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Presidential Address: Surgery and the Ultimate Public Good

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THE CENTENNIAL MEETING'S EXAMINATION of the history of the Southern Surgical Association provided clear direction for the subject of this first address of the Association's second hundred years. We have appreciated the past and it is now more than time to consider both the impending and distant future. I believe this is a serious time and I intend these to be serious comments. Focusing on the future, of course, brings the inevitable dangers that our predecessors faced when anticipating the present. A contemporary forecaster must choose between having his shortsightedness ridiculed and taking responsibility for inducing unrelenting depression as a result of Orwellian projections.

If, however, we are to undertake an examination of the future and entertain some suggestions as to reasonable strategies, we must develop a polygonal line of response. Such response must embrace the social, the public, and the political sectors, the practicalities of interfaces with other professions, and ultimately include both the clinical and basic scientific future of surgery. If we are to have any kind of reasonable influence on the shape of things to come, it is essential that we use an integrated approach to these issues and offer viable solutions to both visible and anticipated threats.

I wish to briefly outline the broad ramifications of the current unfavorable social and political climate for quality surgery, in particular, and for medicine as a whole. I am convinced that virtually all components of this situation will significantly worsen in the near term and I trust that these remarks will persuade most of you that it is long past time to respond. I will close with a prescription for action and an example of how a related group, with far fewer resources, overcame a specific problem and turned the American public toward greater health and, in the process, established a clearer and more respected role for itself in future considerations.

I must acknowledge three primary data sources for these comments and, ironically enough, two are derived from the American Medical Association. The first is a conference proceedings from early 1987 entitled, "The Medical Profession: Enduring Values and New Challenges,"[1] and the second is a report from the summer of 1988 from the AMA Council on Long-Range Planning and Development on the Future of General Surgery.[2] The third source encompasses various comments by futurists on likely prospects for American health, medicine, and sur-

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TABLE 1. *Definition of a Profession**

1. A unique body of knowledge and/or skills
2. A valid testing and/or credentialing system
3. Pertinently defined quality and ethics
4. Appropriately defined and responsive entity to speak for the profession
5. Altruistic services
6. Autonomy
7. General public acceptance of the foregoing

* From Freidson.[4]

gery.[3-4] These have provided strong focus for concepts that have been building for more than a decade.

As a further digression I wish to briefly redefine the characteristics of a profession (Table 1).[5] Each of you, to a substantial extent, exemplify them all. Moreover, by examining them in the abstract, we have an opportunity to test and retest the issues to be raised later in a more objective way. Before leaving such comfortable and nonthreatening criteria, it is only fair to comment on how well several currently apply to us. Yes, we do retain a special body of knowledge and skills. Our credentialing system has come under fire and yet seems to have survived. We do have responsible entities to speak for us but their long-range perspectives are blurred and they have problems choosing who they shall represent. But there the good news ends.

Quality will surely prove the victim of the current infatuation with cost control. Our ethics are being damned by allegations of conflict of interest, plagiarism, and scientific fraud. Professional altruism has been drawn and quartered, initially by Medicare fraud and abuse claims, and now by the Washington agenda on reimbursement and surgery's inability to define a winnable pose. Autonomy and public acceptance go hand in glove and both are dangerously threatened. Surely, medicine's failure to recognize the ultimate threat embodied by the initial trends in the early 1960s precluded playing the game under more favorable circumstances; clearly that was a time when physician respect was at a peak. Had we all recognized the significance of those gentle winds of change we could have altered many of the events of the last decade. But no one did!

A Litany of Threats

Further definition of the major conflicts addressing quality surgery is both easy and depressing. Try this list for starters: surgical practice infringements run the gamut from biliary lithotripsy to percutaneous interventions to fiberoptic endoscopy, and the list grows even while we meet. What do they have in common? First is the continuing disciplinary failure of surgeons to pursue new technologies. Second is the unchallenged public misrepresentation that invasiveness is inversely proportional to both value and safety. But more about that later.

