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ANNUAL ORATION

THE APPRECIATION OF MEDICAL POLITICIANS*

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WEST ROXBURY

THE seed of this discourse was planted several years ago when the Council of the Massachusetts Medical Society raised the dues to $35. It is well known that stimulation of the pocketbook will make the subject cry out. Members of the Society were at once heard crying out to each other: "What is this Council anyway? Who elects it? What do we get for our $35?" Those questions were actually put in so many words by men who are successful practitioners but who had never paid attention to anything outside their own practices. They had been too busy. One would suppose they could be answered readily enough; yet it was all but impossible to convince doubters that the Society is democratic, that the Council represents the membership, or that the districts are not run by cliques. When it was suggested to one man that because he was so much interested he would make a good councilor, his reply was that he did not want to be a "medical politician." He meant to imply that he had no urge to show himself in public, and no desire to dominate others. But what he really said was that although he declined to exercise his right to vote he still reserved his right to criticize.

Over the years one can see that to be a medical politician is gradually becoming more respectable. There must be a reason. In an office of the DuPont company there hangs, I have heard, a motto, which reads:

> In order to succeed
> You must satisfy a need.

It can be shown that today, as never before, there is need for medical politicians, that as a consequence their value is appreciating and that willy-nilly all physicians must participate in medical politics or be in danger of becoming something less than a profession. What does that mean? A few definitions will make the subject clearer.

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DEFINITIONS

Medical Politician

A medical politician means to me a physician (or even a layman) who not only talks about nonclinical medical problems but tries to do something about them. He is actively concerned with the ethics, the economics and all the other social implications of his profession. If, incidentally, he is also afflicted, like the poet Bunthorne, with a "morbid love of admiration" that is his misfortune. Of course, you here today are covered by this definition or you would not be here, and I realize that it is always the congregation in the pews who least need the sermon. One can only hope that the backsliders will read it later.

Profession

A profession has been described by Professor Himsworth as a purely social concept, implying a sort of contract between society and the profession. Society, the party of the first part, agrees that a group of men and women, having been trained intensively to perform a function that is uniquely valuable to society, shall be accorded special privileges, so that their work may be accomplished without interference. The profession, the party of the second part, agrees merely to act always so as to warrant that trust.

The function of the medical politician is to see that each party lives up to the letter of the agreement. Alert medical politicians realize that an amorphous, faceless state is not the only large organization that can dictate to the medical profession. What about the nation-wide medical facilities of the Veterans Administration? What about the Trades Union Health Centers such as the Garment Workers' Center in New York, the Labor Health Institute of the Teamsters' Union in St. Louis, the centers of the Amalgamated Clothing Workers in New York, Chicago, Philadelphia and other cities, and the Hotel Association Health Center of the New York Hotel Trades Council? What about the argument of metropolitan hospitals that

modern methods justify their sending patients home to continue treatment by the hospital staffs, thus saving, so they say, the expense of long hospitalization? What about the Kaiser–Permanente plan or the Health Insurance Plan of New York or any other scheme whereby large groups of patients are treated by small groups of salaried physicians, whether or not this involves exploitation of the salaried physicians?

I am not here to pass judgment on these sudden innovations. My point is that they are here and that there is no excuse for any practicing physician to be unconcerned about them. My thesis is that it is both honorable and necessary for the medical profession to try its hand at influencing the method by which the wonders of medicine are furnished to the people. There are hundreds, perhaps thousands, of lay volunteers for this job. Some of them are hucksters with an ax to grind. Here is a commodity, they say, and it should be sold. Yet the members of the medical profession make up the commodity that is about to be sold, and surely there is every reason why they should want to have a voice in their own disposition. It will prove extremely practical, particularly for the younger physicians, "to take arms against a sea of troubles And by opposing end them," instead of merely, in the words of a later and lesser poet, to

> Awake, arise, resume our clothing,
> And crawl another day toward dying.

