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THE PRESIDENTIAL ADDRESS

The ongoing pursuit of high quality

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Former Chairman of the College's Board of Regents, ***Dr. G. Tom Shires*** *became President at the 1981 Clinical Congress.*

During the past year I have read all of the previous Presidential Addresses given since the founding of the American College of Surgeons in 1913. This rewarding experience has given me some additional insight into the thoughts and feelings of the individuals who have been elected to this College's presidency.

A most appealing address was the rather simple but extremely cogent message delivered in 1962 by one of the most respected members of the American College of Surgeons, Dr. Loyal Davis. Dr. Davis, as you know, was Chairman of the Board of Regents and subsequently President of the College. In addition, he has written a book about the American College entitled, "A Fellowship of Surgeons," and has served with eminent distinction as the Editor of *Surgery, Gynecology & Obstetrics* for over 40 years. His experience, therefore, enabled him to reduce his remarks to two simple questions: What is the reason for existence of the American College of Surgeons? and Why did each of us voluntarily seek its Fellowship? I would like to paraphrase the answers he gave and examine the progress made in the last 20 years.

In answer to the first question, Dr. Davis said, "The American College of Surgeons was founded 50 years ago for the sole purpose of elevating the standards of care of surgical patients. There was no other purpose then and the goal has remained the same." Now 68 years after its founding, the College still has as its main guiding purpose the goal of elevating the standards of care of the surgical patient.

In 1962 Dr. Davis enumerated six specific areas in which the American College had been working to upgrade standards of care. The

College: established minimum standards for the hospitals to which surgical patients were admitted for treatment; provided a forum for discussion of cancer care and care of the injured patient; endorsed the principle that medical school faculties should prescribe and direct postgraduate as well as undergraduate teaching in surgery; affirmed the belief that contributions to the advancement of knowledge in the medical sciences would inevitably lead to more extensive use of hospitals and that an elevation in living standards would be accompanied by wage increases and a rise in hospital costs. Consequently, in 1934 the Regents proposed a health insurance program to be planned and administered cooperatively by the medical profession and insurance industry; enunciated ethics and principles related to both ethical and financial relations among the patient, the surgeon, and family physicians; and recognized the hazards of full and unrestricted state licensure that allows the practice of all kinds of medicine, including complex surgical procedures.

I thought it might be appropriate to look briefly at the areas he identified, to update the efforts made in these areas, and perhaps propose possible changes that may be needed to further the overall goal of improved quality of care for the surgical patient.

Hospital accreditation

As Dr. Davis said so well, "Shortly after its founding, in 1913, in addition to annual gatherings at which they exchanged knowledge, talents, skills, individual characteristic traits and mannerisms, Fellows of the College attacked the problem of establishing minimum standards for the hospitals to which their patients were admitted for surgical treatment. Some insisted that the initial reports of the investigation into the current standards were so damning that, if published, the ultimate goal would be defeated. So the papers were burned, it has been said, in the furnace of a New York hotel. There was the minority who, because they held so deeply that indifference becomes a crime, believed that it was a mistake to be moderate in condemning."

Subsequently, these efforts evolved into what has come to be known as the JCAH—the Joint Commission on Accreditation of Hospitals. As the number of hospitals with increasingly sophisticated technology and increasingly specialized functions evolved, this costly accreditation function had to be shared with other medical organizations. Subsequently, the Joint Commission was organized by the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons; each organization participates in the JCAH's independent governing body, the Board of Commissioners.

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While accreditation by the Joint Commission on Accreditation of Hospitals is entirely voluntary, most of the 7,000 acute-care hospitals in the United States do seek accreditation because most third-party insurance payers will not reimburse for services rendered in an unapproved hospital.