Similarly, we have allowed other surgeons and, most unfortunately, even nonsurgeons to narrow the base of so-called general surgery; the major erosions of the 1960s and 70s have only recently begun to be reversed. As a further example, surgeons, even some in this audience, regularly permit the delegation of pre- and postoperative care and, indeed, pre- and posthospital care, to nonsurgeons. I am certain that this is permitted in order to protect referral lines, but it clearly is contrary to the best interest of the surgical patient, the surgical trainee, and to the best long-term interests of surgery as a profession.

Further to our present state, let us examine the components of the reimbursement confrontation. Why are surgeons fighting a losing battle on reimbursement? Who determined this agenda in the first place? Health care costs are high and loopholes in DRGs have failed to impact hospital fees in the manner that was anticipated by social planners. If hospitals were too clever to have their charges contained, then what about physician fees? Are they high and rising? Of course they are and who leads the way but surgeons, notably cardiac, ophthalmic, and orthopedic. How can we win the reimbursement debate when we represent everyone's version of the world's highest paid profession? If one were seeking to reduce doctors' fees drastically and perhaps even drive the entire profession into salaried civil service, what better way exists than to have surgery defend a small number of surgeons who charge and collect excessive fees, especially for coronary artery bypass and cataract extraction. Just to seal the coffin of personal-fee-for-service medicine, why not set doctor against doctor and push the cognitive reimbursement dispute onto the front pages. Let the surgeons belittle the thinking physician and cajole the internists into discrediting anyone who does anything. That is exactly what is happening to us now. Our American College of Surgeons, in trying to represent all of its members, has chosen to defend a charge-based relative-value scale in order to preserve the doctor's right to participate in determining the amount billed to the patient. With this decision surgery has been manipulated into a classic lose/lose position.

Consider the price-*versus*-quality issue that is moving to center stage. What happens when gatekeepers outnumber doctors, and they already do. Whether we gave the key away or had it taken from us by those disappointed or infuriated with our conduct in this area is a subject in and of itself and will not be pursued further here. A most incisive analysis of appendicitis in a private metropolitan teaching hospital will be the lead article in the March 1989 issue of the *American Journal of Surgery*.[6] Table 2 projects the essence of that paper. A sharp increase in advanced appendicitis with abscess formation was associated with a significant increase in so-called "prehospital

treatment" and corresponding increases in major morbidity. What accounted for this remarkable change? A major increase in the proportion of "managed care" patients; the gatekeepers locked their portal and lost the key. Everyone of you has seen and the majority have acquiesced to parts of new null hypotheses: How far can you push nurse-staffing ratios before overt complications and unnecessary deaths supervene? How many reactions to generic pharmaceuticals will you permit before the altar of cost containment? How many wound complications are justified by the third party's savings on outpatient surgery?

Indigenous to the cost-*versus*-quality issue, the decision of the Federal Government to disallow full Part A Medicare reimbursement for salaries of some surgical residents is exemplified by the new rulings setting a maximum of five years' reimbursement for trainees in accredited programs. Note that a hospital is permitted total salary recovery for an internal medicine resident who stays up to two years beyond his or her required three, but only one half for the sixth, seventh, or more years of training and service required in cardiothoracic, neurologic, or plastic surgery. Discrimination it is, as well as specific downward pressure upon the quality attributes of added training in our most elegant specialties. The latest communique from the compromisers at the AAMC provides an outline of how to maximize one's number of reimbursable resident slots without a further word about the disenfranchisement of surgical superspecialists.

