

Presidential Address

The College, general surgery, and fragmentation

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"The investiture with these robes of honor brings with it a sense of humility, especially when one remembers the distinguished surgeons who have preceded him. They are accepted, however, as an expression of your desire that each and every member of the College should feel that duties and responsibilities of membership should be shared by all...the concrete expression of the ideal that the most enduring progress in social movements follows the participation of all, even the humblest, in its deliberation and activities."

It was with these words that Allen B. Kanavel began his address to the newly initiated Fellows of the College in 1932. In this my first task as President, I shall emphasize two aspects contained in Kanavel's statement: the duties and responsibilities of Fellowship and the idea that enduring progress follows the participation of all. If there are to be solutions to generic problems facing patients and surgeons, it will require the participation of all of us.

I welcome the new Fellows to our ranks and congratulate them. You now take a place among your peers with full recognition as a surgeon. This is not the beginning of your career. It is the end of the beginning. You have already accomplished something outstanding. There is no doubt nor question that you will adequately replace those who have taught you and help you educate yourselves. Some of you will be the future leaders of American surgery, some the great teachers, some brilliant clinical

surgeons. I wish you great good luck and as much satisfaction in your future career as I've had in mine. I must admit that I envy you, your youth and your future in the promise of exciting years ahead in the practice of surgery.

A reading of the addresses of all the preceding Presidents of the College discloses a pattern—that of a state-of-the-College address. I shall not depart from that tradition. I will briefly sketch out some of the pertinent history of the College.

The beginnings may be traced to 1904 when a new journal devoted to surgery and edited by practical surgeons was conceived by Franklin Martin of Chicago, IL. To be called *Surgery, Gynecology and Obstetrics (SG&O)*, the journal had its first issue July 1, 1905. Aside from the *Journal of the American Medical Association*, it was the only medical journal then in existence not published by a commercial firm.

In July 1903, the Society of Clinical Surgery was formed by a group of surgeons that included George W. Crile, Harvey Cushing, and William Mayo, among others. The meetings of this group were held in turn at the members' respective hospitals and medical schools. In 1910 Martin proposed that SG&O invite its subscribers to visit the surgical clinics of Chicago. Emulating the plan established by the Society of Clinical Surgery, the journal organized the clinics, invited prominent surgeons of Chicago to participate, and arranged a two-week meeting in November 1910. Thirteen hundred surgeons attended this meeting—approximately 200 had been planned by the organizers.

It was decided by those in attendance on the last day of the meeting to organize into a new society to be called "The Clinical Congress of Surgeons of North America." Albert J. Ochsner of New Orleans was President and SG&O made the official journal.

Three years later at the third Clinical Congress held in New York, the 2,500 surgeons who attended voted to organize a College of Surgeons with the Clinical Congress to represent the scientific meeting of the College. J.M.T. Finney of Baltimore, MD, was elected President. In his Presidential Address he stated that "the aim of this organization and the

reason for its existence lie in its disinterested and unselfish efforts to elevate the standards of the profession, moral as well as intellectual, to educate the public that there is a difference between the honest, conscientious, well trained surgeon, and the purely commercial operator." He spoke of the vision of the founders, of "a profession free from the taint of commercialism or graft, in which there shall be no room for the base, the unscrupulous, the ignorant, or unskilled; in which the test for membership has to do only with character and attainment."

The ideals of the College have not changed since that first iteration. The attainment of Fellowship means recognition by one's peers as an honest, conscientious, competent surgeon. In a sense Fellows have been conferred with a higher degree, Fellow of the American College of Surgeons, symbolic of achievement beyond the MD degree, beyond certification by a specialty board. Competence is performance-based and can only be directly judged by observation and outcome. You have been so judged.

The duties and responsibilities of Fellowship mandate not only continuation of a conscientious practice of surgery, but also, as Kanavel pointed out, participation in the affairs of the College so that enduring progress can be made. What are some of the achievements of the College as a collective body?

