The surgeon, the system, and patient care

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Dr. Rhoads, Distinguished Guests, Officers, Regents, Governors, Fellows, Initiates of 1972, Ladies and Gentlemen:

Thirty-five years ago, as a fourth year medical student, I sat in this assembly—awed, anxious, and inspired—witnessing my first convocation of Initiates of the American College of Surgeons. Tonight, in humbly accepting the role of your President, those same feelings of overwhelming anxiety momentarily temper my enthusiasm for the honor of this office. To follow in the footsteps of so many illustrious surgeons who have served as President of this great College, and to have arrived in the office at such a crucial period in American medicine, makes one acutely aware of the enormous responsibilities implied by this honor. I simply state that my response will be to promote vigorously those policies and ideals that encourage the best of care for the surgical patient, which is, after all, the basic goal of the American College of Surgeons.

May I express my congratulations to you 1527 initiates and to your spouses and families who have shared in your unstinted sacrifice and effort. You have achieved the two basic qualifications that distinguish the trained surgeon—eligibility for specialty board certification and Fellowship in the American College of Surgeons.

To attain your first goal you have completed the requirements of training, demonstrated your proficiency in clinical surgery, and most of you have passed the qualifying examination of your specialty board. You have, however, gone beyond this in attaining your second qualification, that of Fellowship in this College. You have exhibited mastery of the knowledge and skills of your specialty; you have proceeded under the critically appraising eye of your peers to demonstrate your ability to apply these talents for the benefit of your patients in the practice of surgery; and you have demonstrated those qualities of professional behavior and interpersonal relationships that characterize the accepted ethical standards of a responsible physician and an effective member of society.

The significance of the hurdles you have voluntarily surmounted and the milestones you have thus achieved cannot be overestimated, for these are goals established by our profession for itself in a totally unselfish effort to improve the quality of surgical care.

You are the surgeons of your generation. There are few acceptable reasons for a less well prepared physician to perform a surgical operation in this country today.

Organized medicine has vigorously defended the public against those irregular practitioners who would betray the sick with ineffective unscientific remedies and treatments. Organized medicine has insisted on the attainment of an approved MD degree or its equivalent as a requisite for practice. Organized medicine has participated in the development of quality training programs for surgical specialists, and yet organized medicine has steadfastly refused to take the final step and insist that the attainment of specialty certification is as essential to the proper practice of surgery as the MD degree is to the competent practice of medicine. In some parts of the United States there are few operations performed by non-certified surgeons; in other areas there are many. For example,

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In brief . . .

This is the Presidential Address delivered by Dr. Longmire following his inauguration as fifty-third President of the American College of Surgeons during convocation ceremonies in San Francisco October 5, 1972.

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Riley and co-workers[1] found that 65 percent of family practitioners in upstate New York performed hospital surgery, and, according to statistics compiled by the American Medical Association in 1970, there were more than 71,000 doctors in this country who classified themselves as surgeons. Thirty percent, however, were not certified by an American surgical specialty board.

But there are other reasons for restricting the practice of surgery to certified surgeons. According to the Commission on Professional and Hospital Activities, in 1971 33 million operative procedures were performed on 21 million patients. If, in any given year, there are a certain number of operations to be performed in this country, it should be possible to calculate with some accuracy the number of surgeons necessary to perform these procedures when working at optimum efficiency. This, then, is the number of surgeons we should strive to train. However, if a significant but unknown percentage of this work is to be done by incompletely trained physicians, the volume of work to be performed by the trained specialist cannot possibly be estimated, and all efforts to project and to train the number of qual fied surgeons required to meet our needs are doomed to failure.