I am persuaded that the entire resident working-hours hoax is but another attack upon quality medical education. Consider how easy it was to distort the fundamental issues related to untoward patient outcome on a nonsurgical serivce in a major teaching hospital in the New York metropolitan area. The key issues in those unfortunate events appear to be incompletely supervised house officers and a vague but worrisome story of drug use by the patient. Fatigue was always a minor issue[7] and it is a study in Machiavellian manipulation to see how quickly the fatigue issue was translated into abuse of working hours, a cause that is sweeping through graduate medical education even while evolving evidence in the case itself progressively diminishes its importance. Only the statement by our American College of Surgeons has stripped away the sham and the shortsighted goals of a few and exposed the matter as an assault on the quality of care. Limited work hours belie an unlimited personal commitment. Interrupted continuity of care, a diminished sense of personal responsibility by physicians in training, acceptance by those patients devoid of other choices, and the evolution of a shift mentality among physicians will erode the surgical residency experience toward civil service complacency. Every step has been an unjustified rush to judgment in the absence of any meaningful confirming data. Not only will such a process alter the quality and substance of the surgical commitment,but the pecuniary lever will further diminish the attractions of highest quality training for a surgical career. Here the College must be joined by the American Board of Surgery and the Residency Review Committee for Surgery. The latter group, under pressure from its AMA-dominated staff, has already developed in draft form new special requirements, conceding crucial points on the working-hours issue. There are times and places at which the "reasonable man" pose protects, but there are critical quality issues in which compromise becomes appeasement. I remain in the minority but you all must recall Dean Warren's presidential address to the American Surgical six years ago that so clearly called for independent staffing for the only accrediting body that general surgical education has.[8] Failing that, our "weekend warriors" must assume a stronger stance in defense of quality and that is progressively unlikely.

TABLE 2. *Acute Appendicitis**

	1980	1986–87
Number of cases	38	89
Uncomplicated appendicitis	74%	64%
Complicated appendicitis	26%	15%
Advanced appendicitis (abscess)	0	21%†
Morbidity	5%	19%*‡
Prehospital treatment	8%	33%†

* From Cacioppo.[6]
† $p < 0.005$ compared to 1980.
‡ $p < 0.02$ compared to 1980.

A Sense of Evil

How do conflict of interest allegations impact patient care? While we open the second century of this grand Association devoted to the highest ideals of surgical care, the *Wall Street Journal* has a staff pursuing a major exposé on the breadth and depth of conflicts of interest in medicine. Can even full disclosure restore the damage that will be done by the headlines? Our Conjoint Council on Surgical Research is about to become a standing entity within the College, seeking to protect and enhance intrinsic surgical research. At a time when we have finally demonstrated a consistent failure at the national level to offer even a facsimile of true peer review to surgical investigators, the public's attention is focused upon scientific fraud by nonsurgeons. At a time when we are set to demand a fair surgical share of federal research funds, public scrutiny will surely trade scientific vigilance for vigilantes. And who will lose most by the further exclusion of the surgical investigator from the process? Those who have benefited from the fruits of past surgical research—the pump oxygenator and open heart surgery, pacemaker technology, transplantation science, and vascular surgery.

It will be our grandchildren and their children who pay the ultimate price for our devotion to here-and-now clinical care at the expense of the there-and-then fruits of investments in basic research today.

The war against disease is fought on a shifting battlefront and if surgery is to continue to play a major role, it must be prepared to constantly adjust its focus, orientation, and direction well in advance of obvious needs. The pattern of investigative success in the past is the beacon to which our successors must look as a key to renewed vigor in the future. The continued dynamic efforts to maintain both emotional support and funding for basic research by surgeons is the only method that will permit the next century's surgeons to continue the rich tradition of surgical excellence on the frontiers of human health. For too long we have been excluded from major new technologies in medicine. We need to go back to the innately innovative era of Gibbon and the pump oxygenator. It is long past time that surgeons and surgery envelop technical change instead of being excluded from it. What direction should this take? Today technology moves so fast that none of us are wise enough to predict a course beyond the very next few years. As an isolated example of need, consider how little energy, effort, and money are being devoted to the care of closed head injury when it is the second most common cause of death after major trauma in the United States.[9]

For example, let me examine a research field in which I may be less speculative and more definitive. Clearly, infection has remained a significant source of morbidity and continuing mortality in the surgical patient. Only the most naive individuals could expect that further advances will come from new antibiotics. That story is now 50 years old and it has been played to a predictable outcome. Yes, there may be some clinical advances made in methods of delivering existing drugs more effectively to the potential sites of injury or infection. But it is exactly the innate shortcomings of such obvious alternatives that led us, more than a decade ago, to pursue once again the long discarded idea of host defense enhancement.[10] The growing espousal of such concepts as a supplement to existing methods of surgical infection control reaffirm that such a different direction is at least promising. After a decade of work, the first FDA-approved randomized clinical trial of host defense enhancement was begun last week. One must first understand the field to succeed in directing, or even encouraging, future inquiry.