Various alterations in the standards and structure of the JCAH have occurred recently in response to litigation or threatened litigation. Moreover, certain resolutions from the deliberative bodies of the American Medical Association and the American Hospital Association have been interpreted as calling for critical changes in the orientation of the JCAH. Recently an ad hoc committee has bypassed the normal functions of the Board of Commissioners and its standing committees and has threatened the orderly review of standards that has been conducted with full approval and participation of all sponsoring organizations over many years. In a number of instances of recent change in standards, quality has been a casualty of these new initiatives, as reflected in the increasing scope and freedom of practice within hospitals for nonphysician personnel.

The American College of Surgeons and the American College of Physicians have resisted vigorously some of these profound alterations in policy, but the voting structure of the JCAH puts policy determinations outside the effective influence of the two professional organizations.

A disappointing feature of the Joint Commission has been its unwillingness to assess professional standards in any meaningful way.

Consequently, surgery is performed in many approved hospitals by untrained and unqualified individuals. This is a problem that has existed since the American College of Surgeons was founded. An effective survey or accreditation of professional qualifications is still lacking. It may well be that a commission on surgical competence, initiated by the American College of Surgeons, would be an appropriate solution to improve the quality of surgery done in many hospitals in the United States.

Cancer and trauma programs

Shortly after its founding, the College created the first opportunity for discussion of cancer before a public audience, enlisted the help and interest of a popular author to write about the disease in lay magazines, and encouraged its Fellows to form an independent society with the purpose of controlling cancer.

Similarly, at the time the College was formed, the United States was involved in the Industrial Revolution; consequently, the College instituted panel discussions on the health problems resulting from accidental industrial injury. These efforts were directed toward educating the medical professional about the immediate and definitive treatment of the injured patient, as well as educating the public about the surgical, social, and economic aspects of trauma.

These two pioneering efforts resulted in two standing committees: the ACS Committee on Trauma and the Commission on Cancer, a multidisciplinary group. Subsequently, these two areas of major interest to surgeons were developed into full departments of the American College of Surgeons with full-time assistant directors to spearhead the activities. The activities of the ACS Cancer Commission include: the approvals program, the Committee on Patient Care and Research, the Committee on Education, and the Committee on Field Liaison.

Similarly, the Committee on Trauma has developed a number of innovative programs relative to the care of the injured patient. These include, to mention only a few, the delineation of standards and categorization of hospitals for care of the severely injured patient; a recently launched advanced trauma life support program for physicians; and an ongoing effort in continuing education of physicians with regard to the traumatized patient. In these two areas, cancer and trauma, not only has public awareness been heightened but high standards of quality in surgical care have been established and continue to be further delineated.

Undergraduate surgical education

The American College of Surgeons has long been concerned with the status of undergraduate education in surgery. It now has a standing Committee on Undergraduate Education.

The Regents have met with the Committee on Undergraduate Education to plan a program to define the objectives of basic surgical education, and particularly to present a positive and correct image of surgical careers to medical students. I recognize the distinct possibility of disenchantment with surgical careers, a possibility that was underscored by the failure to fill approximately 500 postgraduate year-one positions in surgery during the last academic year. Students have interpreted existing manpower reports to mean that there are or will be too many surgeons, and students educated in larger urban areas have noted that their local situations do suggest a saturation point.

Projections for the future from available medical data are being acted upon by the surgical specialty boards and the American College of Surgeons. However, there is little information being disseminated to medical schools and medical students that the resulting realignment should stabilize manpower needs. If a student is accepted into an approved surgical residency, the residency pipeline will *not* now overproduce at the end of training.

Furthermore, there has been a significant movement to entice students into medical school who are, in fact, not interested in specialty care. If this trend continues, I am concerned that the talented, highly motivated potential surgeons of the future could be lost rapidly, not merely from surgical practice but even from participation in medical education in this country. Consequently, the Committee on Undergraduate Education is preparing a plan to disseminate accurate information, define the objectives of basic surgical education, and formulate the best way of implementing such a program.

Graduate education in surgery

In January of 1975, as the result of a number of studies, including the Millis Commission Report, a new attempt at an organizational

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structure for graduate medical education in this country was made through the formation of the Coordinating Council on Medical Education (CCME) consisting of four liaison committees concerned with: undergraduate medical education, graduate medical education, continuing medical education, and allied-health education. The American College of Surgeons, with its long tradition of support for education, cooperated fully in this attempt to structure formally a broad base of education, especially for graduate education in all of the disciplines in the United States.