The College was the first organization in America to establish qualifications for surgeons. It was quickly apparent that standards needed to be established for hospitals as well. Other organizations were approached to cooperate in a survey of hospitals and establish standards but none were able or willing to do so. The College carried on alone, at its own expense without any charge to hospitals, the hospital accreditation program from 1919 until 1952. It was then turned over to the Joint Commission on the accreditation of Hospitals, which the College was instrumental in establishing.

When the College was formed a committee was appointed to plan an educational campaign to inform women of the early symptoms of cancer. This stimulated public interest to the extent that it led to the formation of the American Society for the Control of Cancer, the establishment of cancer clinics in hospitals, and an accreditation system.

In 1922, a study of the treatment of fractures was started. Treatment standards were established and a manual published, one that I used as a surgical intern and assistant resident some 30 years later. The Committee on Fractures evolved into the College's Committee on Trauma, which has established standards for trauma care, a highly successful training program, and now an accreditation process.

In 1926 the Committee on Motion Pictures was established to continue the original idea of the Clinical Congress to bring practical surgical information to practical surgeons.

In 1934 the College made a study of methods to provide medical care to the public. As a result, the Regents proposed a health insurance plan to be designed and administered cooperatively by the medical profession and insurance companies. As Loyal Davis described it, "this admittedly undetailed, but creative suggestion was greeted by a flood of resolutions introduced in other medical organizations, now a familiar technique, attacking not only the inexactness of the principle but the jurisdictional right to enunciate it."

In the same period the College instituted a program of inspection and accreditation of industrial clinics to upgrade the standards of care for labor and the working man.

The College was instrumental in the formation of the American Board of Surgery in 1937, an effort spearheaded by Everts Graham and the Graduate Education Committee. The College is parent to seven of the surgical residency review committees, a concept it championed in the spirit of pluralism and voluntary accreditation rather than any autocratic system of control of graduate education vested in any one organization.

In 1941 the Forum for Fundamental Problems in Surgery was established and has played an important role in enhancing scientific education in surgery.

In 1970 the concept of a self-evaluation process as a powerful stimulus to continuing education and maintenance of competence was initiated in the Surgical Education and Self-Assessment Program (SESAP), that immensely successful undertaking

now in its sixth iteration. The Committee on Pre- and Postoperative Care originally established many years ago as the Committee on Surgical Nutrition has embarked upon an ambitious undertaking with *Scientific American* to place a continuously updated version of these most important aspects of surgical care in the hands of practicing surgeons.

These are examples of the great force for good that the College has been and will continue to be not only in North America but throughout the world. Clearly, the American College of Surgeons has taken its rightful place among the great surgical colleges of the world because its members have taken very seriously the stern duty imposed upon them by the responsibility of Fellowship in the College.

During my tenure on the Board of Regents, the College grew out of its space requirements in the headquarters building in Chicago. Options were debated, including the building of a high rise office complex, updating and enlarging the present buildings, or moving the College headquarters to Washington, DC. After due study and debate the College chose to renovate and enlarge the building in Chicago. At the same time it was deemed wise to depart from the role of an observer of legislative affairs and to become a much more active participant in the legislative process.

As a result we have moved from rented space to a handsome College building in Georgetown with appropriate staff, and have established an ongoing relationship with a firm of health policy advisors. Because of the forthright, honest stance the College has taken as a staunch advocate for the patient, it has been a credible and constructive participant in the federal policy-making process and is increasingly being called upon for its view on physician payment issues.

Two examples—the first having to do with graduate education. When the government's share in funding resident training through Medicare reached \$1 billion, there was a great fervor in Congress to drastically cut or eliminate such funding. The argument of a subsidy for rich doctors charging high fees was part of the rhetoric. Under the leadership of Oliver Beahrs and George Sheldon, among others, the College was able to counter that specious charge and to make its views heard so that the out-

come of the resulting legislation was less negative than what originally had been proposed.

