"To think and act as a unit"

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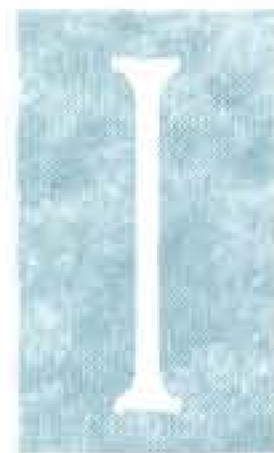
Editor's note: *This Presidential Address was delivered during the 75th Convocation of the College on October 24, 1991, in Chicago, IL. The title is taken from a quote by George W. Crile, MD, in the book,* George Crile: An Autobiography *(1947).*



I want to congratulate all of the Initiates, and your spouses and your families. You have achieved two basic goals that distinguish the well-trained surgeon—namely, certification by your specialty board and fellowship in the American College of Surgeons. We expect you, as Fellows of the College, to participate in its activities and to support its fundamental goals "to improve the quality of care of the surgical patient by setting high standards for surgical education and practice."

It is a great honor for me to be elected President of the American College of Surgeons. When I look at the list of distinguished surgeons who have held this office, I stand in awe of being here myself. This is a critical time for American medicine, and the leadership of the College as a unified voice for American surgery has never been more important. I humbly accept the challenge of this office and pledge to you that I will do my best to vigorously support the policies and ideals of this great College.

History of the College

Since I plan to address my remarks to the Initiates, it would seem appropriate to provide you with a brief historical description of the founding of the American College of Surgeons. The concept of the College was developed by Dr. Franklin H. Martin, a gynecologist from Chicago, IL, who in 1905 founded a new surgical journal called *Surgery, Gynecology and Obstetrics* (*SG&O*). He had been an occasional guest of The Society of Clinical Surgery, which was founded in 1903 by Crile, Cushing, the Mayo Brothers, and others. Recognizing the educational value of these meetings, he conceived a plan to hold the same type of clinical meeting on a larger scale in Chicago. The invitation to attend this first meeting was issued as an editorial in the September 1910 issue of *Surgery, Gynecology and Obstetrics* (*SG&O*), and over 1,300 physicians attended the 10-day meeting. It was such an overwhelming success that before its conclusion a decision was made to create a surgical organization and to hold this meeting on an annual basis. The organization was named the Clinical Congress of Surgeons of North America, and Dr. Albert Ochsner was elected President. Its initial membership was to consist of all reputable surgeons who subscribed to *SG&O* and who attended the annual meeting.

En route to the third Clinical Congress in 1912, Martin formulated plans for a new organization that he called the American College of Surgeons. The objective of this society was to "evaluate the standard of surgery, to provide a method of granting fellowship in the organization and to formulate a plan which would indicate to the public and to the profession that the surgeon possessing such fellowship is specifically qualified to perform surgery." The organizational committee invited 500 leading surgeons in the United States and Canada to attend the organizational meeting, which was held in Washington, DC, on May 5, 1913. Dr. J.M.T. Finney of Baltimore, MD, was elected President, and a constitution and bylaws were adopted. Guidelines were also developed to allow surgeons to qualify for fellowship in the new organization.

Organizational structure

The Fellows of the American College of Surgeons, a position you have achieved this evening, are the "backbone" of the College. There are over 50,000 members in the United States, Canada, and abroad. Of this group, 58 percent are specialists and 42 percent are general surgeons. You are all aware of the rigorous requirements that must be met to attain Fellowship, and I again congratulate all of you on having achieved this high honor.

The first chapter of the American College of Surgeons was formed in Brooklyn, NY, in 1925. A group of Fellows banded together to address their concerns regarding the level of clinical care and ethics they observed being practiced among surgeons in the area. They petitioned the Regents for designation as a chapter. This chapter was so successful that Fellows in other areas organized themselves, and today there are 69 chapters in the United States and Canada and 22 international chapters. Since the College is not a federation, the chapters are not part of the formal structure of the College. Each chapter is autonomous, but its activities and actions must be in line with the policies and practices of the American College of Surgeons.