To those who shy away from medical politics I should like to quote a statement by the late Frank Buchanan, of Ohio, once chairman of the House Committee on Lobbying Activities:

> Groups and individuals seek to influence government and education as a matter of constitutional rights. We cannot in any way abridge those rights without poisoning our system. I cannot imagine Congress operating without pressure groups. They raise issues, clarify them, and often provide the facts and points of view which are necessary to equitable legislation. The problem is to keep group activity honest with respect to its methods and open to public scrutiny.

Growth of Influence of Medical Politicians

This nation, being the age that it is, has lately been through a series of sesquicentennials. In 1931, for instance, the eloquent Harvey Cushing's oration celebrated the sesquicentennial of the Massachusetts Medical Society. It may or may not interest the fellows to learn that today is the sesquicentennial of the Massachusetts Medical Society Orations—a good place to stop and look both ways. A hundred and fifty years from now will be the three hundredth anniversary, in the year 2104! Human enterprises have a way of lasting just so long and then subsiding into dust, and the runaway technology of the present seems to act as a catalyst to hasten their disintegration. This being the case, it could be that today marks the half-way point, the point of no return, in the annual orations. For, if it is granted for the sake of argument that the glory of the Egyptian empire lasted four thousand years, that of the Roman a thousand and that of the British four hundred, who can say that the Society will retain its spark longer than three hundred years—or beyond the year 2104? It is admitted that the Massachusetts Medical Society is by no means equivalent to the whole of American culture, yet in every land the flowering of medicine has always been coterminous with the nation's fertile period. What this country will be like in 2104 no one can say. Benito Mussolini, it will be remembered, thought that in view of the vital statistics it would largely be a nation of Negroes, and Arnold Toynbee, a better judge, predicted that French Canadian would be the predominant stock. At any rate the United States will no longer be a young nation in a hurry, but rather, like Shakespeare's Justice, "In fair round belly, with good capon lined," with too much at stake to take chances and ready to exchange initiative for social security. Indeed there are signs that this is already happening.

If all this seems to take too much for granted, it will at least be agreed that before 1932 it would have been inconceivable that medical economics, which had apparently evolved comfortably into a function of the American Medical Association, would be, as pointed out below, in danger of becoming instead a creature of the trades unions. Not that there were no social problems before President Roosevelt, but rather that the medical profession up to then felt secure. The physician had his definite place in society. He followed the call of his profession and in doing so was sure to make a living. Today, however, everyone knows that things have changed—everyone, that is, except those who refuse to enter into medical politics. American society is becoming stabilized and class conscious,—in other words, more like Europe,—and if it is to be spared the trials Europe went through it must study to avoid their mistakes. Should physicians stand aside, letting things go and then complaining if they do not like developments, or should they take an active part in the conflicts that are brewing?

Agreeing, then, that all doctors are going to be medical politicians, the tools they have to work with should first be examined. These tools are the ideas that have evolved since men first attempted to organize and influence medical practice. One need go no farther back than seventeenth-century England, when the European world was emerging from the Middle Ages. This was a time of great curiosity, reform and innovation. An excellent description of the medical care of that day and its significance for the present-day system is given by George Rosen in the *Bulletin of the New York Academy of Medicine*. Even after the Middle Ages, he says, medical indigence was regarded as a disgraceful social disease caused by lack of methodical, constant labor. Poverty, moreover, was considered a potential danger to the national economy. For this reason alone the Elizabethan Poor Laws were enacted to relieve the "lame, impotent, old, blind, and such other . . . being poor and unable to work." These laws were set up not because of the Ten Commandments or the Beatitudes but rather be-

cause the Queen's ministers had computed on the one hand the cost of idleness to the nation and on the other the increase in national wealth if the poor could be made productive. (These are reasons that are being used today, to prove that medical care should be tax-supported.) Since fertility and population were national assets conditions should be created that would promote health, prevent disease and render medical care accessible to all. The number of trained physicians was small, and medical practitioners more and more formed a group of steadily improving status and remuneration, so that their services were not generally available to the poor. Today, that situation would have been taken care of by the women's magazines, but in the seventeenth century there were no feature writers and columnists. There were, however, pamphleteers who espoused special causes and were widely read. So the pamphleteers got to work.