The second example has to do with physician reimbursement. The College shares the concern of third-party payers and others about mounting costs and about access to and the quality of health care. High fees, wide geographic variations in charges that go beyond obvious or rational explanations such as the cost of professional liability insurance, unbundling of services, and "creative" coding are but some of the evils. As you are aware, the College chose not to support the Harvard project that developed a resource-based relative value scale. The College took that position because the project was flawed in its methodology; it also failed to address the volume and intensity of services, a major cause of runaway costs pointed out by William Roper, then Secretary of the Health Care Financing Administration. Moreover, its admitted aim, as explained by its principal investigator, was not to control costs but, rather, to redress the income disparity accruing to the providers of cognitive services as opposed to preceudural services.

In 1986, the College offered the first of two proposals with regard to physician payment reform. This alternative plan was based on the following objectives:

1. To avoid changes in payment methodology that would adversely affect the beneficiary because of loss of access to care, compromises in quality of care, or burdensome increase in beneficiary cost.
2. To support the best practice of medical care and to encourage continued improvements in clinical diagnosis and treatment.
3. To make future costs of services more predictable and acceptable.
4. To provide for a system of administration that would ensure effectiveness and fairness in implementation.

The College proposed the creation of a single Medicare relative value scale (MRVS) in each state to begin with, reflecting the 75th percentile of charges for services in all localities in the state. In time the goal was to establish one MRVS nationwide.

The problem of unbundling was addressed by proposing that the Secretary of Health and Human Services establish a mechanism for creating and

updating a national dictionary for payment purposes by relying on experts from the private sector for assistance. The College included a proposal to define those instances when qualified surgical assistance is needed for a given operation. These activities had been initiated in 1985 under the leadership of ACS Director Paul A. Ebert; W. Gerald Austen, Chairman of the College's Physician Reimbursement Committee; and Oliver Beahrs, who at that time was the sole surgical representative to the Physician Payment Review Commission (PPRC).

As a result of its efforts, the College has seen several of its concepts either enacted into law or become the subject of study mandated by Congress.

In 1988, in the debate over the RBRVS project, the College pointed out that not only did the report fail to address volume and intensity of services that were mainly responsible for the 15 percent annual increase in Medicare part B expenditures, but also that if implemented the proposed RBRVS would only exacerbate existing problems. In its second proposal, which was issued that year, the College included the following elements:

1. An emphasis on the development and application of practice guidelines coupled with a determination of a separate national expenditure target for surgical services. The purpose of this portion of the College's plan is both to moderate growth in Medicare expenditures by addressing the issue of volume of services and to make expenditures more predictable for beneficiaries and the government.

2. Payment for services provided to Medicare patients with incomes at or below a level to be determined by Congress on the basis of the scheduled payment only. In addition, provisions are to be made for patients who require emergency surgical services and who cannot choose their surgeon. The intent here is to improve the financial protection of Medicare patients through fundamental changes in the assignment program.

3. A fee schedule for surgical services under Medicare based on a 50/50 blend of resource costs and demand-side factors. This blended schedule would reflect both improved measurements of supply-side or resource cost inputs, with important

demand-side considerations, including the efficacy and benefit of treatment as seen by both patients and physicians.

The Physician Payment Review Commission and the House Ways and Means Committee have recommended the setting of expenditure targets for the Medicare program, beginning with the 1990 budget. A separate target would be set for surgical services and for any other categories of services deemed appropriate by the Secretary of Health and Human Services. The College has been asked by the PPRC staff to provide information and guidance with regard to setting targets for surgical expenditures.

The College proposal has not met with universal approval by certain physician organizations. Recently I received a letter from a past president of the AMA that accused the College of "abandoning the house of medicine" and of "cutting a deal with Congress to support continued high surgical fees." I need not point out the absurdity of that accusation—the notion that Congress as a body would enter into collusion with surgeons to fix fees clearly departs from reality. It does reflect, however, intensity of emotion over the issue of expenditure targets. It should be pointed out that the Medicare program for years has been subject to an implicit national expenditure target established as part of the federal budget process. These are highly visible problems and Dr. Beahrs' leadership in dealing with them has been exemplary.

