September 26, 1994

A.M.A. PRESIDENT’S ADDRESS

Robert McAfee, MD
President of the American Medical Association

DR. BAKER: When I met our next speaker, Dr. Bob McAfee in Springfield this past winter, he gave us his usual cogent, succinct analysis of problems that existed and his speech to us and his solutions were fantastic. This is one of the things that makes Bob McAfee so different. He’s able to communicate. He’s able to analyze. He’s able to get us all with him. And when I asked him to speak at this meeting, I was very, very gratified when the time was open and he was able to do it.

I thought it would be an honor to introduce him because he and I were at medical school together. I was probably way ahead of him in years. We both have had sons who graduated from the same medical school. But there’s a member among us here today, our AMA delegate Frank Smith, who has even more in common with him. I’ve asked Frank to introduce Bob this morning. Frank?

DR. SMITH: Thank you, Bill. Bob McAfee and I go back a long way, dating to freshmen at Bates College when we both wore beanies. If you’re old enough to remember those, please smile. We then went on to Tufts Medical and we were classmates there.

Somewhere one of us took a wrong turn. He went into surgery and became president of the AMA, and I went into the Navy and became an internist and ended up here. I won’t bore you with the long ten page CV that I obtained about Bob. The highlights of his career of service to patients and people are highlighted on page 16 of your program.

In the interest of brevity, if you have seen the CNN News recently, there’s a series of ads run by the AMA featuring Dr. Bob. Let me then present to you the AMA’s answer to Harry and Louise, Dr. Bob.

(Applause.)

DR. MCAFEE: Thank you very much, gentlemen for both of your kind words. Good morning to you, ladies and gentlemen. Frank, I did point out that you forgot to tell them I was one of nine children, though. I didn’t get to sleep alone until I got married.

(Laughter.)

DR. MCAFEE: They always teach us in public speaking 101, be sure that our sound system is working and I trust you’re hearing me in the back of the room all right. I say that because I’m more keenly aware of that particular ability to hear, since my wife and I had a discussion a couple weeks ago that I suspect, looking over this audience today, some of you may have had with your spouses recently as well.

For no apparent reason one evening after dinner my wife suggested the time had come for me to have my hearing checked. I say for no apparent reason because you know there’s actually nothing wrong with my hearing.

But she said, “When the children visited they noticed dad seemed to be losing it a little bit,” and “My dear, I notice that you don’t seem to be hearing me as well as you used to. I wish you’d go and have it checked.” I said, “Look, dear, there’s nothing wrong with my hearing, my hearing is fine. It would be a total waste of money. I don’t intend to do it.” I said, “By the way, if there’s anyone in this household who perhaps might need to have their hearing checked, my dear, I might suggest it’s you.”

Now, at that point I thought she left the discussion rather abruptly. She went in the living room and she sat down in the chair and she began to read the newspaper. And I said, “Look, I am a scientist. I can prove this.” So I paced off 20 feet behind her. I’m now out in the hallway of our home. The house is otherwise very quiet. And I say in a normal tone of voice, “Can you hear me?” Dead silence.

I have a little smile on my face at this point. I now split the difference, I’m now ten feet behind her chair. Again normal tone of voice in a house otherwise quiet, “Can you hear me?” Dead silence. Now, a much broader grin on my face. I get right up behind her chair, ready to spring the trap and say again, “Can you hear me?” At which point my wife says, “For the third time, yes.”

(Laughter.)

DR. MCAFEE: I’ve revised my comments a little bit, particularly in regard to the marvelous speech just heard by your CEO. I’ll fill you in a bit on health system reform and where I think some of the mistakes were made and where I think we’re going from here.
I'd also like to share with you the observations, four in number, that I've had the opportunity to make as I travel this country as a representative of organized medicine, as a surgeon in the last few years. Then I'd like to finish with telling you what I think truly is the secret of health system reform in this country. Let's see if we can't do it all in the time allotted.

Let me begin by saying, as we began this whole debate on health system reform, we had looked for this debate in Washington to be a four-act play. This was to be the first act dominated by Mr. Clinton and the first lady.

The second act would be the Congressional subcommittee debates, each of those committees whose jurisdiction on health.

The third act would be the total debate in both the House and Senate and finally the reconciliation conference that would take place to reconcile the differences prior to the election this fall. That was the scenario most everybody was looking at as we began last spring when the President began this process.