The Governors act as a liaison between the Board of Regents and the Fellows, and the Regents depend heavily on the Board of Governors to keep them informed regarding the concerns of the Fellows. Currently, there are 245 Governors, which include 145 Governors-at-Large, 72 Governors representing 62 different specialty societies, and 32 Governors from other countries. Each Governor is required to submit an annual report to the Chairman of the Board of Governors regarding surgical issues and problems that are of major concern to the Fellows. The Governors are also requested to participate in chapter activities.

The College is governed by 19 Regents who are elected by the Board of Governors. Regular meetings of the Regents are scheduled three times per year. There is an Executive Committee and several liaison committees that consider issues related to one or more departments of the College's central office prior to each Regental meeting.

The Nominating Committee of Fellows offers a list of nominations for the office of President, First Vice-President, and Second Vice-President, and these officers are elected at the annual meeting of the Fellows that is held during the Clinical Congress. The Secretary, Treasurer, and Chairman of the Board of Regents are appointed by the Regents themselves.

The Director of the College is the chief executive officer, and we have been fortunate in having a distinguished group of Directors over the course of the College's history. The most recent are Dr. C. Rollins Hanlon, who retired in 1986, and our current Director, Dr. Paul A. Ebert, who has done a superb job of managing the affairs of the College. He has been an eloquent spokesman for the College and is a very effective witness testifying on behalf of the College in Washington. He is ably assisted by an outstanding staff who manage the various departments of the College.

Surgical specialty societies: Since the founding of the College, the surgical specialties have been involved in College activities. Several pathways have been developed for specialty participation. Approximately one-third of the members of the Board of Governors come from the various specialty societies, and each specialty has at least one Re-

gent on the Board of Regents.

Advisory councils: The major avenue for input from the specialty societies has been through the Advisory Council for the Surgical Specialties. There are currently 12 advisory councils that relate directly to the Regents. The functions performed by these advisory councils are as follows:

1. To advise the Board of Regents on policy matters and policy formulation.
2. To present issues of concern to the Board of Regents or other appropriate College bodies.
3. To serve as a communications link between the surgical specialties and the Board of Regents.
4. To nominate members of the specialties to serve on committees and other bodies.
5. To aid in the development of programs for the Clinical Congress.

As new Fellows of the College, you might be particularly interested in one of its special committees—the Young Surgeons Committee. This committee was established in 1969 as an ad hoc committee to establish closer relations with the Candidate Group and younger Fellows. It has now become a standing committee of the College, and its chairman represents the committee at each Board of Regents meeting.

The specialty societies, the advisory councils, and special committees are very important constituents of the American College of Surgeons.

Landmark decisions/accomplishments

Time does not permit me to describe all of the important contributions the College has made to the practice of medicine in America. I will list a few highlights, however, to help you realize the important role the College has played.

1. *Ethics*: At the initial meeting of the College in 1913, Dr. Miles Porter, a surgeon from Ft. Wayne, IN, stated that "fee-splitters" should not become members of this organization. This statement was the genesis of the College's long-standing position against the unethical practice of fee-splitting. The Regents have recently established a Regental Ethics Committee.

2. *Cancer*: In 1913, the American College of Surgeons was the first professional organization to inform the public about cancer through an article in *Ladies' Home Journal* and a series of public meetings about the disease. This event initiated an effective collaborative effort between the College and the American Cancer Society. It also led to the formulation of the current Commission on Cancer. The College has a long, distinguished record that continues today in the areas of education and standard setting and through the establishment of registries and the certification of hospital cancer programs.

3. *Trauma*: In 1922, Dr. Charles Scudder was appointed by the Regents as Chairman of the Committee on the Treatment of Fractures, which developed standards for the care of fractures. This effort eventually led to the formation of the Committee on Trauma (COT), which continues to maintain an active agenda that includes the development of educational programs, standards for emergency services, and the Advanced Trauma Life Support Program (ATLS). The COT hopes to soon develop a national registry on trauma.

Due in large part to the efforts of the College, Congress passed the Trauma Care Systems Planning and Development Act in 1990. When funded, this legislation will allow states to receive grants to improve their trauma systems if they take into account existing national standards that have been developed by the American College of Surgeons, the American College of Emergency Physicians, and the American Academy of Pediatrics.