One problem, much less visible, much less public, but of enormous implication for patient care and for the College itself has to do with fragmentation in surgery. I would point out that the gradual loss of a coherent center is not unique to surgery but is a corrosive malady of modern man. It is particularly apparent in our cities when business hours are over. It has much to do with man's alienation with self and the aimless search for meaning in existence. It profoundly affects professional practice. There are immense problems in the professions—in medicine, in law, in government, in business, and in the ministry. It would be presumptuous of me to attempt to speak to these issues excepting as they pertain to surgery.

The problem of fragmentation is a recent one. In 1886, for example, Samuel D. Gross said in his inaugural address as president of the American Sur-

gical Association that he felt safe in saying that there was not then in the whole country a medical man who devoted himself exclusively to the practice of surgery. A quarter of a century later, the first Convocation of the American College of Surgeons in Chicago admitted 1,059 surgeons to Fellowship.

By 1939, Howard Naffziger of San Francisco, in his Presidential Address, noted the rapid rise of specialization and spoke about some of the obvious advantages and some of the problems. He pointed out, for example, the disadvantage to the public, "who in the presence of disorders in some particular part, attempt to seek directly the appropriate specialist."

By 1950, Fred Collier noted the "complaints of high fees without consideration of financial status, multiple fees from several specialists, and a general indifference of the specialist to the patient as a human organism." The following year, Henry Cave remarked, "Certainly the status of the general surgeon has changed greatly in recent years and is still changing. His field of activity has been greatly narrowed by the development of the specialties. Will this trend continue, and to what extent is it desirable to do so? What is the proper function of the general surgeon today? What part, if any, will he play in the medical world of tomorrow?"

These same questions have been asked repeatedly since that time. Their most recent iteration came a year ago. Head and neck surgery was the issue, a field in which Dr. Beahrs and I both have great interest. Specifically, the general surgical community perceived the inclusion of thyroid and parathyroid surgery in the program of another surgical specialty in the realm of the Clinical Congress as an incursion into the field of endocrine surgery, highly developed and managed by general surgeons.

The Advisory Council in General Surgery as well as the Council of the American Surgical Association, the Southern Surgical Association, the Association of Academic Chairmen, and the American Board of Surgery were of one voice in condemnation. That part of the program was withdrawn. However, the issue remains divisive and potentially of great harm to the College.

The terms of the immediate problem that galvanized the general surgical community are overly narrow if a remedy is to be achieved. Clearly these terms need explication and enlargement beyond those of a beleaguered specialty encroached upon by another. The general issue of fragmentation and subspecialization in all fields of surgery needs intense study, as well as the central question asked by Henry Cave in 1951: "What is the future of the general surgeon?"

In my view the future of the general surgeon, the future of surgery itself, and the future of the College are linked inseparably. The College must undertake the quest for coherence within the disciplines and between the disciplines of surgery. It is consistent with the original purpose of the College, that is, "... its disinterested and unselfish aim to elevate the standards of the profession and to educate the public ..."

I believe that any proposed solution lies within the graduate education of the surgeon. I would agree with Frank H. T. Rhodes, president of Cornell University, when he said, "unbridled specialization is higher education's mortal sickness leading to atomistic narrowness and incoherence. In the words of John Donne, 'Tis all in pieces, all coherence gone.'"

My fellow colleagues, the graduate education of the surgeon is in pieces without a coherent center. The curriculum is largely outlined by a specialty board and partly fleshed out by the residency review committee. Thus minimum requirements are established by groups of dedicated individuals, but individuals who work in relative isolation. The American Board of Medical Specialties serves as a forum for the boards and much good has come from workshops, symposia, and committee meetings dedicated to evaluation procedures. Residency review committees are charged with the evaluation of the curriculum of a given specialty, in a given institution. While they write special requirements for a specialty, and thus in a sense the curriculum, they do so independently. The Accreditation Council for Graduate and Medical Education is concerned with process. There is no forum for the discussion of substance in the curriculum in surgery. Moreover, the university, the

hospital, the public are left out. Thus the academy, the venue, and the beneficiary do not participate.