Let me first of all say that although the perception of the American Medical Association was shut out of the debate because we weren't officially on the secretive task force, the anonymous 500 people which we have since found out was a very expensive proposition, but some 16 times we had to meet with the administration.

Personally I had the opportunity to sit down with the first lady, to be in the oval office on a number of occasions and to have every opportunity to have our agenda, 15 points of the health access America proposal that AMA has had on the table for four years now, part of what ultimately was to evolve in this country.

So I don't think we can be critical of the inopportunity that existed. There are different ways I think we would have suggested doing it, but nevertheless that was the process that was chosen by the President.

Now, in retrospect, many people have pointed out that the creation of that 1,300 page term paper that came out of that process was so complex, was so difficult to understand that that was one of the first mistakes that was made, that the concept that one could either take the complexities of health system and federalize it to fill in the blanks, without bringing everyone aboard as to where the complexities existed, was probably a major mistake to begin with. And suspect that the administration, given their druthers, would suggest a different process next time around.

I think it was obvious that not only did we, but your industry perhaps did not have the opportunity sitting at the table from day one. Despite the fact that you have as much expertise to bring to the solution of this problem, as anyone. I think the other player who felt, and have labored long in the health system reform vineyard, felt a little bit put out.

Imagine if you were a Ted Kennedy or a Jay Rockefeller or a Henry Waxman or a Pete Stark or even a George Mitchell, my junior senator, who have for many years labored to try and correct the problems in our healthcare system and finally see a President elected of your party and now say I see a light at the end of the tunnel.

Now, let's get moving. And when the President begins the process, he doesn't even invite you to come to the table. That problem played itself out in some many ways this year in Congress, in the debate and at present, that it has caused many people to adopt strange policies, strange positions, the least of which is a resignation from my junior senator from Maine who, although he is a loyal soldier and does feel very strongly about health system reform, I think his resignation tells you that when you're majority leader and the President is of your party, it's a lousy job.

I will tell you that I think George Mitchell's own thoughts about health system reform are a little different than perhaps what he may be announcing now in supporting the President. Certainly they were not what he was telling us last year and the year before in Maine and things that we have supported publicly on AMA in George Mitchell's behalf in the past. His explanation has been, well, I think the President's plan perhaps is better than my suggestions in the past, etcetera.

I point out to you because the process to begin with was one that has come back to haunt the ultimate end process here that we have to deal with. I was reminded by a conversation I had with Congressman Pete Stark who is a gentleman that you know that we have had political problems with in the past. But he's become an individual that we know quite well. We respect his word. He always tells us what he thinks.

I went up to him and I said, "Mr. Stark, I can't believe that there are 30 people in Congress who understand the issues of health system reform." He said, "Doctor, you are being very generous." I said, "I also see, Mr. Stark, that you have signed on as a sponsor to the President's plan and I know that's not what you, in public and in private, were telling us what you think ought to be done." He said, "Yes, doctor, you're right. I kiss the frog but it's still a frog."

I think that when the President had really scraped to get 100 sponsors of his bill, including the three non-voting members of Congress, you had another inkling that what was being sold was not what was being bought, even by a substantial part of his own party.

I think that that should have alerted us a little bit earlier on and should have alerted the administration to begin to mold, to modify, to back off and look at a more narrower package and perhaps not to hold the pen up quite so high and to make the challenge quite so much that universal coverage must be the end point or nothing else will be signed and passed.
I think a lot of people took the President at his word at that point and said, okay, if we can't get to 100 percent or 98 or 99 percent, then it doesn't make any difference for us to debate the other issues before us. I think that was a mistake because we could have moved on so many other parts of the system that had to be fixed before we ultimately get to the goal which the AMA embraces of universal coverage. But as a goal, not a first day policy to be implemented prior to fixing the system.

When the second act came about and the committees of the House and Senate began the debate, you then saw a fascinating process occur. Instead of welcoming and embracing and really taking this opportunity to try, you saw the ways and means committee going through terrible machinations, not the least of which was a loss of their chair and struggling even within those representing the majority of the party to reach consensus and then a one or two vote margin prevailed, hardly the kind of groundswell of support that you would want to see coming out of that particular committee.

But indeed something came out of the committee as opposed to what happened in energy and commerce where John Dingle, whose father was the author of the Murray-Wagner-Dingle Bill way back, as a predecessor of Medicare, and who has been introduced every year since in his father's memory, finally having the opportunity to say okay, here's where we're going to create the biggest part of social legislation in the last 50 years in this country and then the committee not even willing to have hearings and a debate on the issue.