Inquiries into all these fields must proceed with an increased recognition that the entire health industry, and an industry it is, should commit some portion of its total resources toward research and development. This certainly applies in surgery. Within the last decade we have seen a number of surgical leadership organizations begin to provide fellowships for training of the next generation of surgical investigators. This is an effective, but stopgap, effort. Research training must be funded through an infinitely broader base that includes the pharmaceutical industry, federal government, and all hospitals in order to provide the kind of long-term support that will lead to further advances in important surgical fields. Such changes will require surgery to establish a new dialogue and basis for same with many components of the "industry," a dialogue that is understandable in their terms.

I believe that all of these trends are most clearly seen and crystallized in the precipitously declining quantity and quality of medical school applicants across this country. High school and college students see the future more clearly than we do and have acted accordingly. Could there be a more objective expression of loss of respect and status—a clearer knell of decay?

A Darker Horizon

I have just skimmed the surface, but these examples demonstrate many interlocking, seemingly inexorable, and corrupting influences on quality surgery and its public perception. Who is responsible? Begin with the greedy physician who would rather manipulate fee schedules than restore electrolyte balance. Consider the staff officers of the executive branch of government, now styled Health and Human Services, who still, even today, espouse the original sin postures of Wilbur Cohen and John Kennedy, both determined to subdue and control the profession. Finally, in our society today, one must always examine the motives and actions of the media, a pervasive force that relentlessly seeks to level every pinnacle of American accomplishment. All of the above or none of the above? Blame is irrelevant but recognition of the breadth and depth of these attitudes and their potential to ultimately erode all that this Association embodies should be challenge enough. Regardless, the last half of the eighties is characterized by mindless infatuation with cost control in medicine and virtually any legitimate public opinion survey underlines its importance in our society. What are some simple indices of the foreboding inflation in the surgical sector? Try an escalation of surgical charges alone for Medicare from $3.8 billion in 1980 to $9.4 billion in 1985. Consider that ophthalmological charges escalated from $517 million to $1.758 billion—more than tripling the amount—in those same five years.[11] And for a tiny specialty! While I believe too many of these increases are the responsibility of surgeons and reflect an increase in price per unit of service, the HCFA data are probably flawed to some degree and have not been corrected for an increasing and aging population and, most importantly, for the seemingly insatiable damand of the American public for expensive health care. But more about that later.

To gain a riveting perspective, join me on a space odyssey to the year 2001. While 1984 was not nearly so bad

as Orwell predicted, do recall that he had a 50-year lead time and we have only twelve years.

Insurance costs, legal costs, and medical costs will continue to rise far faster than any reasonable economic index, reflecting to some degree the parasitic role of the legal system in American life. The artificially controlled medical costs of the last three years will explode again into double-digit inflation and exacerbate all cost-control clamor. Physician income will not increase enough to offset the escalation of professional liability premiums. Most doctors will be salaried and most medications will be generic. Hospital closures, now occurring at the rate of one hospital every five days, will increase and then cease. Numerous communities, especially rural ones, will be left unserved by hospital care for the first time in 40 years.

Even more ominous is a scenario of exploding utilization review, melding into fully managed care. Significant forces will push physicians' incomes toward the national mean and produce a 30% to 40% decline in purchasing power. Quality standards in some facilities in some regions will drop precipitously. HMOs will fail even more frequently than they do today and will disappear altogether. Health insurance companies will linger in financial crisis. With this scenario, the "doc in the box" becomes the "quack in the shack." Industry will refuse to pay more, seeking both value and data that they understand and appreciate. Industry will then progressively pass more of the cost back to the patient. The proportion of the gross national product committed to health will breeze past 15% and on toward 20%.In this situation health becomes the nation's largest industry. Litigation increases and antitrust becomes as big a hazard as professional liability. Predictably, physicians, nurses, and hospitals will become dispirited, and a siege mentality will set in. Physicians will begin to be unemployed and that number will grow. Surgeons will retire, not necessarily of their own volition, at progressively earlier ages. The downside of the current infatuation with competition and consumerism will become the medical dispossession of the poor and needy. The decline in quality and quantity of medical school applicants will begin a toboggan slide, forcing many medical schools, in effect, to close.