4. *Hospital standardization program*: When they developed the requirements for fellowship, the College's first Regents required applicants to submit hospital records on 100 patients as evidence of surgical competence. During the first three years after implementation of these requirements, 60 percent of the candidates were rejected by the Central Credentials Committee because of poor surgical records. In 1918, the College established the first hospital standardization program. The "minimum standards for hospitals" were sent to all hospitals, and those that voluntarily sought approval were inspected by a team from the College. In the first year, only 89 of 692 hospitals that were inspected met these standards. In 1952, the Joint Commission on Accreditation of Hospitals (now known as the Joint Commission on Accreditation of Healthcare Organizations) grew out of this College program. The College remains a member of this commission today.

5. *Graduate medical education*: In 1930, the

Regents appointed a Committee on Undergraduate, Graduate, and Postgraduate Teaching of Surgery and the Surgical Specialties. This body became the Graduate Education Committee, which was the beginning of a major effort by the College in ensuring the training of highly qualified surgeons. With the establishment of the American specialty boards, the College became a participant as a sponsor on six of these boards. Each specialty board sends a representative once a year to present a report to the Regents. The College also participates in the process of accreditation by appointing representatives to seven of the surgical residency review committees.

6. *Socioeconomics*: In view of significant changes that had been occurring in health care delivery during the late 1970s and early 1980s, the Board of Regents held a planning meeting in 1985 to discuss the structure, function, and basic orientation of the College. At the conclusion of this meeting, the Regents decided that the College should continue its role in the areas of education, standard setting, and ethics, but that it should also become more involved in socioeconomic issues. The Regents stressed the need for the College to take a leadership role on behalf of the entire surgical community and to communicate its positions widely and forcefully.

Recognition of selected individuals

There are a number of individuals I want to recognize who have played an important role in the development of the College and who are of particular interest to me personally.

Dr. George Crile was a founder of the College and was its second President from 1916 to 1917. He was also a founder of the Cleveland Clinic Foundation in 1921.

Dr. J. Bentley Squier was the first urologist to become President of the College in 1932-33. He played a major role in the establishment of urology at Columbia Presbyterian Hospital in New York City.

Dr. Frederick A. Coller was professor and chairman of the department of surgery at the University of Michigan Medical Center. He was a skilled surgeon, clinician, dedicated humanitarian, and scholar. Dr. Coller was my mentor when I started my surgical training in 1953. He was President of the College in 1949-50.

Dr. Reed M. Nesbit was professor of surgery and chairman of the department of urology at The University of Michigan Medical Center. Dr. Nesbit was the second urologist to be President of the College and held this office in 1967-68. He was my chief and mentor in urology during my training and was a brilliant clinical surgeon. It is a great honor for me to follow Dr. Nesbit in this position as President of the College.

Dr. Charles C. Higgins, who was head of the department of urology at the Cleveland Clinic Foundation when I joined the staff in 1959, was Chairman of the Board of Governors from 1955 to 1958 and First Vice-President of the College in 1960-61.

You can see that these are impressive men, each in their own right, and I wanted to mention them in my address to you this evening because I hold them in such high esteem.

Issues faced by surgeons

Access to and cost of health care: The health care needs of America have been debated in Congress in 1991 and will be the focus of discussion throughout the rest of this decade. Comprehensive proposals for change have been authored by various private groups, public commissions, and federal task forces. Some reports advocate cautious change and others radical change. A Harris Poll conducted earlier this year showed that 89 percent of Americans felt a need to change our health care system, although 55 percent were satisfied with their own medical care. The main problems identified are related to cost of and access to health care.

The American people are concerned about the amount of money that currently is being spent on health care. In 1990, spending amounted to $670 billion, or 11.2 percent of the gross national product (GNP). This amount represented an increase of 10.4 percent over health care spending in 1989. Costs projected for 1991 are $756 billion, or 12.2 percent of the GNP.

It is worthwhile to look briefly at who pays our health care bills. In 1989, health care expenditures totaled about $604 billion. Private payors accounted for 58 percent of the costs, or $350.8 billion, and the government paid for 42 percent of the costs, or $253.3 billion.