He didn't have votes, he didn't have consensus. There was no report, no report coming out of the committee that has jurisdiction to advise other members of Congress. That should have been our second warning that things were indeed troubled.

In the Senate, where each member is a committee of one and reminds you of that on a continuing basis, you have seen all over the place a feeling of what needs to be done in this country and you've seen personal agendas play itself out in the finance committee, in labor and the other committees dealing with this to the point now where Senator Mitchell can't get the votes to put anything on the table in the few precious remaining days that are left.

So we won't get to see the full debate in the House and Senate. The House now, despite their work on this endeavor, as you know, did not want to be BTU'd again, having embraced something and lost some support, and then only to have the Senate not follow through on the energy bill, said no, sir, you go first.

You set the stage, then we'll tell you what we think in the House. And now theoretically are willing to abrogate that whole process to the Senate, and when the Senate says we can't do anything, the House, for a whole variety of reasons, may accept that same procedure.

I'm concerned that the fourth act, which was to be the conference committee, obviously will not be. And this play that we have been watching is not only closing after the third, the third curtain hasn't even come down yet and the audience has left. But the issue remains, and the issues are as serious now as they've been in the past and they demand our debate. Yeah, 85 percent of people do have access still to our healthcare system which still is the envy of the world and our ability to apply technology and to make a difference.

Any other problem that Congress is asked to address, if it's 85 percent solved, they usually say, okay, next problem. But the debate will continue to focus because I think the problems, particularly that of cost, will continue to be of significance. Yes, they've moderated because of the impact of managed care. Yes, they've moderated because of competition. It has come at great expense dollarwise, but it has also come at great expense in unity in communities among physicians.

I'll tell you, it's becoming to come at great expense between the doctor/patient relationship. I'll expand upon that in just a minute. The time may have to have come for us to say, to certain members of the insurance industry who are involved in managed care, that this far and no further.

Let me share with you again that certainly we embrace the President's recommendation for universal coverage. But again, as a goal, not a policy to be implemented on day one. The administrative savings that the Vice President wants to impose on the Medicare system, terrific. You won't find a doctor in this country who is going to disagree with that. It just strikes us a bit strange that it's the federal government who is going to lead us through this efficiency tunnel. Nonetheless, let's give a try at it.

Certainly insurance reform, the insurance industry, everyone is beating up on you people this year. I think that you'll find very few people willing to think otherwise, when people talk about, well, maybe community rating, maybe elimination of pre-existing condition, maybe increased portability will give us cheaper insurance yet you know the very strong arguments otherwise that may not make that all happen.

But nonetheless the perception in Washington is that's what may happen and that's the perception of patients, many of whom are your subscribers. So probably you'll see a continuing wish for that kind of highly visible activity that might not have a whole lot to do with the bottom line.

The thing that we opposed a great deal was the bureaucracy that was suggested by the President's plan, and I think whatever happens from this point on, the bureaucracy cannot be expanded to solve this problem. Last year for the first time we had more people employed in government in this country for the very first time than in manufacturing. We have enough people to solve this problem in government in this country.
Secondly, the financing as the President suggested, including a rather substantial cigarette tax, as well as the administrative savings that would be spent to increase access to those who don’t currently have it. Unfortunately the President’s plan was suspended before we got it and that seemed to us a bit strange. It would be a little bit better to make those savings, put it in the bank and then could spend it to invite those aboard who do not currently have some coverage.

Certainly the cigarette tax would be helpful, but ladies and gentlemen, unless every man, woman and child in this country smokes 16 packs a day, we wouldn’t generate the income nearly enough to meet and fill in that particular gap.

The two issues that we were, one we were promised that is tort reform. When the first lady said to me, “Doctor, if anything else we will assure you that meaningful tort reform will be part of our health system reform package.” Well, it isn’t. It wasn’t. And I guess I felt surprised because I had taken the first lady at her word. I had taken the administration at their word that they would seriously look at a cap on pain and suffering which has been so meaningful to physicians, let’s say, in California who pay roughly one third less per class simply because of the micro reforms that exist in that state.