How likely are such events? I say they are certain if quality medicine and surgery do not choose to radically intervene. Is there an element of good news? Yes, a major projected asset to general surgery, is, of all things, the aging baby boomer. Just as this group of citizens stressed and expanded our schools and colleges, leaving those institutions gaping after their departure, we can now see this cohort of Americans entering that stage in their lives where they are more likely to require the services of general surgeons for the traditional illnesses that have come to our attention in years past. Indeed, projections suggest that a decade from now general surgery may even be transiently undermanned and overworked; I can only pray that our successors do not succumb to the wails of another generation of false prophets of doctor shortages. In any case, the baby boomers can represent a short-term reprieve while surgery literally pulls its act together to stem the incipient tide of social mediocrity.

Choices–Wise and Not So

Another trend requires detailed analysis of current public attitudes toward choices related to the cost of personal medical care. Increasingly, employers are offering an array of benefit options; some even permit employees to select increased income at the exclusion of health insurance. It is likely that those most tempted by such an arrangement will ultimately add to the public tax burden when illness comes their way. However, given a reasonable opportunity to select among lowest cost, least choice, and most impersonal schemes and those which are most costly and provide maximum flexibility and quality benefits, each worker may be able to select the situation that best suits both his pocketbook and his tastes. There may be a lesson from other contemporary public choices; will it be K-Mart or Cartier? Won't the wise insurance provider offer the most broadly appealing choice: K-Mart prices and convenience for the impersonal aspects of care such as electrocardiograms, chest x-rays, and basic lab work but very personal, individualized family medical, obstetric, and surgical treatment? In a time of a dispiriting rush to judgment in many such areas, three large groups of Kentuckians have made such recent choices. The number choosing the lowest price, least-choice HMO type of plan increased slightly. But remarkably, individual employees in good old mid-America often chose to pay more from their monthly paychecks in order to retain the right to go to the doctors and to the hospitals of their choice. Such value judgments offer more than a glimmer of hope.

Clinical Futurism

Threats to the more remote scientific future are obviously much less well defined. Two examples may focus our attention on the importance of and the simultaneous fragility of long-range predictions. If one were to argue confidently today which major fields of surgery will remain intact and solidly within the realm of surgical practice for the foreseeable future, none would seem more secure than the management of the trauma victim and the transplantation of organs and tissues. Consider, if you will, both trauma and transplantation not as secure, but as extraordinarily vulnerable. Our own service has had both a long-standing commitment and recorded scientific contribution to the care of the injured patient.[12] Is it secure? By no means.

It will be healthy for our society as a whole for certain trends to continue: declining alcohol use, mandatory seat

belt use, and some form of handgun control. Broader acceptance of all three of these will diminish the need for surgical trauma care in a significant way, barring only another World War. The sharp reduction of alcohol consumption is causing the liquor industry, even in my home city, to aggressively diversify into unrelated fields. Seat belts, now compulsory for toddlers in infant car seats, will cause their generation to grow up as cognizant of seat belts as many of us were of the addition of vitamin D to whole milk. At the same time, one would have to be particularly obdurate to ignore some ultimate restriction of access to handguns. Diminished alcohol use and improved seat-belt and other restraint laws, combined with diminished access to guns will change the pattern and volume of trauma in a significant way, possibly by the turn of the century.

Transplantation is another field of great interest because ultimately we will favorably influence public attitudes toward organ donation, which will facilitate transplantation. On the other hand, nearly 40 years of penicillin therapy for upper respiratory infection has virtually eliminated glomerulonephritis and rheumatic fever. Given the ultimate 20 year half-life effect upon surgical complications of remote streptococcal disease, it is not surprising that rheumatic heart disease has largely disappeared from the surgical arena. Won't there be a decreasing need for transplantation of the kidney from most streptococcal complications? Just consider for a moment what impending effective antiviral therapy will mean to the indications for hepatic and cardiac transplantation, since that is the underlying illness for many such transplant candidates.