Among the private payors, individual out-of-

pocket expense was around $126 billion (21 percent), and private health insurance covered nearly $200 billion (33 percent). Among the government payors, the federal government paid out $179 billion (29 percent), and the states paid about $79 billion (13 percent).

There are at least four reasons why costs have become a major concern for health care and they include: (1) the budget deficit, (2) the solvency of the Medicare Trust Fund, (3) the financial status of the states, and (4) the pressures that health care costs are putting on private industry.

National budget deficit: In 1981, the federal budget deficit was $24 billion, and it currently is over $200 billion. Servicing the national debt has become a major cost for the federal government. Medicare Part B and the federal government's share of Medicaid come from the general revenue fund.

Solvency of the Medicare Trust Fund: The Medicare Trust Fund is financed through a Social Security payroll tax. Changes produced by the Social Security amendments of 1983 helped forestall insolvency of this fund. Medicare Part A is funded by the Medicare Trust Fund.

Financial viability of the state: The Medicaid program has been a major drain on financial resources in most states, and they are simply unable to fund it adequately. Designed to serve individuals whose income falls below the federal poverty line, the program has been unable to service the increasing number of citizens who are eligible for it. Many states have imposed severe eligibility requirements to control costs. As a result, Medicaid currently covers only about 40 percent of people whose income falls below the federal poverty line.

Burden on private employers: In 1988, the typical employer paid about $2,300 per employee for health care benefits. It is estimated that this cost increased to $3,200 per employee in 1990. There are also contractual obligations of corporations to cover health care costs of retirees, and most of these liabilities have not been funded.

Health care costs will undoubtedly rise for the following reasons:

Aging population: The fastest growing segment of the population is people over 100 years of age, and the next fastest is those who are over 85 years of age. The costs of acute and long-term care for the elderly are already high and will increase as more people enter these age groups.

Physician supply: Between 1970 and 1980, medical schools dramatically increased the output of physicians. The number of physicians increased from 153 per 100,000 in 1970 to 228 per 100,000 in 1990. This number is projected to be over 240 per 100,000 by the year 2000. The supply of physicians is important because physicians are believed to influence 70 percent of all health care expenditures.

It is important to point out that while the total supply of physicians has been increasing, the number of surgical residents and the number of surgeons who are board certified has remained relatively constant over the past several years.

Unionization of health care workers: On April 23, 1991, the Supreme Court in an unanimous decision upheld the right of this country's 3.3 million hospital workers to unionize. The eight units of workers that are affected by the decision are: salaried physicians, nurses, all other professional staff, technicians, skilled maintenance workers, clerical workers, guards, and nonprofessional workers. The costs of health care could increase rather substantially as a result of this decision. Most of the workers who are affected by the decision historically have been paid at relatively low salary levels. If they become unionized, they could demand higher salaries than they have had in the past.

Technology: New technology is expensive and increases health care costs. Government economists estimate that new procedures are adding over $12 billion annually to our national medical costs.

Trauma: In the United States, one death in every 12 is the result of trauma, and severe trauma is the leading cause of death in all age groups up to 44 years of age. Unintentional injuries cost the nation $145.8 billion in 1989 due to lost wages, medical expenses, insurance administrative costs, property damage, and indirect costs. These costs will probably continue to increase yearly.

Changing patterns of disease: It is difficult to predict the epidemiologic vagaries of various diseases. Who would have suspected the impact that AIDS would have on society and the cost—estimated to be $5.8 billion in 1991—that is associ-

ated with the care of these patients?

Professional liability insurance: Professional liability insurance costs have increased, as have the direct costs of practicing defensive medicine. This cost is estimated to be about $19 billion per year.

Care for the uninsured: It is estimated that we have from 31 to 33 million people without health insurance. Among this group, some individuals have insurance coverage for part of the year, but 10 million people probably are uninsured during the entire year.

According to recent surveys, about 80 percent of the uninsured are either employed or are dependents of those who have jobs. Most small companies do not offer health insurance, and 95 percent of all companies have fewer than 50 employees. About one-third of the uninsured work at companies with fewer than 10 employees, and another 25 percent work at firms employing less than 100 individuals. Fifty percent of the uninsured are 24 years of age or younger, and 30 percent are from families with annual incomes below the federal poverty line.