And I was pleased when people like Congressman Stark and Kennedy and others have allowed some substantive tort reform to get into their proposals, including a cap on pain and suffering and hopefully it is still alive and the debate that’s going on will have a life of its own even if health system reform doesn’t go, but it’s got to be addressed.

I just paid my premium the other day. It’s twice what I paid for my first house. Granted that’s a long time ago and it was a small house, but I have to pay it every year, I can’t mortgage it. When a psychic in Philadelphia can have a head CAT scan and claim she’s lost the ability to predict the future and collects $3 million for pain and suffering, then we have a system that’s immensely unfair to non-psychics.

(Laughter.)

DR. MCAFEE: And from an actuarial point of view, when only 39 cents of the current professional liability dollar gets back to patients and 61 cents goes to the legal cost of our system, then we have a system that’s immensely unfair to the patients. And that’s the issue we’ve got to hammer home on.

There’s got to be a better way and if the caps aren’t going to occur then we must look at other systems, maybe an alternative dispute resolution system a la worker’s comp, administrative law judge, etc., something to get the costs of the system down to a reasonable way so that we can continue to provide the protection for patients.

I remind you I don’t have insurance that allows me to create medical malpractice. I have professional liability insurance in which I have assumed the liability of patients while under my care. That’s what the insurance is for. It’s for patients; not for me.

Fourthly, the anti-trust concerns which prevent doctors, such as this group, sitting in this room, deciding for any population what is an appropriate way to allocate resources is against the law of this country.

And it’s time we did something that allows groups of physicians who know in local communities what may be best, how they can get together, without threat of triple damages under anti-trust, either codify what is current language or give us prospective guidelines. Don’t tell us, after we’ve spent a million dollars, that this cannot be done or is against the law of this country. That’s what’s in the Hatch-Archer bills and that will still be with us, even if the whole system of reform doesn’t go.

Certainly the concerns about quality, about medical education, quotas and others that we had serious disagreements with the President on, the Congressional administration has goofed up three times in the last four years on Medicare projections and manpower needs and I don’t think they should be given the opportunity to try it again.

The marketplace will tell young people who are going into medicine where the opportunities lie, why primary care probably is the specialty of the future and they’ll make that decision. But don’t do it at the expense of the other specialties that have made our system great.

Don’t penalize the hospitals that continue to train surgeons and ophthalmologists and dermatologists and psychiatrists that their full time equivalency is less than that of somebody going into primary care and the Medicare program won’t subsidize that care any longer. We can do much better than that.

Voice and choice and coverage is essentially our bumper sticker. It will be next year when we go back again. I remind you what probably will happen next year. We’re still optimistic that something still might get through this year that will begin a process for which we can build, but it’s highly unlikely given the now less than three weeks of Congressional session still there.

I saw a bumper sticker the other day in Washington, DC. It said, “Washington, DC, a workfree drug place.” That was interesting.

(Laughter.)

DR. MCAFEE: I think you’ve seen Mayor Barry is back again to take another crack at it.

(Laughter.)

DR. MCAFEE: One of the advantages of traveling is that you learn how to deal with the federal government in different parts of the country. In one of my recent visits down to Mississippi, I learned there were three U’s in Biloxi. They told me how you
deal with the federal government in Mississippi. There was a Mississippi farmer who lived up in the delta country, a rather poor producing farm, but he made a little supplemental living by making whiskey on the side. He'd done this for a number of years and people stopped by now and then for a little bit and it didn't seem to bother anybody.

But somebody spilled the beans and the federal government found out about it. They sent a revenue agent, a very big fellow, bigger than I am. He raps at the door and this little kid answers, about this tall. He says, "I'm from the federal government. Where's your father?" The kid says, "Well, he's out making whiskey." He says, "All right. I want you to take me to him." The kid says, "Well, it's going to cost you $10." The agent says, "Okay. Let's go." The kid says, "Give me the $10." The agent says, "I'll give it to you when we get back." The kid says, "You ain't coming back."

(Laughter.)

DR. MCAFEE: Let me share with you four observations that I think this group particularly may identify with because I think there are things which will have a lot to do with impacting on where our health system goes. It will impact a lot upon what the previous speaker mentioned to you this morning, which I thought was a marvelous expression of the problems that we're facing, particularly in the demographics of our society.

Don't forget for one minute that we are probably the most aging society on the face of the earth. We have more people currently over the age of 65 in this country than the entire population of Canada.

