THE PRESIDENT'S ADDRESS

A call for unity

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Editor's note . . .

In his presidential address before the 1977 Clinical Congress in Dallas, Dr. Stinchfield presented a strong case for unity within the surgical profession. Citing a "campaign of criticism" directed at surgeons, the new ACS president called unity "our strongest defense." He discussed current charges of unnecessary surgery and the threat of government control.

Dr. Stinchfield was installed as president of the College on October 20, following a year as president-elect and nine years as a member of the ACS Board of Regents. He was chairman of the Board of Regents for the last three years of his term. He is the first orthopaedist to hold the position of president.

Internationally recognized as a surgeon, teacher, and research scientist, Dr. Stinchfield has spent most of his professional career at the Columbia-Presbyterian Medical Center in New York. Until 1976, he was professor of orthopaedic surgery and chairman of the department at Columbia-Presbyterian. He has also served on the executive committee and as president of the medical board of the center. He continues to serve as attending orthopaedic surgeon at Columbia-Presbyterian, and as a consultant in orthopaedics to several hospitals in New Jersey, Connecticut, and New York.

Dr. Stinchfield's experimental research has included investigation into the use of oxidized cellulose in arthroplasties on dogs, the effect of heparin and dicumarol on bone repair in rabbits and dogs, and a continuing investigation of the effect of anticoagulant therapy on bone repair and prophylactic penicillin in orthopaedic surgery.

He is widely known as the founder of The Hip Society which he organized in 1969. He served as its first president from 1969 to 1972. In 1975 he founded the International Hip Society and was its first president. He is a member of 17 medical and surgical

societies and holds honorary degrees from a number of colleges. Last year he was named a member of the Low Friction Society of the Wrightington Centre for Hip Surgery in England and an Honorary Fellow of the Royal Australasian College of Surgeons.

Dr. Stinchfield is senior orthopaedic consultant to the United States Air Force, and a consultant in orthopaedics to the National Football League.

He is a native of Minnesota and a graduate of Northwestern University Medical School. He went to New York in 1941 as attending surgeon at Goldwater Memorial Hospital. In 1947 he was named medical director and orthopaedic surgeon-in-chief at the Institute for the Crippled and Disabled in New York. In 1951 he went to the Columbia-Presbyterian Medical Center and has remained there since. Under his guidance, the Medical Center's small laboratory for orthopaedic research has been expanded into one of the nation's largest laboratories in its field.

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When a great honor comes to a man, even a year is not sufficient time to muster the ability to express appropriate thanks. However, I do want you to know how happy and proud I am to be here as your president.

Maybe one reason that I am your president is that I am an expert in hindsight! It is easy to be a "Monday morning quarterback." It is easy because the game has been played and the results are available to evaluate. However, being an expert during the game is a different matter. It is not easy for a quarterback to decide, instantly, the play that may win the game, or lose it. Nor is it easy for the surgeon who, at the operating table, must decide instantly how to deal with a dilemma—both horns of which may be as sharp as death.

Therefore, let us discuss how the American College of Surgeons can help us.

They threw bricks

When Dr. Franklin Martin founded the College in 1913, it was a decision to which he committed himself totally and without reservation. There was no unanimity among his peers for an organization devoted to surgery. Dr. Martin recalled some years later: "They threw bricks at me, as they threw them at all who had the courage of their convictions."

I also have the courage of my convictions. And, if any of you are planning to toss bricks towards this podium, I suggest that you not waste the few you might have with you. Wait until I have finished my term and then let me have them, all at once.

Dr. Martin's concept of surgery was based on what was happening in his day; mine on what is happening today—and tomorrow. Surgery faces greater problems now than ever before, or possibly ever again!

'Unnecessary surgery'

First, let us look at what has been happening. Let us examine why accusations are being made against us and how we can eliminate these attacks.

The physicians in this country are now a target of an unabating and accelerating campaign of criticism. The present line of attack is directed specifically at surgeons. They say we are insensitive, arrogant, incompetent, and make too much money! However, the real thrust of the attack is labeled "unnecessary surgery"!