The cost of providing health care for this group is carried by the Medicaid program (over $40 billion per year). In addition, hospitals provided $11.2 billion in charity care in 1989, and physicians provided an estimated $6.3 billion of free care in 1988. Cost shifting to private insurance carriers from Medicare, Medicaid, CHAMPUS, and the uninsured amounts to about $25 billion annually.

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Implications of rising costs

The implications of these predicted rising costs on our health care system are serious. Policymakers, such as the federal government, not fully understanding the reasons for the increasing costs, choose to relate it to inefficiencies in the system and simply continue to cut reimbursement in all areas. If this pattern continues, the outcome will be detrimental to our health care system and to the people it serves.

Hospitals: The most important change in hospital reimbursement occurred in 1983 when Congress established a prospective payment system (PPS) for inpatient services provided to Medicare beneficiaries. The intent was to control costs by giving hospitals financial incentives to deliver services more efficiently.

During the first three years (1984-86) the system was in place, the majority of urban and rural hospitals profited from treating Medicare patients, but profits declined each year. Declining utilization plus continued changes in the hospital reimbursement system have placed considerable financial pressure on both urban and rural hospitals. From 1985 to 1988, 260 hospitals closed in the United States, and about half of those that closed were in rural areas. It will be only the well-managed hospitals that survive.

Physicians: The years ahead for physicians will be difficult. They will lose market share as more physicians enter the marketplace. Reimbursement will be less under the Medicare program's new payment system, which uses a resource-based relative value scale (RBRVS) for physicians' services, and the stage is set for interspecialty divisiveness as never before seen. This system allows the government to reduce physicians' income further under the alleged goal of redistributing dollars from the proceduralists to the nonproceduralists.

Patients: Efforts of payors to hold down costs may prevent patients from having access to high-quality care as well as to new technology in a timely fashion.

We must consider what can be done to address these problems. Thus far this year, more than 15

bills addressing costs and access have been introduced to Congress. The measures under consideration vary widely. In addition, many private and public groups have introduced plans to deal with these problems. There are four types of plans under discussion:

Type 1. Compulsory, private insurance through employers with the government insuring nonworkers and the poor. This type of plan has been proposed by the American Medical Association, the American Hospital Association, and by the Pepper Commission. Senate Majority Leader Mitchell, in June of 1991, introduced a bill containing many of these recommendations.

Type 2. A law requiring employers to provide private insurance to employees or to pay equivalent taxes with the government insuring nonworkers and the poor. These principles are incorporated in the proposals introduced by Enthoven and Kronick and by Karen Davis.

Type 3. Tax credit for the purchase of private insurance under a plan outlined by the Heritage Foundation.

Type 4. An all-government insurance system as proposed by Representative Roybal and the Physicians for a National Health Program.

In addition, many plans to address the problem of the uninsured are being introduced at the state level. It is unlikely that any major legislation will be enacted in 1991, but the issue will be addressed in the future and will probably be a major issue in the 1992 presidential election.

Physician reimbursement

In the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Congress enacted the most significant changes in physician reimbursement since the Medicare program was started in 1965. These changes were made because of concern that the current "reasonable charge" system led to inequities in relative payment levels between "procedural" and "evaluation and management" services. The Medicare physician payment reform plan enacted by OBRA '89 consists of three parts: (1) creating separate Medicare volume performance standards (MVPS) for surgical and other physicians' services as a mechanism for controlling increases in the volume of services provided to patients, (2) setting limits on the financial liability of Medicare beneficiaries by controlling balance billing, and (3) establishing a Medicare fee schedule according to a resource-based relative value scale (RBRVS).

The first MVPS was established in 1990, and the Health Care Financing Administration (HCFA) began phasing in beneficiary protection provisions in 1991. The third component, the Medicare fee schedule, is to be initiated by law on January 1, 1992, and is to be phased in over four years. The RBRVS used to construct the Medicare fee schedule is based, to a large extent, on the results of a project that was conducted by researchers at the Harvard School of Public Health and directed by William Hsiao, PhD.