The single fastest growing segment is age 85 and over. We're going to have over 100,000 people at the age of 100 or over by the year 2000, six years from now. Just think of poor Willard Scott on the "Today Show." He's going to dominate the program just wishing happy birthday to everybody.

(Laughter.)

DR. MCAFEE: But you know, 100 years of age is 35 years on Medicare, 35 years that the 25-year-old father of two, working here in Chicago, will have had to pay through his tax dollars the healthcare benefits of Lee Iacocca, simply because Lee Iacocca is over the age of 65. That's what Medicare is in this country this year. We vote every year as to whether we want to continue it through the appropriations resolution and that's what we do.

Do you remember back in 1965, 55 percent of people in this country had private health insurance over the age of 65 the day that Medicare was implemented and government says, never mind, you don't need it anymore. We're going to give it to you. And you probably don't remember that the AMA, at that time, said, no, that's not right. We don't have that amount of money now or in the future to do for the entire population, based on age alone, that which you call the Medicare program.

We had an alternative. It was called Eldercare, an expansion of the Kerr-Mills program which had been in focus for five years at that point. We said we need to provide, the government needs to provide, for those who can't provide for themselves because as our society ages, more and more will be taken up by that population and we need to set aside those dollars to meet their needs. It has to be complimented by the private sector through the continuation of private insurance.

Well, it's taken us 30 years to make our argument, apparent to many people in this country, but the argument I think holds just as much water now as it did then and it's time for us to re-visit Medicare because we've got to begin the means to test that program relatively soon for the reasons that your CEO presented to you just a minute ago. We're going from 35 million people to 40 million people over the age of 65 by the year 2010, that's 16 years away.

But in the next 15 years, that 2010 to 2025, that 40 million people becomes 80 million people over the age of 65. That's the baby boomer, that's the crunch, that's the actuarial numbers. From 2010 to 2025, 40 to 80 million people over 65.

You know, right now the Medicare trust fund is programmed to go belly up in six years, Social Security shortly after the turn of the century depending on who you read. It's going to have serious problems in meeting the needs of that population prior to getting to that.

Why? Oh, yes, there's a Social Security trust fund. Oh, yes, it has been invested. What have we done? Well, we invested it in the good paper of the United States government. If you haven't looked lately, balancing the budget last year, we came within 200 billion and we said that's the best year we've had in the last ten. That paper isn't going to be worth a heck of a lot after the turn of the century.

In addition to the concerns and the need for savings that you've just heard, you're headed for the most major inter-generational squabble that this country has ever had. All you're going to need is a focus, a political organization representing those under the age of 40 who are going to be asked to pay for those over the age of 55 to 60 at that point.

I suggest to you that at that point you may find two political parties in this country, one for the old folks and one for the young folks and along those lines will you find substantial political divisions that will dominate the social agenda unless we begin something now that will play itself out and cover those contingencies down the road.

I think the entitlement commission, Senator Carey having created this as an exchange for his vote on the budget and NAFTA, is a good exercise and I hope the courage that he has shown will be matched by others who serve on that commission, and even if there's bad news to come out of it, that we begin to look at it seriously.
The second observation I make to you is something that makes this country uniquely American, and we tend to forget about it because we enjoy it every day. And I'm really not suggesting that we change it but we merely recognize it. Our society's demands exceed our needs.

Now, that's a simple concept but it's something that has become so ingrained in the fabric of our society that it's hard for us to deal otherwise with rationing some of those demands, much less the needs. If you don't believe this, you know, 28 flavors of ice cream is a bare minimum in our society, right? We stopped being vanilla and chocolate a long time ago. Forty-two cable channels on your television set, one or two of which you have never watched and if I would suggest taking it away from you tomorrow, you would resist, you would get a referendum.

Next time you go down to your supermarket go to the express line, ten items or less. First of all half of the people in line have more than ten items, because you and I count as we wait, right? Then if somebody in the express line has a coupon to cash or a check to cash and they're in the express line which they shouldn't be and they hold us up for ten seconds, you see problems break out like you've never seen before in our country.

We tried to do the same thing in education. We have done the same thing in healthcare. We have tried to provide everything for everybody, 24 hours a day, and we can't afford it any longer. That's the message. It isn't that people don't want it, it's that our system cannot afford it because we've been able to bring that technology to the bedside so rapidly, but at too great a cost for society, the percent of GNP or whatever index we're going to use to make it happen.