The Graduate Education Committee of the American College of Surgeons is a unique committee composed of representatives from all of the surgical specialty boards and surgical residency review committees. This committee has had, as one of its major functions in recent years, the task of monitoring the activities of the Coordinating Council on Medical Education and its liaison committees, particularly the Liaison Committee on Graduate Medical Education (LCGME) and that committee's major accrediting bodies, the residency review committees. In response to action by the College's Graduate Education Committee, the Board of Regents has repeatedly requested that improvements be made in the accreditation of graduate education programs in surgery. Among other things, the Regents have requested:

- That the residency review committees be designated as the approval body for graduate education residency programs in the surgical specialties, subject to authorization by the Liaison Committee on Graduate Medical Education to do so.
- That all policy matters of the residency review committees be approved by the organizations that actively sponsor the residency review committees before they are submitted to the Liaison Committee on Graduate Medical Education.
- That the Liaison Committee on Graduate Medical Education be designated as the appeals body for graduate education residency training programs in the surgical specialties, and be given the authority to resolve questions in concert with the residency review committees.
- That the staff of the Liaison Committee on Graduate Medical Education and the residency review committees be independent of their parent organizations.

Since the College's Graduate Education Committee could only speak for surgical disciplines, the proposal was carried forward to the Council of Medical Specialty Societies (CMSS). This organization was the College's entry point to official participation in the Coordinating Council and in the Liaison Committee on Graduate Medical Education. It became clear that *all* of the specialties in medicine, in addition to those in surgery, were interested in significant reform of the graduate education process. Subsequently, twelve points of agreement were unanimously detailed by the Graduate Education Committee of the Council of Medical Specialty Societies, and unanimously approved by the entire assembly of the CMSS. These major points include:

- Independent staffing for the LCGME and residency review committees.
- Independent financing for the residency review process.
- Accreditation authority be given to the residency review committees.

In the last year the parent organizations abolished the Coordinating Council on Medical Education and replaced the Liaison Committee on Graduate Medical Education with the Accreditation Council on Graduate Medical Education (ACGME).

The Council's five parents—the American Medical Association, the American Hospital Association, the American Board of Medical Specialties, the Council of Medical Specialty Societies, and the Association of American Medical Colleges—will have equal votes. The parents have agreed to strive for independent

financing through capitation charges on each resident in residency programs. The staffing, however, was not made independent of the parents, but was designated to be staffed by the AMA for at least two more years. Each residency review committee, if it elected, could conduct its own approval and accreditation program under authority from the ACGME. Veto power on policy matters remains a privilege for each parent organization. Policy matters include budgeting, staffing, and the essentials of residency programs. Operational decisions could be made by a two-thirds majority vote.

In this new Council, many of the aims of the American College of Surgeons Graduate Education Committee appear, at first glance, to have been achieved. However, critical changes, including truly independent staffing, abolition of the power of each organization to veto, which has been so abused in the past, and truly independent financing, have not yet been achieved. But the ability of the residency review committees to approve and accredit residencies as well as the involvement of the parents of the residency review committees in the development of policy matters are real advances.

Since the graduate education of surgeons is of such vital importance to maintaining the quality of surgical care, the American College of Surgeons believes that the accreditation system must be made as responsive and as efficient as possible. Additional and perhaps alternative methods for approval of graduate education programs may well become necessary.

Continuing education

Continuing education continues to be one of the major thrusts of the American College of Surgeons. The College's major continuing education activities are:

- The annual Clinical Congress and Spring Meeting.
- The Surgical Education and Self-Assessment Program (SESAP).
- The Motion Picture Library and the Clinitape program.

All of these activities undergo constant reassessment by standing committees of the College. Chapters, Governors, and Regents have a voice in the major committees, whether they be the Program Committee, the Surgical Education and Self-Assessment Committee, or the Motion Picture Committee.