Computerization of many routine aspects of patient care will make operations safer than air travel. Surgeons will file and recheck flight plans for operations as surely as pilots do today.[13] Individualized risk assessment and identification of occult risk factors will render subjective components of clinical judgment nearly infallible. New tools will make surgery, when appropriate, bloodless. Genetic engineering and recombinant gene technology will alter the entire substance of human health. Tissue implants and progressively precise microsurgical techniques will restore even impaired neurologic function to a significant degree. Drug delivery systems will place the correct agent in the correct spot at the correct time. New and supplemental agents will add to conventional antimicrobial therapy. Is this a Wonderland? I think not, but it may well be if the medical community as a whole does not constructively face the current public challenges regarding both fraud and conflicts of interest in publicly funded research.

Strategies

I trust that this brief discussion of existent and impending events has convinced each of you that there are real threats, possibly orchestrated, but destined to significantly reduce the substance of surgical services historically provided to the American public. The only thing necessary for the triumph of evil is for good men to do nothing.[14] Would you like to change the current and future scenarios? Would you be willing to commit personal time and money to protect the professional future of our successors and the physical and mental health of our grandchildren and their children? I am going to assume that your answers are yes to both and outline, succinctly, what I see as some key elements of a promising strategy. It will demand near-term unselfishness and a willingness to ignore the half-time score.

Let's try a few moments of free association. Organizations can be and can do anything that their memberships wish; we need to change the way we look at health, surgery, and all of medicine. In a negative sense we must: (1) realize that the future will not be found in the past; (2) avoid the search for a quick cure for our plight; (3) seek to enhance wellness in every sense for society as a whole; (4) discard selfish concerns; and (5) promote a vision of a better future for all.Dickens called it the best of times and the worst of times and he was correct. Our system is crashing. But the end of the old way is always the beginning of the new and we have the chance to determine the future health for unborn generations.

In times of change, a few principles apply. (1) If we don't control the future, it will control us. (2) It is difficult to thrive on chaos and crisis, but the next generation's leaders always do. (3) A boat without a rudder never survives a storm. Consider the health implications of some simple business concepts. Medical care is but a means to an end. Most of us are born and will die in hospitals, thus hospitals and doctors control much of the environs of life's entry and exit. We should best use that relationship to convince the comers and the goers that medicine exists primarily to enhance the quality of life. Surely a progressive democratic society could have no greater goal!

Our American College of Surgeons is the only entity that can act for us, but given the predictable success of the concept to be presented, the AMA will quickly follow. Our College is heavily committed to its present worthy and effective duties, but it needs a well-funded and adequately staffed long-range planning group to examine proposals and implement strategies such as those that follow. Such a group could and should become the natural leader of a new consortium of physicians, hospitals, employers, and patients, all committed to the public's health in the broadest sense.

The secret of caring for the patient is no secret. It is simply that one must care about the patient.[15] Surgery must become the consistent, unyielding, unselfish, even belligerent advocate for the health of all American people. If we take the longest view of every health issue and elim-

inate from our agenda any concern about the well-being or personal privilege of existing institutions, especially our own, we will succeed. I believe that the intrinsic merit of the honest doctor-patient relationship is so sound that employers, insurers, and even hospitals can only contribute through that unique bond. So it should be and we will only strengthen ourselves by returning to such catholic, old fashioned altruism.

Again, let me develop a few examples that I believe illuminate both the feasibility of this posture and also its likely success. Our only banner is quality patient care but what follows are just a few highlights of an integrated program that must be fully developed. Point one: The American Board of Surgery is 51 years old. Only certified surgeons should be permitted to work in accredited hospitals and only certified and recertified surgeons should be paid for surgical care. Justifiable exceptions are obvious: specialized, underserved geographic sites, young surgeons in accredited training programs, and those briefly, and I mean very briefly, completing the certification process at trainings' end. The retirement of the last "G.P. surgeon" is long overdue.