This campaign against us began when a colleague of ours, Dr. John Bunker, an anesthesiologist, published an article in *The New England Journal of Medicine*[1] in June 1970 in which he compared the frequency of surgery in the United States with that of Great Britain. The conclusion: there were, in relation to size of population, about twice as many operations and twice as many surgeons in the United States as in England and Wales.

His writing was immediately seized upon by critics as proof that there are too many operations in this country, assuming that England and Wales are the ideal norm.

Bunker knew better and explained why England and Wales had so few operations.[2] Dr. Bunker said, "By limiting personnel and facilities

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the British National Health Service determines how much surgical care will be available in Great Britain. This is not a scientific judgment; it is a hard political decision made on the basis of national resources and priorities."

Informed consumers

It is strange how rarely these judicious words of Dr. Bunker are quoted by those who like to cite his comparison of British and American surgery. Moreover, one usually searches in vain among the publications of those who attack American surgery to find any mention of what is most likely Dr. Bunker's most important study —the one in which he looked at the rate of surgery among informed consumers, that is, among those least likely to have "unnecessary" or unwanted surgery.

The following statement is taken from Dr. Bunker's article, "The Physician-Patient as an Informed Consumer of Surgical Services."[3] I quote: "The alleged overuse of surgical services in this country is often attributed to lack of consumer knowledge." Dr. Bunker continued, "Assuming that physicians possess such knowledge, we have examined their utilization of surgical services and compared it with that of lawyers, ministers and businessmen. Operation rates for physicians and their spouses were found to be as high as or higher than for other groups. Overall operation rates for physicians and for the other professional groups studied were estimated to be 25 to 30 percent higher than for the country as a whole." We can conclude, therefore, that the physician-patient, as an informed consumer, places a high value on surgical care, and the idea that a large fee results in unnecessary operations is a naive one and is based on a fundamental misconception as to the nature and purpose of surgery.

What is 'unnecessary'?

We all know that the indications for surgery are often difficult to determine and sometimes difficult to interpret. It is even more difficult to reach agreement on what constitutes "unnecessary" surgery.

If there is no medical indication for an operation, it is clearly unnecessary. However, if a surgical procedure constitutes one of two or more options for the treatment of an individual with a given diagnosis, or a provisional diagnosis, the selection of the surgical option does not result in an "unnecessary" operation. Such a selection is based on the judgment of facts and circumstances surrounding a particular patient at a given time. That a second physician might recommend a non-surgical treatment does not render a procedure "unnecessary." The conclusion of a panel of physicians, in a retrospective analysis, that it would have been better or wiser to have instituted non-surgical treatment should not result in labeling the operation "unnecessary."

It is important to insist on semantic agreement here. The tendency is to lump together all nuances of "unnecessary" in order to magnify the problem of a possibly greedy, unscrupulous surgeon who subjects a patient to an operation because the surgeon wants money rather than what is in the best interest of the patient.

We must not let the discussion of unnecessary surgery box us into a situation in which we begin to equate necessary only with life-saving or emergency procedures. And, we must not accept the notion that only treatments less expensive than surgical treatments are necessary.

If nothing else, the blanket nature of the charges against our entire profession ought to remind us of the need for unity, and of the need to subordinate petty jurisdictional or other minor disagreements to the broader problem of the surgical profession as a whole.

The way to approach the criticism being directed at us is by action both defensive and aggressive. We have some powerful accusers. They say, without justification, that we operate merely to collect fees. We are accused often of being so mercenary that large numbers of Americans are dying each year, during the course of "unnecessary surgery."

Faulty data

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to verify the contention that an alarming number of surgeons are incompetent to do many of the procedures they do. In other words, the devil can quote the Bible.

This fiction is being repeated by the media and in the higher offices of the land. The Subcommittee on Oversight and Investigations of the House of Representatives, United States Congress, in a report entitled, "Cost and Quality of Health Care—Unnecessary Surgery"[4] asserts, "In 1974 approximately 2,380,000 surgeries were unnecessarily performed at a cost of almost four billion dollars, as well as 11,900 deaths." Needless to say, these charges were widely reported throughout the country.