I don't object to us slowing down. I don't object to us putting the brakes on. I don't object to us having to tell patients, we can't do your surgery tomorrow, it has to be put off until Monday because we've closed down one of the operating rooms and I'm sorry we can't do your CAT scan tomorrow because we finally are going to let the technician go home at 5:00. We can't squeeze you in, you'll have to have it the day after.

As long as it doesn't impact on outcomes, then that's what we're going to have to do. You and I as physicians are going to have to be the messenger to the bedside. I wish there were politicians standing next to us because those that have promised more will not be able to be delivering more and yet the message is not coming back through them. It's coming back through us.

I pointed out to you a movement that has to happen, it will happen and will cause some increasing unfriendliness in our system in the eyes of the average patient. But it's a movement that is very strong and will have to prevail.

Third observation I make to you, those of you, I don't know how many of you have anything to do with clinical practice, but if you practiced in an acute care hospital in the last ten years you can't help but be impressed that people are walking out of our critical care units how that had universally fatal problems ten years ago. The application of that technology, particularly the critical ill patient, has made a difference. It has come at great expense. But we will be able, through the use of powerful new drugs and antibiotics, resuscitators, respirators in order to do things that we couldn't do just ten years ago.

Now, if you believe anything John Nesbitt told us in his book Megatrends, the high tech, high touch phenomenon, that for every new high technological achievement in our society, it's balanced by something highly touching and highly personalized and it doesn't seem to stay around very long.

Isn't it interesting, at a time when we have this highly intensive care hospital institutionalized care system, we suddenly see in this country a powerful movement dealing with death with dignity, the living will, the advanced directives and more recently the incredible popularity of the suicide books.

Now, I interpret this, ladies and gentlemen, as my patients saying to me, "Doctor, when it comes to going to special care, you're my best friend and if by going there for one or two days on a respirator after you resect my aneurysm it will make a difference and allow me to walk out of the hospital, then I will do it."

But if you're not really sure, Doctor, that one or two days might not be one or two weeks, and if you're not sure that it might not be one or two months, then frankly Doctor, I don't want to go because I don't want to lose control." This is powerful in the older age group as well, in this information age in which we live. My most compliant patients, your most compliant patients in the past have been those in the older age group. They're now saying no, I don't want to lose control over myself, my life, my resources, my legacy, my family even though it may extend my life a little bit.

Let me tell you, ladies and gentlemen, if they're not willing to lose control to me and you, perhaps their best friends in this equation, they certainly aren't willing to lose control to a centralized bureaucratic allocation system run by the federal government that would determine and make those decisions for them.

It was wise not to have the Medicare system as part of this debate this year, but it's going to have to be next year and the year after as we look at this total package because that's where we're going to have to deal with some of these other problems.

The fourth issue I raise to you, don't forget for one minute that we do live in a most violent country on the face of the earth. We the people of the United States of America, in order to form a more perfect union, will manage to kill 27,500 people by homicide this year in this country, 13,220 by handgun homicide.

We the people of the United States of America in order to form a more perfect union and insure our right to bear arms will allow tomorrow, in this country, 100,000 children to go to school with
a gun. The number one cause of death in males in this country, accidental death, between the ages of 18 and 26 is homicide.

The number one cause of death of women in the workplace in this country is not industrial accidents, asbestos, toxins, it's homicide. Forty-one percent of women killed in the workplace die of homicide. Now, it's not homicide indigenous to the workplace; it's domestic violence playing itself out in the workplace.

When a child in this country can get a gun in 24 hours, as 60 percent of those sixth graders to 12th graders told Harvard in a recent study, and this is in every neighborhood across the country, can get a gun in 24 hours and it takes 48 hours to get a library card, we have a focus that's evolving in this country on violence that we have to turn around. Frankly I'm sick and tired of being sent the bill for violence as a member of the medical profession.

As I told the first lady, "Please, madam, don't ask us to put a cap on the cost of healthcare until you and the rest of society can put a cap on the cost of violence. Then we can sit down and talk about allocating resources. But don't do it before that because we are being asked to provide resources, tremendous resources to those who suffer injury as a result of violence in our society."

There are more years of life lost to violence in the United States than years of life lost to cancer, heart disease and stroke combined, according to the CDC in 1994.