With the mounting level of governmental support of medical schools, hospitals, and training programs, our responsibility to the taxpayers makes it mandatory that we conduct surgical specialty training with efficiency of manpower and economy of money and facilities. The number of residency positions available, and thereby the number of surgeons trained each year, must not be based solely on the number of hospitals with the facilities to support a training program and a staff desirous of training residents. Rather, the number of residents trained, and their proportionate distribution into the various surgical specialties, must be based on the anticipated manpower required to perform the essential volume of surgical service for this country. Further, the effectiveness of other specialists, including family physicians, should not be compromised by the taking of time from their primary duties to engage in the technical aspects of surgery.

To seek suggestions and possible solutions to some of our problems, a questionnaire concerning surgical training and requirements for practice was submitted to prominent surgeons in 14 foreign countries (Table 1). In all but four, the license to practice medicine includes the license to perform surgery, as is the case in the United States. There seems to be an almost universal reluctance to prohibit a physician, by law, from performing operations because of possible emergency situations. All countries but one have a recognized plan for the training of surgeons, with minimal requirements ranging from three to seven years. In those countries with a minimum of three years, however, it was indicated that few doctors practice surgery without a much more extensive training experience. In few countries is the surgical training program as standardized and formalized as in this country. Generally, there is a much greater reliance on, and authority in the hands of, the chief of the surgical training program, which is usually conducted in a university hospital. In only six of the countries queried is it believed that a significant number of surgical procedures are being done by non-certified surgeons; in three of these the level of activity of such non-certified surgeons is considered to be rapidly diminishing, due, in part, to the lower surgical fees received.

Incorporating this information from other lands with a critical review of the situation in this country, it is clear that if we are to establish an orderly national plan for the training of appropriate surgical personnel, we must proceed with the following steps:

(*1*) Establish an acceptable definition of a surgical specialist to include the following criteria: with certain detailed modifications, not herein enumerated, a surgical specialist must, by reason of his training and experience, be certified by an American surgical specialty board approved by the American Board of Medical Specialties, or be judged eligible by such a board for its examination, or be a Fellow of the American College of Surgeons elected prior to 1955, or, on the basis of training obtained outside of the United States, have satisfied the training requirements for Fellowship in the American College of Surgeons.

(*2*) Determine ways to limit the practice of surgery to surgeons who meet these requirements. In general, the public is more inclined to act to enforce such limitations than is the medical profession itself, and it seems quite probable that the most effective mechanism will come by way of federal legislation that will establish differential surgical fees for certified and non-certified specialists, a system not unlike that which has been in effect for many

years in the military services and the Veterans Administration. Additional pressures should also be exerted by the American College of Surgeons through the distribution to hospital governing boards of the established policies of the College in regard to the training requirements of properly qualified surgeons.

(3) Provide estimates of the national requirements for surgical specialists based on past experience and the additional information to be obtained from the Study on Surgical Services for the United States now being conducted jointly by the American College of Surgeons and the American Surgical Association.

(4) Control through the residency review committees of the nine established surgical specialties the number of residency positions available each year and thereby relate the number of specialists trained to the national need. If necessary, the authority of the residency review committee in this process could be strengthened by the support of the newly formed Liaison Committee for Graduate Medical Education.

Such measures, if adopted, would provide surgeons in the generation of tonight's initiates with an unprecedented and unparalleled position of protected privilege. To paraphrase Rosemary Stevens, how could such surgical elitism be justified in our egalitarian society? My answer would be that it could only be justified by the offering of certain sacrifices and the acceptance of certain restrictions, for with privilege comes responsibility. And here I would remind you that the so-called idealism of the 60's needs more than lofty notions to make it effective. To quote from Anne Somers:[2] "The new humanism—both that of the student idealists (who, not so incidentally, have won for themselves the highest graduate stipends in medical history) and their affluent fathers—is greatly to be welcomed as a long reaction to over-preoccupation with scientific medicine and entrepreneurial medicine. However, if past history tells us anything it is that idealism alone is not an adequate guarantor of social usefulness. To be effective, personal idealism must be translated into organizational policy and institutional structure."