In 1641 a certain Samuel Hartlib wrote "A Description of the Famous Kingdom of Macaria," which consisted of proposals for social and economic reform, a special feature being a "College of Experience, where they deliver out yearly such medicines as they find out by experience; and all such as shall be able to demonstrate any experiment for the health and wealth of other men are honorably rewarded at the public charge"—a sort of Elizabethan Nobel Prize. In 1647 he suggested an "Office for the Relief of Human Necessities," in which one function would be a listing of physicians willing to give their services gratis. Such offices were actually organized in London in 1650 though apparently the idea died aborning. Three hundred years later they emerge in modified form as emergency coverage services.

The awakened enthusiasm of that age is perhaps best represented in the writings of another of the pamphleteers, an unusual character named Sir William Petty. He was Deputy Professor of Anatomy at Oxford, Doctor of Physic and one of the first members of the Royal Society, and was described as "excelling in all mathematical and mechanical learning." What is more important today he was also the pioneer in the science of comparative statistics. He proposed that the optimum number of medical personnel be calculated and adjusted to the actual need for medical care:

> As for physicians, it is not hard by the help of observations . . . to know how many are sick by the number of them that dye . . . and . . . to calculate how many physicians were requisite for the whole nation; and consequently how many students in that art to permit and encourage; and lastly, having calculated these numbers, to adaptate a proportion of chyrurgeons, apothecaries, and nurses to them and so by the whole to cut off and extinguish that infinite swarm of vain pretenders into, and abusers of that God-like Faculty. . . .

He made it sound so easy that one wishes he might be alive today to act as arbiter between Dr. Means and the American Medical Association.

He had read Hartlib's essays, and at the age of twenty-four he wrote a thirty-page book entitled, "The advice of W. P. to Mr. S. Hartlib for the Advancement of Some Particular Parts of Learning." In it he set forth his views on the social and economic implications of health problems. George Rosen calls this book "beyond all comparison the most significant English contribution to this area of social thought prior to the nineteenth century." Sir William took the position, revived in the present time as the "New Deal," that although the Government undoubtedly had the right to harness individuals or groups to the needs of the State, public policy demanded that their living standards be improved so that the people would be healthy and happy. He reiterated the theme that hospitals are crucial in medical research and education.

> Another cause of defect in the art of medicine and consequently of its contempt is that there have not been Hospitalls for the accommodation of sick people, Rich as well as Poor, so instituted and fitted as to encourage all sick persons to resort unto them . . . [for] a man shall learn in a well regulated hospitall, where he may within halfe a hower's time observe his choice of a thousand patients, more in one year than in ten without it, even by reading the best Books that can be written.

He supplemented his general recommendations by specific proposals. The hospital was to be fully equipped with an anatomic theater, a chemical laboratory, an apothecary shop, a garden and a library. There would be a physician-in-chief, who "shall either dissect or overlook the Dissection of Bodies dying of Diseases, and lastly shall take care that all luciferous Experiments whatsoever may be carefully brought to him, and recorded for the Benefit of Posterity." There would also be a surgeon and an apothecary, and students would learn by accompanying members of the staff from patient to patient.

All this was in 1648, over three hundred years ago, when the American settlements were still nothing but an untidy fringe along the vast wilderness, and the only American hospital was the pesthouse.

For in America in the early years there was little time for the purely extraclinical or political side of medicine. During the first hundred and fifty years the settlers were too busy fighting off the Indians from the west and the tax collectors from the east. But the raw struggle for survival having been won by the end of the eighteenth century, they could turn to developing their own distinctive culture. It would have to be based, because they knew nothing else, on the thinking of the England from which they had come. An early manifestation was the founding in 1781 of the Massachusetts Medical Society. Only twenty-three years later the Massachusetts Society founded in turn the series of annual discourses of which today's is one. These discourses make interesting if uneven reading, and one may obtain from them a running commentary on a century and a half of medical thought, by "sifting them," as a certain lady novelist puts it, "keeping what is worth keeping, and then with the breath of kindness blowing the rest away." The titles chosen by the speakers since 1804

show a gradual shift in emphasis away from clinical subjects and an increasing preoccupation with public relations.