We've been on the road about a week this time. We've been home to Maine five days since we were inaugurated in the middle of June and that's tough when you live in Maine. It's a good time of year up there. I invite you all to come on up. It's pretty warm temperature yet. The foliage is perfect, a little off shore breeze and lobster's down to 2.50 a pound. That's my plug for the Maine Chamber of Commerce. They ask me to give wherever I go.

(Laughter.)

DR. MCAFEE: I was in Boston for the American Academy of Family Practice annual meeting and I was there to put on a panel on domestic violence. Next month is domestic violence awareness month in this country. It is ironic that we do have a major case coming out of Southern California playing itself out right in the middle of this particular month. So you're going to hear a lot about it.

We the people of the United States of America in order to form a more perfect union and insure domestic tranquility are going to allow more women to be killed in their homes by their husbands or boyfriends in slightly more than a ten year period than men died in the Vietnam war.

Picture, if you will, the President addressing us on Memorial Day, a second wall has appeared on the Vietnam memorial since he spoke to us last, in slightly more than ten years, so now a third wall perhaps, inscribed with the names of women who were killed in their safest haven in their lives by those who theoretically loved them the most.

There's so much we have to do in violence in our society. Do we need a "Terminator VI?" Do we need a "Lethal Weapon XII?" Do we need cartoon shows on Saturday morning, 19 of which show more than 12 acts of violence per hour?

Kids growing up in violent societies will perpetuate that violence and you and I have a tremendous obligation, not only as physicians, but citizens in our community to begin the coordinated unit effort that it's going to take at the local level because no matter what they do in Washington, no matter what we, the AMA, does nationally to provide guidelines in the physicians coalition of protocol, it's what you and I as citizens are going to do in our neighborhoods that is truly going to make a difference. There's so much ahead of us to do.

I just call your attention to that because if we overlook that, we will have created perhaps a financially secure country but one which nobody perhaps wants to live in.

Let me finish with what I truly think is the secret of health system reform in this country, and it's a simple message. It was brought to me by one of my colleagues during his presidential address in Maine a number of years ago.

He was a marvelous orthopedic surgeon who came to us in the middle of his career. He's a marvelous technical orthopedic surgeon. He chose to practice, having come from a major university setting, in a rather small 50 bed hospital in a delightful part of the coast of Maine, the mid-part of the coast. Because it was a quality of life issue for him, and it's something which the people in that community have benefited substantially from.

On the occasion of this annual meeting, this black tie affair in Maine, it's about as elegant as we get in Maine, he chose to use a case history, which was somewhat unusual, as his presidential address. It took an hour. I will condense it into three minutes.

He used the case of an 81-year-old retired lobster man whose name I still recall, called Horace Jackson, who came to him because he could no longer fish. He had retired from fishing because of serious arthritis in both knees. But he was the most marvelous flower gardener on the whole coast of Maine. People would come from miles around to see what Horace could do with Mother Earth.

Horace only wanted in his life, he had no remaining family, only wanted to be able to kneel down and stand up. That was his simple request. He said, "I can't garden unless I can do that." My colleague sized him up and he has serious degenerative arthritis in both knees. He obviously needed bi-lateral total knee prosthesis, something you think secondly and thirdly about in an 81-year-old but Horace had no other major risk factors, no cardiac, no pulmonary, no metabolic problems. There was really no other reason to deny him that.
And after a second opinion agreed that it was a reasonable thing to do, they brought him in to that little hospital where surprisingly my colleague had done that operation hundreds of times. He did his right knee. It went well, except he did have a large benign prostate and required a Foley catheter because of urinary retention post-op and they, they couldn't get the catheter out without him going back into retention.

So they decided to leave it in and let him go home with a leg bag et cetera, even though there was perhaps, a slight risk of infection. The urologist followed him carefully as an inpatient, tried a couple of times but couldn't get by without the need to return him to the hospital and do a trans-urethral resection because the catheter had to come out because of the risk of sepsis. The knee was fine.

But while under anesthesia, under the drapes, in the stirrups, having a trans-urethral resection, he developed a partial dislocation of his new prosthesis. It was noticed the minute they took the drape off. They restabilized the knee, and put a cylinder cast on.

That began, at that point, a cascade of events that my colleague took an hour to tell us about, which quickly went instability of the knee, took the cylinder off, still instability, exercises didn't work, PT, additional therapies unsuccessful, continued instability, pin in the tibia, infected pin, infected knee joint, drainage of the knee joint, IV antibiotics, subsequent right above knee amputation 18 months later.