Ethics

The American College of Surgeons has held, since shortly after its inception, that many ethical considerations are worthy of strong support. These include abolition of itinerant surgery and the plague of fee-splitting, and the desirability of open discussion and reasonable financial consideration for surgical patients. Abuses of ethical standards provide the potential for serious damage to the surgical patient, either directly or indirectly. Recently the College has received a serious legal challenge to its tenets on itinerant surgery. The Board of Regents reaffirmed the strong stand of the College against itinerant surgery. Although this lawsuit has not yet been resolved definitely, preliminary legal actions have been favorable to the College.

Fee-splitting has been diminished but not eradicated from the American scene following stands by the College as well as by other organizations in American medicine.

Recently the Board of Regents appointed a committee to study surgical fees. This is an attempt to examine surgical fee structures, particularly exorbitant surgical fees.

Unrestricted licensure

For many years the College has recognized the hazards of full and unrestricted state medical licensure that allows the practice of all kinds of medicine, including the performance of complex surgical procedures. A number of programs have been initiated to deal with this problem. One recent example is the nationwide public opinion survey commissioned by the College and conducted by the Gallup Organization. This study was very helpful in pointing out priorities to which the College should turn its attention in the area of public relations. The study showed, among other highly positive findings, that surgeons enjoy an extremely favorable image among the general public, and that the public gives a high rating to the quality of surgical care in the United States today. One interesting finding was that only six percent of the public surveyed showed any recognition of the American College of Surgeons as an organization.

Subsequently, a major public information campaign with the theme "Surgery by Surgeons" was implemented by the College last year. The campaign stresses the College's position that operations should be performed

by properly trained surgical specialists who are the most qualified to provide competent care to surgical patients.

Following a study conducted jointly by the American College of Surgeons and the American Surgical Association concerning surgical services in the United States, the College developed a Department of Surgical Practice. This department now monitors legislative, regulatory, and socioeconomic activities pertinent to surgery and acts as a resource to the staff, the officers, and the Regents of the College. This office also maintains liaison with congressional staff members, government agencies, and private health organizations. A "Key Contact" program, under which selected knowledgeable Fellows of the College will provide individual counsel to Congress and its staff on various issues under review by the federal government, is being developed. The Department of Surgical Practice also prepares and distributes a monthly legislative summary, "The Washington Report," as one of its many socioeconomic activities.

Long range planning

In 1976 the Board of Regents appointed a Long Range Planning Committee consisting of Regents and Governors of the College. Several interesting programs have been recommended and developed by the Long Range Planning Committee. These are generally divided into two areas: internal affairs and external affairs.

Internal affairs. With recommendations from the Long Range Planning Committee, the Board of Regents carefully investigated and established a Washington office of the American College of Surgeons. This office is under direction of the Department of Surgical Practice, and reports through it directly to the Director of the College. This office is largely for informational exchange between the American College of Surgeons, the Congress, and private and public health agencies. Several meetings have been arranged between the Board of Regents and congressional and health leaders in Washington so that a College presence is now felt in the nation's capital.

Consideration has been given to the future building needs of the College. Over the past several years, the College has developed a Building Reserve Fund, which is adequate to meet the currently projected needs for increased building space at the Chicago office.

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The question of relocating the College offices to Washington or other sites was carefully considered, and the decision was made that the Chicago site is preferable for the foreseeable future.

The College's specialty advisory councils have been reorganized and afforded much stronger communication with the surgical specialty councils, the Board of Governors, and the Board of Regents. This new arrangement provides the leadership in the surgical specialties with direct and continuous input to the governance of the College.

External affairs. The Long Range Planning Committee has updated the relationships of the College to undergraduate education.

Initiatives and alternatives for continuing medical education have been spearheaded by this committee. A major international effort has been augmented.

The initiative to study surgical fees was suggested by this committee, and a committee on fees has been appointed by the Board of Regents.