HCFA is the agency that is responsible for implementing the new fee schedule, and it published the regulations in the *Federal Register* in June 1991. The Physician Payment Review Commission (PPRC) is a congressional advisory panel that initially recommended many of the payment reforms and that continues to advise both Congress and HCFA on many issues that must be addressed before implementation.

The College has been involved in physician reimbursement issues since 1983 when the Board of Regents appointed a committee on physician reimbursement chaired by Dr. Gerald Austen. Under the leadership of this committee, the College has initiated a number of proactive efforts to establish its position as a major participant in the payment reform debate.

The surgical specialty societies have played an integral role in the reimbursement activities undertaken by the College. The College has hosted more than 25 meetings with representatives of the surgical specialty societies since 1984. The purpose of these meetings has been to inform the surgical specialties about current activities in Washington with regard to reimbursement. The College has elicited the views of the specialty societies on the issues to develop a plan under which the College and the specialties can work together.

Because of concerns regarding the purpose and methodology of the Harvard research project, the College supported a blended Medicare fee schedule based equally on supply and demand considerations. The College has played a significant role in other payment reform activities, having testified 30 times in the past five years before Con-

gress, the PPRC, and other federal advisory committees.

The College has also been called upon frequently to provide clinical information and advice on issues associated with implementation of the Medicare payment reform. These activities include participation in: (1) the PPRC's consensus panel to develop the global surgical fee policy, (2) the PPRC/AMA consensus panel on reforming the visit code system, (3) a joint effort with the surgical specialty societies to develop data on the use of assistants at surgery, (4) a joint meeting with the surgical specialty societies to compile information on technological changes that are expected to impact the volume of services, (5) a review of RBRVS preliminary work values and interspecialty links for general surgery procedures, and (6) a review for HCFA of the intraoperative services that are associated with general surgery procedures.

In addition, the American College of Surgeons has taken a position on the following important issues:

Global surgical fees: The concept of global surgical fees is supported by the College. It has endorsed the views of PPRC, which would define a global surgical service to include: (1) all preoperative hospital visits occurring the day before and the day of operation, (2) all intraoperative services, and (3) all postoperative visits occurring within 90 days after the operation. The initial consultation as well as any return trips to the operating room to deal with complications should be paid for separately.

Assistants at surgery: The College believes that payment policies relating to the use of an assistant at surgery should be driven first and foremost by quality and safety concerns for the patient. Reimbursement of the assistant should be related to the actual work performed—hence, in the same manner in which payments are to be established for other physician services under the new Medicare fee system.

Newly practicing physicians: The College opposes paying newly practicing physicians at lower reimbursement rates during their first four years in practice. There is no evidence that resource inputs of new physicians are any different from other physicians and they should be paid at the same rates.

Multiple operations: According to proposed regulations, payment for multiple operations is based on an inflexible formula where each succeeding operation would be paid at a smaller and smaller fraction of the global fee. The College has urged HCFA to consider basing payment for multiple operations on at least the full value of the intraoperative portion of each succeeding procedure.

Malpractice expense: The College has continued to support the development of a more refined method for determining payment for malpractice expense. The payment for such expenses should be determined by spreading the premiums for professional liability insurance over services in proportion to the risk for service.

Medicare volume performance standards: The College supported the concept of the MVPS and worked for and achieved a separate target for surgical services. There has always been concern that once the MVPS and the Medicare fee schedule were established, Congress would attempt budget reductions without concern for the quality of patient care. An unrealistic and unattainable MVPS for surgical services will undermine attempts to ensure that the Medicare population receives optimal surgical care.