History of the Orations

The original offering a hundred and fifty years ago today was that of Isaac Rand, president of the Massachusetts Medical Society, "On Phthisis Pulmonalis and the Use of the Warm Bath." His was followed in succession by talks on mercury, narcotic vegetable substances, heat and cold, and blisters. The first philosophic discussion was in 1811, by Josiah Bartlett, of Charlestown, "On the Progress of Medical Science in Massachusetts." This idea must have had great appeal, for it has recurred once in every generation since then. In 1823 Henry Childs, of Pittsfield, spoke "On the Progress of Medical Science in this State." A hundred years ago William Workman, of Worcester, not to be limited by state lines, talked "On the Progress of Medical Science" (period). In 1861 Oliver Wendell Holmes switched the title to "Currents and Counter-currents in Medicine," and the switch must have caught on, for in 1886 R. W. Hodges, of Boston, called it "Undercurrents of Modern Medicine." In 1916 David Edsall used the variation "Movements in Medicine," and in 1933 Channing Frothingham, "The Trend of Medicine in the 20th Century." Of the first ten lectures all but one had been concerned with single clinical entities, but of the last ten, since World War II, only two can be called clinical: Dr. Frank Lahey's, on "Gastric Surgery," and Dr. John O'Meara's, on "Management of Fractures." In between appeared treatises such as George C. Shattuck's, in 1826, "On the *Un*certainty of the Healing Art," which seems to have been contradicted by Morrill Wyman's, in 1863, "On the Reality and *Certainty* of Medicine." In 1865 Benjamin Cotting, of Roxbury, used a curious title, "Disease—A Part of the Plan of Creation." (There is absolutely no indication that he intended it as an apology before the fact for the luncheons that have since born his name.)

Then, as the century drew to a close, the orations came to treat almost not at all of disease in the individual patient and more and more of mass relations with the public. The oration of 1875 was entitled "The Interests of the Public and the Medical Profession," that of 1884, "The Physician a Popular Educator," that of 1888, "Reestablishment of the Medical Profession," that of 1892, "The Medical Profession and the Commonwealth," that of 1894, "The Legislative Control of Medical Practice, and that of 1895, "The Physician's Extraprofessional Duties."

For a while after the turn of the century the orators tended to focus on surgery. Possibly this was a reflection of the developments in asepsis, anesthesia and pathology that were beginning to make surgery more attractive and resulted in the advent of the great surgical personalities of that era.

Then came the social upheavals accompanying World War I, and the orations again evidence concern with the public's part in the practice of medicine. One example was Horace D. Arnold's oration in 1914, "The Education of the Public in Medical Matters."

Meanwhile, a trend toward community care of the sick was developing in Massachusetts. In the oration of 1918 Myles Standish viewed this development as a not unmixed blessing, for he took as his subject "Socialization of the Practice of Medicine." He listed the opening of the Massachusetts General Hospital in 1811, the formal establishment of its outpatient department in 1846 and the beginning of Social Service there in 1905 as milestones in the humanitarian or medical side of the question. But, he continued, "for the last two decades a demand for governmental aid and authority . . . has been pressed from the economic side, the argument being [and now one hears Sir William Petty speaking from his three-hundred-year-old grave] that the health and efficiency of the community was an economic asset of great value and therefore the law should compel manufacturing corporations and the people themselves to provide for the prompt restoration of health to the incapacitated." As a result of this demand an act was passed in 1911 requiring compulsory insurance by employers against industrial accidents. At first the insurance companies would pay only their own contract physicians, and it was not until 1917 that the injured employee was allowed his own choice of physician. One may be sure that this amendment was forced by the medical politicians of thirty-seven years ago.

Between the two world wars came the report of the Committee on the Costs of Medical Care, which is still the subject of controversy. Many of those present today heard reverberations of the Report echoing in the orations of Lincoln Davis, in 1934, on "Objectives of Medical Progress," Elliott Joslin, in 1939, on "Phases of Social Medicine," A. Warren Stearns, in 1941, on "The Role of the Physician in a Competitive Society," and Leland McKittrick, in 1947, on "Medical Care in Our Free Society." These politically minded orations, coming in such rapid succession, were in effect storm signals that the medical winds were blowing steadily from the socioeconomic quarter and with increasing force.