At this point you're saying, why are you telling us this case, Bob? It doesn't sound like you're going to make the bone and joint journal on this one. Then he got to this point, he said, "When Horace Jackson came back to my office sitting in the wheelchair in which he would always sit at that point, to have the sutures removed from his right above-knee stump which had healed nicely and I took them out."

I tried to avoid Horace's gaze but he looked at me and he held out his hand and he said, 'Doc, I want you to know you done a good job," and my colleague said, "I didn't know what to say. I said thank you, Horace."

"I turned and I went into my office, I shut the door and said, what was this kind and gentle man saying to me? He had come to me with the simplest of requests and I, the system, had lost his leg."

When Horace Jackson came into that tiny hospital in Maine, whether it be the admitting clerk, the housekeeper, the security people, the therapist, the nurses, the doctors, they all knew him. They desperately wanted him to get well and walk and go back to his garden. They cared for him. And what Horace was saying was that's the only thing I have a right to ask is that you indeed care for me.

Ladies and gentlemen, from this point on, if we together, collectively, with Congress, with the special interests, are not able to create a newer, better healthcare system that cares for patients more than our current system, then none of us deserve our subscribers, our clients, our patients to come to us and say, "Doc, you done a good job." Thank you very much.

(Applause.)

DR. BAKER: I think you all understand what I meant by Bob McAfee being able to communicate. He has time for one or two questions. Can you go to the middle of the aisle and ask your question?

AUDIENCE MEMBER: Dr. McAfee, you sound just like Marcus Welby. You have a gentle presence and I really enjoyed your comments.

The one thing I wanted to ask you about was also a phenomenal growth in alternative medicine. I think it also speaks a lot to the issue that you talked about, about technology being so impersonal and although we have this tremendous system, I think it says something that people want some touch, they want somebody to care about them. I think also that people are looking for more than just the drugs.

They're looking for healing, they're looking for some peace of mind, stress reduction. This managed care, it's a processed system and I wish you'd maybe address the alternative medicine issue.

DR. MCAFEE: I couldn't agree with you more. It is not just that it's focusing now. If you look back over time, there's been a couple papers written, I think Castileth out of Philadelphia wrote a very seminal paper a number of years ago looking at alternatives to cancer therapy, why people were seeking alternatives when the options were readily apparent.

It was obvious that most of those patients had already gone through conventional therapies. They were, I hesitate to say, abandoned, but they were told that there was no more that chemotherapy could do, there was no more that surgery could do, there was no more that radiation could do. And I think the message, and those of you that may have had an opportunity to read my inaugural address to the AMA, which was essentially a conversation with my son who was beginning the private practice of medicine in Boston the week after my inauguration. It was what I expected him to do as a physician.
The emphasis I made was he's taken the tough specialty of oncology and hematology and I reminded him that when you can no longer cure, you can still care. And that's when the largest of your commitment of your professional career is going to be made. And I couldn't agree with you more, that we have abandoned some of that realization that there is so much that we can do, the perception that we can be the persons to care, to solve these problems is significant.

When you ask victims of domestic violence who they would rather have told of this repetitive behavior in their home, you and I as family physicians are named 87 percent of the time. That's more than want to tell their priest, their pastor, their rabbi. It's 20 percent more than want to tell the police. Because we're perceived as someone who cares.

Well, I think those in alternative therapies, which as you know are being investigated by a NIH study now, a division is spending a fair amount of money to see if there is some special new therapeutic endeavor that's coming from these. I suspect the message will be just as you've identified, that once the study has come, the value has come in somebody taking the time to sit down, to be empathetic, to understand, to love and to care and that's what it's all about. I think for that reason it has brought our focus back to that.

I think the suicide books have focused again on this horrible way to end your life, if you read *Fatal Wish*, that you and I should have been fulfilling a long time ago. And we do, by and large. But I think I couldn't agree with you more. Let's look at it from the science but let's realize that the reason we're being asked to look at it is that we're not doing the job in caring as we are in care for the patient.

Okay. Anything else?

DR. BAKER: Thanks very much, Bob. That's all the time we have this morning. I think we all thank Dr. McAfee for representing us, the AMA, this year. I think we understand why he's the president.

(Applause.)

DR. BAKER: We're ready now for our first refreshment break. Let's all get together again soon after 10:30. It's in the French Room right across the way.

(A recess was taken.)