Budget neutrality requirement of the 1992 Medicare fee schedule: OBRA '89 required that the new Medicare fee schedule be budget neutral when it is implemented in 1992. Therefore, the new fee schedule must neither increase nor decrease aggregate 1992 Medicare payments. The fee schedule transition rules will cause payments for "undervalued" procedures to rise more rapidly than "overvalued" procedures will fall, producing a net cost to the program estimated by HCFA to be 6.2 percent. In addition, they have assumed that physicians will increase the volume of services provided to patients. HCFA has estimated this cost to be 10.5 percent. The conversion factor that was used in the model fee schedule to multiply the relative values to obtain the fee schedule amount has therefore been reduced 16.7 percent, resulting in a conversion factor of $26.873. By law, this amount is to be adjusted by the Medicare update factor, which has been recommended by both the PPRC and HCFA to be 2.2 percent for 1992. Congress, however, must make the final decision regarding this

Medicare fee update.*

Believing that Hsiao had not accurately assessed the relative value of the various procedures studied in their field, the Society of Thoracic Surgeons and the Society for Vascular Surgery petitioned HCFA to be resurveyed. They were allowed by HCFA to have Abt Associates of Boston, MA, at their own expense, reevaluate the RBRVS in their specialty using the same technique utilized by Hsiao. This reevaluation has been completed, and the work units given to various surgical procedures is quite different from those assigned by the Hsiao study. It would appear that there was a tendency by Hsiao to overvalue minor procedures and to undervalue major procedures in terms of relative value work units. In addition, the Hsiao project had assigned higher work units to some procedures that were obviously less difficult and time-consuming than procedures that were assigned lower work units. It is believed that Abt utilized a larger group of well-informed specialists in these fields to arrive at the new relative value units. This study cast considerable doubt on the validity of the Hsiao study in all specialty fields.

Any change in the fee schedule for physician reimbursement under Medicare will require action by Congress. The PPRC may have some influence, but the College and other medical organizations must lobby hard to question the validity of the Hsiao relative value study as well as the use of such a high behavioral (10.5 percent) and transition (6.2 percent) offset in reducing the conversion factor. To assume that this volume increase will occur and not allow Medicare volume performance standards to manage this problem is contrary to the spirit of the legislation that was enacted by Congress.

Future issues for the College

I believe it is unlikely that we will have national health insurance in the near future. The budget deficit and financing requirements of such a massive plan would be too expensive. It has been estimated that the cost of a Canadian type of health care system in the United States would require over $250 billion in additional new taxes. This would be true even though it is estimated that this country would save more than $30 billion in administrative costs if it had a single payor system. It would seem that at this point in time—when we are faced with such a large budget deficit—it would be prudent to approach reform in a well-managed, incremental manner. Congress will undoubtedly continue to control medical costs by controlling physicians' fees and volume of service through mechanisms that were legislated in OBRA '89.

There will be a gradual change in the health care system to cover the uninsured and underinsured. This goal will probably be accomplished through mandated coverage of employees by employers, risk pools to provide insurance for those who are unable to acquire it at this time, and improvements in the coverage and reimbursement levels under the Medicaid program.

The Agency for Healthcare Policy and Research, which was created by OBRA '89, will become an important player in health care delivery. The purpose of this agency is to promote quality, appropriateness, and effectiveness of health care services. This agency is charged with conducting and supporting research to develop practice guidelines and evaluate medical outcomes, among other tasks, and with disseminating this information. I believe that surgeons should participate in these studies, or we will suddenly find ourselves faced with practice guidelines that may not be appropriate for our various specialties.

In spite of all attempts to control health care costs, they will undoubtedly continue to increase. It is estimated that by the year 2000, they will have reached $1.5 trillion and will represent 15 percent of the gross national product. Hospitals will continue to close, and physicians' income will continue to decline relative to the increase that has occurred yearly in the past.

The American College of Surgeons must take a leadership role for all of surgery if we are to be an effective voice in Washington. As Dr. Stinchfield stated in his 1977 Presidential Address, "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 which can be meaningful on our behalf can be productive only if we present a united

*As the *Bulletin* went to press, many of these issues remained unresolved.

front." Your specialty society can speak for you on issues that are important specifically to your specialty, but only the American College of Surgeons can be an effective voice for all of surgery.

Paraphrasing what Dr. George Crile wrote in his journal in 1918 during World War I in France regarding his two associates Bunts and Lower, "We have been rivals in everything, yet through all the vicissitudes of personal, financial and professional relations, we have been able to think and act as a unit." This principle must apply to all members of the American College of Surgeons regardless of your specialty. If this solidarity occurs, we will have an effective and unified voice for all of surgery in the American College of Surgeons. Ω

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