answer was yes, they would be producing what was called the ethics of the medical profession. Medicine is a multi-generational thing and perhaps my greatest legacy to the graduating class would be my own ethical conduct as a physician for the past half century. That with the conduct of all other physicians has helped build a true image of medicine as an ethical profession with a firm moral base. That would be the legacy of this class, as well, to those who follow them.