Actually, this study was based on a misunderstanding of the Second Opinion Program developed by Professor Eugene McCarthy[5] at the New York-Cornell Medical Center, and on an actual misquotation of the data from the Critical Incident Study conducted by Dr. Gardner Child[6] as part of the SOSSUS (Study on Surgical Services for the United States) effort. There is, of course, an irreducible minimum mortality from heart attacks and strokes, but even with these reservations the figures used by the government committee are highly inflated, probably for the purpose of impressing the public with the fact that medicine and surgery need to be controlled by government.

It is interesting that this type of criticism is aimed at surgeons. However, I feel that the vast majority of people don't believe this because they believe in and support their doctors. The average American places a great deal of emphasis on "the quality of life"—not merely the ability to withstand life! Thus, it is imperative to do everything within our power to preserve and justify, through our individual offices and professional groups, their trust and confidence. We can do this by presenting our principles and our positions as surgeons, and we must do this ourselves in a way that we surgeons best understand. Then we can do a better job of serving the public as well as defending our positions.

We know the free enterprise system has raised the level of treatment to the best care available anywhere in the world. And we, as doctors, must remember that the free enterprise system is basic to continued enlightened progress not only of our profession, but of our entire society.

A call for unity

How shall we safeguard the free enterprise system? The answer—and I speak again as an expert in hindsight—the answer lies in our line of attack against our critics. They have aimed their condemnation not at orthopaedic surgeons, not at obstetricians, not at neurosurgeons, not at general surgeons, nor at any one specialty. They have directed their attack at all surgeons!

This, then, should be our line of defense—surgeons united! I believe that unity—unity within the surgical profession—will be the binding link and our strongest defense. This will establish beyond all criticism that surgery is a truly honorable profession, practiced by honorable and dedicated physicians.

One year ago I chose the title and theme of this address, "A Call for Unity," dictated by what I thought were the needs at this time. Ironically, I recently found that a cry was sounded for unity in our profession more than 400 years ago when Robert More wrote:

> Let us all stand together
> The watchword recall
> For all surgery, the confession
> That united we stand, divided we fall.
> For it is union that shall preserve
> the profession.

Times were different, but problems existed.

Honest criticism

I recognize the usefulness and the essentiality of honest criticism. I make no claim that all surgeons are without flaws or beyond criticism. With approximately 72,000 fully trained surgeons performing operations in our country, obviously there have to be different levels of competence. I say fully trained, meaning one who has passed suitable examinations of achievement, who carries the credentials of a national organization such as the College, or one who is board qualified, and one who has made a career commitment to surgery. I make this point because there are many who use the operating

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room but who are not fully trained surgeons!

In this vast number of trained surgeons there are some—a very small percentage, I believe—who are guilty of some of the indiscretions our critics accuse us of. We must also allow for the unavoidable margin of human error in the rendering of any treatment or operation regardless of the degree of skill of the physician or surgeon.

The deviations of a small minority should not be used to blacken the reputation of the entire profession. The College is trying, diligently, to bring to light the wrongdoers for their sake and ours. Through the process of peer review, tissue committees, utilization review committees and PSROs, more surveillance of American surgeons and their activities is now being conducted on a day-to-day basis than at any time in the history of American surgery.

What disturbs me about the current situation is that our critics seem bent on finding flaws, with little or no appreciation for the fact that the world's best surgery is practiced in the United States. The ability of surgeons today to save lives, relieve suffering, and prevent complications has never before been so great. It is at the highest level in the history of surgery. So, again, I am going to be an expert in hindsight. I am taking this role not to be critical merely for the sake of criticism, but in the hope that I can remind my fellow members of this College that the world around us is rapidly changing. Unless we keep pace with it we may lose control, and surgery, the specialty we all cherish, may be controlled by people other than surgeons.

Hindsight on history

So, let us go back.

Hindsight includes history. Without it we cannot interpret or understand the present nor anticipate the future.