Extension of Medical-Care Benefits

Then, suddenly, after World War II, the profession was confronted with full-blown, organized bargaining by the trades unions for medical-care benefits. This is the development that if carried to extremes may yet take over the practice of medicine. The whole movement is described in the *British Journal of Social and*

Preventive Medicine for July, 1953, by Dr. Thomas Parran and Isidore Falk. It all began during the war, when wages were frozen to prevent inflation, but with the provision that 5 per cent of the payroll be approved as a "noninflationary" sickness benefit, deductible from the employer's taxes. If a corporation's excess profits were substantial it could, and usually did, provide, without a penny of cost to itself equally substantial sickness benefits. Thus, most of the first benefits were essentially employer paid in lieu of a raise in wages. Previously, many of the industrial medical-care plans had been created by a checkoff from the wages of the employees, though they had no voice in administering the plans. Collective bargaining was endorsed by the Wagner Labor Act of 1933, and the successive Wagner–Murray–Dingell bills represented Labor's ideas for the prepayment of medical care. The concept of group insurance for medical expenses soon led to Blue Cross, Blue Shield and various commercial plans, and the economics of medical care began to change as the profession watched.

But still collective bargaining with the intention of making the employer foot the bill persisted. By 1945 about 600,000 workers were covered. In 1946 almost 600,000 more came in when the United Mine Workers Welfare and Retirement Fund was created. The steel strike of 1949 revolved around this issue, and in that year the United Steel Workers and the United Auto Workers, 2,000,000 strong, signed agreements that included hospital and surgical service, contributed to jointly by union and company. By 1953 practically all large trade unions possessed partial hospitalization and surgical expense agreements. In 1952 the American Federation of Labor went a step farther when eleven of its constituent unions combined to form the A.F.L. Medical Service Plan in Philadelphia. It is now projecting a similar intercraft center in Chicago, and one in San Francisco. It is important to realize that such projects will involve a majority of the population of those cities, and the vast changes thus set in motion can be only partially imagined. It is inevitable that these ambitious trades-union plans will greatly influence future national health legislation. It is equally inevitable that they will greatly influence the conditions under which physicians must work.

Perhaps, as Dr. James Means says in his recent book, the most contentious question of the day is how far the Government shall participate in medical care. For the time being one will accept Dr. Means's appraisal of the Veterans Administration's medical program as the longest step thus far toward state medicine. One has only to read Admiral Boone's twenty-six-gun salute to the Veterans Administration in the February 27 issue of the *Journal of the American Medical Association* to realize the immensity of its operations. Without belaboring the point, one has to be interested, both as a physician and as a taxpayer, in any federal hospital system that admits over 500,000 patients a year.

However, it begins to look as if by sheer weight of numbers the huge intercraft medical-service plans may take over first place for contentiousness. Any organization that serves a majority of the population controls an awful lot of votes.

Discussion

As pointed out above, it is not in the province of this oration to say what is good and what is bad. Its only purpose is to interest physicians in becoming medical politicians, who, according to my definition, not only talk about the medical weather but do something about it. The weather is stormy, and one must act quickly or suffer the consequences. Politics is everything to the future of medicine. Whether medicine, the arts or the sciences flourish or starve is ultimately the decision of politicians. All physicians as such can do is to point out the facts; as politicians they can hope to determine not only the social and economic directions the profession shall take but even whether the present golden age of medical discovery is to continue. If they ignore the history of England and New Zealand and allow American medicine to become state medicine most members of the profession believe that the progress of medicine will bog down to the speed of Civil Service, chiefly because brilliant young men will no longer be attracted to it. Still, one cannot, as Henry Sigerist is fond of pointing out, successfully oppose trends, because they are part of the evolution of society. But if the doctor recognizes and co-operates with them he may be able to head them in the direction he believes is right. An individual's voice is lost, but an organized young medical generation could have great influence in future developments. It had better, for it is its own future that is being prepared. Otherwise it will be in the position of the lady in the London blitz who complained, "The worst of it is you may be knocked right into maternity and you would never know who did it." It is more satisfying to be informed. If the private practice of medicine is to be knocked right into eternity physicians should at least know who is doing it.