It seems clear that if you find yourself at some future date in such a privileged professional position, you must accept the following responsibilities:

1. To acknowledge some mechanism—peer review, at least—of controlling and, to some degree, of standardizing surgical fees.

2. To strive in your own practice and through hospital committee work to scrutinize and "tighten" the indications for all surgical procedures. As you know, 11 percent of the Fellows of the College who answered the August, 1971 questionnaire believed that unnecessary operations were performed in their hospitals as often as once a week or more.

3. To decide if you are to support a national health service that will preserve the patient's right to free choice of hospital and physician and that will maintain our pluralistic system of medical care. Support for such health care has been overwhelmingly endorsed by the more than 15,500 Fellows who answered the questionnaire. More than 13,000 indicated acceptance of some type of national health insurance system; 1,300 wished to maintain the status quo; and 1,982 were undecided.

4. And, finally, to accept your responsibility to society to assist in planning adequate surgical care in understaffed areas in your region of practice.

Congress has moved with determined effort to meet the health manpower needs of the country by increasing the number and enrollment of our medical schools. In 1959 there were 85 approved medical schools. By 1971 this had increased to 108 with five more schools to start in 1972. In 1960–61, 8,550 new students were accepted into the first year of the medical schools of the United States. Eleven years later, 1971–72, this number had increased to 12,360, and it is estimated that in another three years the enrollment of first year medical students will have increased to more than 15,000 per year. The total enrollment increased from 33,423 in 1966–67 to 40,487 in 1970–71.

In a country such as ours it is ludicrous that more than one-third of the physicians licensed each year are graduates of foreign medical schools. The vast majority of these physicians come from countries that can ill afford to lose their medically educated population. In 1970–71 more than 10,000 foreign medical graduates were examined, 6,749 of whom were licensed to practice medicine in the United States. Any steps that can be taken to modify this import imbalance by educating more of our own citizens must certainly be encouraged, but the undirected injection of thousands of additional physicians each year into the American medical scene may provoke chaos unless planning beyond the MD degree is instituted immediately.

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There is sufficient evidence to indicate that taxpayer support of millions of dollars in expenditures for medical school construction and enrollment reflects the public's desire for more family physicians and improved distribution of the various types of physicians. These goals are, undoubtedly, uppermost in the minds of our Congressmen. But what evidence is there that an unplanned, unguided expansion will not merely serve to engorge still further the currently well-supplied areas and specialties without in any way affecting our current deficiencies? It has been well demonstrated that the simple law of supply and demand will not solve these problems. Furthermore, there is considerable question as to whether the desire of the public for this type of first-contact, continuing-care physician can be achieved with our present applicant selection mechanism, medical school curriculum, and medical practice policies.

Despite efforts to improve the training experience, the professional status, and the practice opportunities for the family practitioner, and despite the increasing evidence of considerably greater interest on the part of entering and junior medical students in a family practice career, there is little satisfaction to be gained from enrollment figures in family and general practice residency programs to date. The 557 residents currently enrolled constitute an insignificant number when compared with the 7,207 residents in internal medicine and the 6,571 in general surgery alone. According to statistics released by the Bureau of Research and Planning of the California Medical Association, the number of physicians in general or family practice continued to decline in California through March of 1972, with a net loss of 900 or 14.2 percent from June of 1969 to March of 1972. Although greater recent emphasis on the field of family practice may result in a reversal of this trend in future years, no such change has yet materialized. There were during this period large increases in the number of certain surgical specialists. Internal medicine and pediatrics also registered sizeable gains.

If the idea of the "feldsher" or minimally trained health worker is not to be considered, it seems that the family physician may have to come chiefly from the specifically designed, broad general medical program of the Board of Internal Medicine. In any event, we must do as several of the European countries have done and as has been previously suggested, that is, to confine the number of medical school graduates who can enter surgical or medical specialty training to the number required to meet the health needs of the country; the remaining graduates must then enter fields that will satisfy other national needs.