Recent initiatives

The College has taken additional initiatives recently to protect the quality of surgical care. These include:

- Continued pressure, including legal pressure, against the persistent push of "limited license practitioners" to enter the surgical arena. This is a continuing challenge to the quality of surgical care, and the College feels it is one of its foremost lines of endeavor.
- The College continues its efforts to study and understand the medical professional liability problem in the United States. The Closed Claim Study of the National Association of Insurance Commissioners, which was supported heavily by the American College of Surgeons, has been completed. Its report reflects disturbing trends in the severity of claims and an increase in large awards against hospitals, physicians, and other providers. The Governors' Committee on Professional Liability closely monitors the evolving trends and seeks new remedies.

A tested approach to hospital accident prevention, which has received wide recognition, has developed through the College's *Patient Safety Manual*. The patient safety program has been expanded this year to offer consulting advice to hospitals that have begun to implement their own patient safety program.

• A multifaceted cost-containment program has been developed to respond to the remarkable cost inflation in medical care that was outlined so clearly in Dr. Harry Muller's Presidential Address in 1979. This effort is an active, ongoing program.

Staff and Director

Probably the most effective and unique asset that the American College of Surgeons has had for the past decade has been its Director and his dedicated, loyal staff of surgeons and their able assistants.

Those of us who have been fortunate enough to be elected to work with this superb group of people feel that the real pursuit of quality in surgery is being spearheaded by Dr. Hanlon and the College's staff.

Short answers

My remarks may seem like a long answer to the short question, "What is the reason for the existence of the American College of Surgeons?" The answer is simple: elevation of standards of care of the surgical patient. The second question, "Why did each of us join the American College of Surgeons voluntarily?", is perhaps easier to answer in view of the role of the College in American surgery.

Many reasons could be cited for joining the American College of Surgeons. Personally, I believe that dedication to the highest quality surgery is the first and foremost reason. This is the primary goal of the College, and over the years the College has proven to be effective in maintaining its pursuit of high quality.

A second and probably equally important reason is pride. In a sense, Fellowship in the College is peer review of the highest order. Certainly the College's requirements of 13 years or more of formal training, submission of records to indicate surgical competence, and observation of the candidate's ethical and practice standards represent unexcelled peer review. Having passed in peer review gives every trained, ethical surgeon direct access to the College. Input from Fellows can and does come through a number of routes: individually through contact with other Fellows, Chapters, Chapter officers, Governors, Regents, and specialty advisory councils, and directly through the departmental directors and the Director of the College. The College is a centralist organization and not a federation. Consequently, direct individual input probably receives more attention than it does in other kinds of organizational structures.

Why is pride important above all to surgeons? The reason is that surgeons, by definition, are individualists. He or she must be an individualist to enjoy the discipline. He or she has to be an individualist with a significant ego to make decisions on a daily basis in an area, the operating theater, where the surgeon is always on stage. His or her mistakes are on public display. This is not a discipline for the faint of heart. If one looks at the remarkable success and voluntary attendance at surgical continuing education programs provided by the College as well as at other forums, it is clear that the individual surgeon constantly seeks new knowledge and modernization of existing knowledge.

In the modern world, the place for the individualist is becoming a more difficult one to obtain. I think the events of the last two or three decades have indicated that it is much more difficult to enter the surgical disciplines. It would appear that maintaining quality in surgical care is probably somewhat easier now than before. The success of the organization at setting standards gives strong support for individual surgeons who request higher quality where they work, i.e., good facilities. This is due to a number of factors, including the work of the American College of Surgeons. The job of maintaining this quality in the future, however, appears to be headed for difficult times. The great egalitarian thrust of the moment is for quantity. There is in many circles an obsession with quantity rather than quality, with numbers rather than with individual performance, with seeking the lowest common denominator which, by definition, means an erosion of quality, and with seeking a more acceptable mediocrity rather than high-level, individualistic quality.

Nevertheless, I think that the Fellows of the American College of Surgeons are equal to this challenge and are heightened in their dedication by participation in "The Fellowship of Surgeons."