I have had time to speak only of national and world-wide issues. Few physicians can step directly onto the national scene. Yet I hope it will by now be agreed that all should get in the picture. I suggest that those who do not quite know how to go about it begin at the grass-roots level, which means, attend the district-society meetings and talk when they have something to say, and attend the Council meetings too. (They may not know that any member of the Society is welcome to do so, whether he is a councilor or not.) It will not be long before they are chosen to take an active part in the work of their organization, and from there it is up to them. If, for instance, they have no unusual ability but do have unusual friends, they may even be asked to deliver the Annual Oration.

In a civilization where man is free to choose what he will and will not do it is the volunteer who is important. This is the theme of James Michener's excellent book, *The Bridges at Toko-Ri.* Everyone remembers the passage where Admiral Tarrant is talking to Lieutenant Brubaker, the pilot who has just been rescued from his sinking plane (the lieutenant would much rather have stayed home with his family and his law practice):

> "Burdens always fall on a few," said the admiral, "You know that. Look at this ship. Everyone aboard thinks he's a hero because he is in Korea. But only a few of you ever really bomb the bridges."
>
> "But why my wife and me?"
>
> "Nobody ever knows why he gets the dirty job. But any society is held together by the efforts—yes, and the sacrifices, of only a few."

Conclusion

I realize that I have not answered the two questions, "Who are the Council?" and "How are they elected?" The answers can be found in the *By-Laws* of the Society. The answer to the question "What are we getting for our $35?" will be understood by all who take part in the meetings of the Society. If they will do so this paper will have been worth while; otherwise, it will not.

Of course, what I have had to say has not been original. It was derived from many sources, and I hope that the reaction will not be that of the old lady who was taken to see *Hamlet* for the first time. When asked how she liked it she replied, "Oh, it was all right, but it was too full of quotations."

WORK ADJUSTMENT FIVE TO TEN YEARS AFTER BILATERAL PREFRONTAL LOBOTOMY*

Follow-up Study of 86 Patients with Chronic Mental Disease

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THE lobotomy operation for the treatment of mental illness has been used at the Boston Psychopathic Hospital since October, 1943. The first 450 patients received bilateral prefrontal lobotomy (developed by Dr. James L. Poppen and his associates at the Lahey Clinic). To assess the effectiveness of this method of treatment groups of patients have been followed, and various aspects of their adjustment have been studied. A careful clinical follow-up study of the first 250 cases, one to four years after operation, has already been presented.[1] Another follow-up study was done five years postoperatively on the first 100 patients who received this operation.[2] The same cases are the basis for the present study, which primarily concerns the work adjustment of patients five to ten years after lobotomy. This aspect was chosen since the expected economic sufficiency and productivity of the patient is of prime interest in any consideration of the effectiveness of a therapeutic procedure.

Four periods in the patient's working life — before illness, before operation, one to four years after operation and more than five years after operation — were investigated to ascertain, first, how their postoperative work adjustment compared with that before operation and, secondly, whether the work adjustment was the same, better or worse five to ten years after operation than at an earlier postoperative period.

Method

Information was obtained on the first 100 patients five to ten years after lobotomy. Of this group 12 had died, 35 were living in the community, and 51 were in State hospitals. There was no information on 2 patients, who had moved out of the State. Thus, the total number of patients whose work adjustment data were available was 86. Of the 35 patients in the community, 32 were interviewed directly by a social worker or psychiatrist or both; 3 patients could not appear for interviews, and information was obtained by telephone. Reports on the 51 hospital patients were obtained from hospital physicians on request.

Population

All the patients in this study were operated on between October, 1943, and April, 1946. They were all chronically ill, and the prognosis was considered hopeless. Fifty per cent had been ill for five years before operation, about 25 per cent for five to ten years, and the rest for ten years or longer. The hospital period was two years or less in 50 per cent, two to ten years in 25 per cent and ten years or longer in 25 per cent of cases.

There were 49 women and 37 men in this study. Of the 86 patients 40 were married, and 46 were single. Over half had graduated from high school,

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