The American College of Surgeons is the greatest single surgical group in the world. From 1913 to 1965—a period of 52 years—it was perceived by many as an organization of general surgeons, and indeed they did predominate numerically. Perhaps it would have been better had the specialties united with the American College of Surgeons, taking the example of the British Royal College of Surgeons, to become a conglomerate of all surgical specialties so that now a united front could be presented in representing all of surgery—so necessary today but not so in 1913.

In the 1950s the Regents made efforts to convince the specialties that the College was not a limited institution devoted solely to the interest of general surgeons. For many years the membership of the College was composed of about one-half general surgeons and one-half other surgical specialists, a fairly accurate reflection of the distribution of the surgical population of the country.

However, many specialists felt that the College was really not very much interested in them. There was substantial feeling on the part of the Regents that this misapprehension should be corrected. Advisory councils were established and there were additional efforts to develop programs at the Clinical Congress and at the sectional meetings which would appeal to the various specialties.

As of now, 54 percent of the College Fellowship is made up of specialists and two-thirds of the recent candidate group were specialists, other than specialists in general surgery.

This might be an appropriate time to reevaluate the very purpose of the College.

Surgery, in itself a specialty, has always been the mother of specialties. Even Hippocrates suggested that surgery be set apart from general medicine because of the particular skills it required. The surgeon was revered by all as the only true physician. He is still revered by the general public for his very special skills and aptitudes. But these skills must be continually honed. As new challenges arise, they must be applied to the development of new concepts and new techniques.

Thus, within each of the specialties there have evolved programs of research, development and continuing education. These programs vary. In continuing education, for example, some take their efforts to the practitioner by way of regional courses. Others prefer to contain their continuing educational efforts within a single national forum or as part of the specialty organization's annual meeting.

Generally, these efforts are serving their stated purpose. First, they are keeping the surgeon abreast of the developments in his chosen field. Second, they are keeping him informed as he goes about his daily practice. There is no proclamation, no statement of dedication, that can raise the standards of a surgical specialty as well as a good, productive program of continuing education.

Consequently, we have each specialty dedi-

cated to raising its own standards. Each group is doing its thing in its own way—to fulfill its commitment to upgrade the capabilities of its members.

There are ten specialty boards in surgery. Is this the sum total of our surgical practice? Ten specialty boards? Ten definite areas of interest? Ten carefully guarded and independent fields of surgical practice?

Unifying interests

I believe we must consider the fundamentals that are not the exclusive property of any specialty: four unifying interests—shock, hemorrhage, wound healing, and trauma. They are concerns shared by all surgeons.

Trauma is a multi-disciplinary subject that in recent years has grown to epidemic proportions in this country. So, I say that trauma, shock, hemorrhage, and wound healing should all be part of the continuing education of every one who calls himself a surgeon. These are the links that bind us together and the means by which we can obtain unity!

Some questions now arise: Who will be responsible for the multidisciplinary subjects? Who will assume the responsibility for establishing a continuing education program in shock, hemorrhage, and wound healing? What about trauma? What about emergency medicine? Shall each group sponsor its own series of courses? Or, would it be better to have a unifying series for everyone?

To me, a single, coordinated educational effort, in the multidisciplinary subjects previously mentioned, would be much more efficient and would add greater impact. I believe the responsibility for providing such an educational program should be borne by the American College of Surgeons. The College can gather a faculty that would be somewhat beyond the means of a single academy or specialty group. It can provide the facilities that will make these courses a valuable and meaningful experience for all. It could be the cohesive force in uniting all specialties and, when necessary and appropriate, it could provide a common voice.

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I am certain that if we are to survive as an independent scientific force, unity in surgery must be established! If we remain fragmented we will lose or greatly diminish whatever chances or political clout we might have for legislative understanding and support. It would be deplorable indeed if, because of stubbornness, shortsightedness, lack of unity, or fears that the College might usurp the prerogatives of the various specialties, we awaken to find we have lost our individualism to government control.

Government control

Anyone can say that it cannot happen here—not in these United States—and certainly not in the year 1977. Let me say, it not only can happen, it is happening here.