Point two: We should embrace valid outcome assessment and put unsatisfactory work in both the professional and public spotlight. The coronary surgeon with a 5% mortality rate for elective surgical work seldom survives much longer than his patients. The same standard should be applied to every common surgical procedure. The public good and the public health is more important than any surgeon's right to work.

Point three: We must develop social and economic value bases to determine whether the unending cast of highly touted medical innovations are truly in the public good. If surgical procedures can safely and routinely be dispensed with, then we should take the lead in so saying. What do I mean? Try these easy examples. How does the social, personal, and economic cost of lithotripsy and lifelong biliary solvent therapy compare with elective cholecystectomy? What is the genuine merit, embracing real costs and honest morbidity, of adjuvant chemotherapy for many surgically cured cancers? Our obligations should not cease when surgery is not the optimum therapy for an illness. We stood aside in polyp disease of the large bowel and permitted endoscopists to charge and collect fees that greatly exceeded that of the replaced surgical procedures. What provides the greatest good at the most reasonable cost for the longest time? Failing disease prevention, surgery is the ultimately cost-effective method of therapy for so many existent illnesses. I am sure that our information era is now, or will soon be, able to answer all such queries. We will then be obliged to take the information to the public and abide by the honest assessment of that data. If medicine fails to gather, compile, report, and interpret its data, Corporate America will do so with both data and interpretation that will be fatally flawed.

Point four: Take the lead in a fully representative, medical–industrial–political–social discourse to define the cause of and methods for blunting the public's insatiable demand for medical services. Is not the British acceptance of standards of care more civilized than our thirst for an unending refinement of expensive and only questionably valuable medical procedures?

Point five: Begin the new program with a believable flourish. Direct our leadership groups to compel a significant lowering of all surgical fees and, what's more, include all pre- and postoperative visits for the patient in the bargain. Now that would be a real value-added product and could suggest to one and all that the surgeon's commitment to his patient exceeds that to his stockbroker. What a magnificent opportunity to gain the public's attention and define our bias as the public good and not self-interest.[16] And could not we, in the same bold stroke, insist that a constant, inflation-proof proportion of the resultant savings go to fund surgical research in the best sense, both basic and applied? Conversation of the peaks of personal gain to investment in the future health of our society would be a powerful persuasion.

Not surprisingly, these kinds of efforts, I believe, will once again appeal to the brightest and best of our young people and reverse the devastating trends of current medical student applicants.

Can a group as small as surgery and its specialties conceivably redirect the social planners, the pathologically destructive media, the folly of some of our elected officials, ombudspersons, and consumer advocates in every form? In the early 1960s a small medically related group chose to expose a public health hazard, then thought to be a harmless vice but backed by a multimillionfold greater public-relations budget. Clearly the altruists had no chance. But the flea continued to evangelize about the elephant's shortcomings. An unwavering commitment to the public good by the American Cancer Society truly promises to see America a smoke-free society by the year 2000.

The problems quality surgery and medicine must overcome are far more diffuse and the interrelationships are more complex, but we have potential resources that are very substantial. We must regain the public trust. Now is the time not to ask the patient to choose one or the other, but to offer surgical care that is reasonably priced and at the same time both high tech and high touch. The finest moment in every one of our day's work is when someone takes your hand and says "Thank you, Doctor." I believe we can transpose that common personal event into a megatrend where all of the public will appreciate our advocacy and, in turn, restore surgery to its proper place as the queen of servants.

I would have liked to have made these comments as enjoyable as my membership in the Southern Surgical has been to me for nearly two decades. On the other hand, I cannot think of an honor that has come to me that would ever be more appreciated than this one. The Southern is special. The Southern is different. I have tried to share with you today my most sincerely felt concerns, convictions, and constructive responses. The challenge for the future is very clear. The Southern must continue to play a major supporting role in that future. At the same time, it must address, identify, and stand up for, as an organization and as individuals, what is sound and sensible about the future practice of medicine, the welfare of the American surgical patient, and what is morally right. I feel confident that the Association will do this, and that it will, at the same time, respect the heritage that has made the Southern special and different.

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