Finally, it is clear that the distribution of physicians is a problem in all countries around the world from Russia to Australia. Numerous attempts have been made in this country to correct the situation, particularly in rural areas by means of various financial inducements. But in a follow-up of the most frequently utilized plan of medical student loans or scholarships, Mason[3] reported that (with the exception of the students from Kentucky) almost one-half of the young physicians failed to follow through with their commitment to practice in rural communities, preferring to return the money at the going interest rate. As unsatisfactory as it may be, the most effective method of meeting this problem in any of the countries surveyed has been a specific location assignment during a period of compulsory national service one to three years after medical school. One may rightly challenge the propriety of the government to single out the medical profession for such service, but as the education and training of physicians become more and more the financial responsibility of government, repayment in obligatory service may not seem so farfetched or unreasonable. As a matter of fact, a small program of this type is already in operation, for there are 152 physicians now assigned to the National Health Service Corps for service in communities with serious health manpower shortages.

Some years hence members of this initiate class will occupy positions of responsibility in the American College of Surgeons. Some of you will work within your chapters, some within the important standing committees of the College, others will become Governors and Officers, but all of you will play a role in improving surgical care in your communities through your association with the affairs and activities of this organization.

In closing, may I express the hope that my feelings of optimism and confidence are shared by all of you here this evening as we witness this vast assembly of new Fellows, a gathering that each year brings fresh initiative, vitality, and strength to the American College of Surgeons. We have the utmost trust that, regardless of the system under which you practice, each of you will strive to provide nothing short of the best of patient care.

References

1. Riley, G.J., C.R. Wille, and R.J. Haggerty, A study of family medicine in upstate New York. *JAMA* 208:307, 1969.
2. Somers, A., Health care in transition: Directions for the future. Hospital research and educational trust. Chicago, Ill., 1971.
3. Mason, H.R., Manpower needs by specialty. *JAMA* 219:1621, 1972.

TABLE 1

Country	Does license to practice include license to perform surgery?	Surgical training program?	Minimal surgical training period?	Surgical training required by law?	Law State or National?	Any significant amount of surgery by uncertified?	Does your system give good surgical care?	Are changes contemplated?	Comments
Germany	yes	yes	6 yrs	no	—	no	yes	no	Certified by chief of service
Australia	yes	yes	4 yrs	no	State	yes, but diminishing	yes	yes	Add. payment for cert. surg. Program to be lengthened to 5–6 yrs.
Lebanon	no	yes	4–7 yrs	yes	National	yes	+/−	yes	Quality of care depends on hospital
Israel	yes	yes	6 yrs	no	—	no	yes	no	Specialty board exam will be given
Russia	yes, emergency only	yes	3+*	yes	National	no	yes	no*	*Plus 3 yrs obligated assignment May take further specialty training
Canada	yes	yes	4 yrs	no	—	yes*	yes, could be improved	yes	*Specialists paid higher fee. Trend is to more specialists.
Japan	yes	no*	6 yrs	no	—	yes	no		*Owing to student movement internships abolished and qualifications of medical specialists have not been established.
Chile	yes	yes	3 yrs+ 2 yrs*	no, but great help	—	yes	yes	no	*Required service in a provincial hospital—2 yrs.
South Africa	yes	yes	6 yrs	no	—	yes, but diminishing	yes	no	Higher specialist fees. Non-cert. surgeons in the country.
Switzerland	yes	yes	5 yrs+	no	—	no	yes	yes	Average total training period 11 yrs. Considering increasing required time to 6 yrs with formal examination.
England	yes	yes	3 yrs*	no	National	no**	yes	yes	*FRCS requirement. **All surgery done by consultants with extensive training.
Sweden	no	yes	5 yrs	yes	National	no	yes	yes	Will require formal exam.
France	no	yes	3 yrs*	yes	National	no	yes	yes	*Usually 6 yrs.
Scotland	yes	yes	7 yrs*	no	—	no	yes	no	*Includes 3 yrs for FRCS Edin.