Congressmen have looked favorably on legislative proposals that would prohibit medical or surgical care to be furnished or paid for by federal funds, unless the patient is first seen by a general practitioner.[7]

This system serves to increase the costs of medical care without improvement in quality. The so-called "emergency physician," who staffs group-practice facilities and the ambulatory care centers, would have the same power to retain a patient. Many such centers are now operating as emergency rooms. Reports indicate that in this type of facility almost 30 percent of the patients required little but examination, reassurance, and disposition.[8] Approximately 55 percent required somewhat more sophisticated care. The remaining 15 percent were evaluated as true emergencies or as having life-threatening conditions. So, it appears that roughly 85 percent of the patients treated in these "emergency rooms" are nonemergencies. A large number of these facilities are being subsidized by government funds! This reduces the obvious benefits of specialization that have been achieved over the past century and particularly the effort of the College to upgrade care by insistence on adequate criteria for hospital privileges.

Yes, it is happening here. Any such requirement that would place the decision for operation in the hands of the general practitioner—one

that actually prevents a patient from going directly to a surgeon—I see as but one of many ominous clouds gathering over our heads.

Also, there is a new threat by government that would require the obtaining of a second opinion before any decision can be made for operation where Medicare or Medicaid is the form of payment for services. This is not always in the best interest of the patient, nor is it in the best interest of the surgeon. Are we going to sit back and let government tell us when and on whom we may operate?

I believe in surgical privileges for those with recognized credentials and demonstrated competence. We must not allow politicians to make that evaluation.

I suggest to you that the only way we can stave off the threat of government control of surgical practice in this country is that all surgeons unite. For any negotiations with federal agencies, negotiations that can be meaningful in our behalf, can be productive only if we present a united front. It is only by standing together that the government can be made aware of our solidarity. It is only by standing together that we can show that there is unity. And in unity there is strength. In unity there is political clout. In unity there is survival. Our profession will be stronger and more effective by having the specialties supporting and working with the College—rather than by multiple, independent approaches.

Many policies that affect the practice of surgery are being made, unfortunately, by politicians or legislators, rather than by surgeons. It is time that this be changed. I believe it must be changed. I believe it can be changed. I believe it will be changed.

Therefore, I believe that the Department of Continuing Education should be enlarged within the College to provide courses staffed by eminent faculties on various multidisciplinary subjects of interest to all practitioners. These courses can be given at frequent intervals throughout the country and can provide every surgeon with the opportunity to learn and consult with other surgeons who ordinarily would not be available to him. The College's annual Clinical Congress is a tremendous event. It happens only once a year, and, unhappily, it is over very quickly. Many surgeons who could well benefit from it are unable to attend. Therefore, by expanding the number of courses given throughout the country, many more surgeons could continue their education.

Surgical specialty center

Also, if our College is to maintain its position of leadership in the affairs of world surgery, consideration should be given to a combined surgical specialty center where the headquarters of all surgical specialties could be accommodated. If all the specialties would consider working in geographical juxtaposition, it would be of great advantage to all.

If this plan could be accomplished, far greater overall efficiency could be achieved by: 1) coordination of educational efforts of all surgical specialties, 2) use of common computer facilities, 3) provision of staff assistance and central facilities, 4) jointly formed guidelines in continuing education, 5) coordination of representatives to government, other medical organizations and educational institutions, 6) consideration of tax matters, 7) consideration of professional liability problems, 8) reduction of costs, 9) increase in development and dissemination of public and professional information programs through all media, and 10) closer and more personal interchange of ideas.

This plan for centralization could be a model for the most progressive surgical teaching in the world. This would not diminish the independence of any specialty but would function in the same manner as a medical center does—rather than as widely dispersed, individual units.

We cannot allow ourselves to drift along fragmented—thereby giving support to critics who say that government must take over because we are busy bickering over our personal goals—failing to address ourselves to the public good. We are dedicated to the public good.

I strongly believe that we cannot stop working. Working for the right. Working for unity. Great results demand great exertion.

Once before, in a different situation, I called upon my colleagues "to stand up and be counted." Now, years later, under even more challenging circumstances, I again am calling for the entire surgical profession to stand up and be counted—in unity!

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