Let me give you an example of a concept widely accepted as valid, yet one that has been rejected by the various specialty groups. It is a concept of basic surgery or core surgery; that is to say, surgical training and knowledge fundamental to the care of patients undergoing operations of whatever part. That idea has been championed by Edward Churchill, Robert Zollinger, William Scott, Frank Glenn, William Holden, and others, beginning in the 1940s. In 1961, the Board of Regents of the College published a statement on basic Surgical Residency Education and Training in the *Bulletin*. A symposium on the subject chaired by William Holden was held in 1969 by the American Surgical Association. More recent proponents have been Robert Chase, Hiram Polk, and Alexander Walt.

The concept, while valid on its face, has been rejected because the appropriate forum for its proper debate did not exist and does not exist. The will to implement it was blocked by political considerations.

Beyond the basic core of surgical experience lies specialty differentiation. General surgery struggles under the obligation of providing two years of experience for some, and five years experience and board qualification for others, including individuals going into cardiothoracic, plastic, vascular, and pediatric surgery. General surgery is no longer capable of providing this experience while still training general surgeons. Moreover, even if this burden were lessened, general surgery needs help just as the other surgical specialties need help. Mutual assistance is mandatory if we are to fulfill training obligations in an optimum way for the ultimate public good.

General surgery is a specialty just as cardiothoracic surgery is a specialty. It needs to be elevated to that status and not continue to be cast into an intermediate role. General surgical board requirements for cardiothoracic, plastic, pediatric, and vascular surgeons have to be reconsidered.

The graduate curriculum, particularly the fourth year of medical school, needs reform. Robert Ebert and Eli Ginzburg coauthored a comprehensive article in *Health Affairs* recently pointing out the sorry excuse for an educational experience that the cur-

rent fourth year in medical school has become. The students seek out active rotation all over the country merely to obtain an extended interview for early entry into specialty training. This clearly is not in the best interest of the student, the specialty, and certainly is not in the public's best interest.

Hiram Polk, speaking to the Southern Surgical Association in the early winter, elaborated on the taxonomy of ills afflicting the surgical profession: surgical practice "infringements," unchallenged public misrepresentation of the surgeon, other surgeons and nonsurgeons narrowing the base of general surgeons, and surgeons fighting a losing battle on reimbursement.

He flatly stated, "Our American College of Surgeons is the only entity that can act for us." I agree emphatically! I have tried to show how the College has responded in a forthright, rational way to high fees, unbundling, and the like. Clearly, it needs to do more and make the public aware of its efforts.

Practice infringements and the beleaguered status of general surgery cannot be ignored. To do so is to imperil the central base of surgery itself and the College as a force for the public good. Etiology of the problem is multifactorial, but clearly the disarray in graduate surgical education is a major causal component. All education—not just surgical education—stands in need. We as surgeons, however, must put our own house in order. To do so requires "discourse and debate as free as possible from guild arrogance, guild complacency and guild fundamentalism," as Kanavel stressed in 1932. Not only surgeons but the university, the hospital, and the public need to be involved. The structure of the College and indeed that of our country require consensus from groups with differing views before new enterprises may be initiated. As Alex Walt pointed out, "While education was the original stimulus to the founding of the College, many other bodies and societies are now deeply involved."

What I am suggesting will require broad involvement and broad support. It will take time. When the College embarked upon a study of the standards of hospital care, an effort as important to the public as was the Flexner report on medical schools, it was funded in part by the Carnegie Foundation. Crucial to the success of this enterprise is foundation sup-

port, as well as broad support by the Fellows. A greatly expanded educational role for the College will require nothing less. Reform of surgical education is in the broad public interest as well as in the interest of surgeons. If there is a guiding strategy for our effort, it is that of Kanavel—the "broad participation by all"—and, I might add, without the imposition of a solution by any one group for the many.

My fellow colleagues, the College needs your help in its urgent mission. Once again I congratulate you on your achievement and I wish you well. Both success and failure will attend you. Be prepared to accept both with grace and humility. □

Dr. Jurkiewicz delivered this Presidential Address during the Convocation ceremonies at the 1989 Clinical Congress in Atlanta.

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