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Staying the Course

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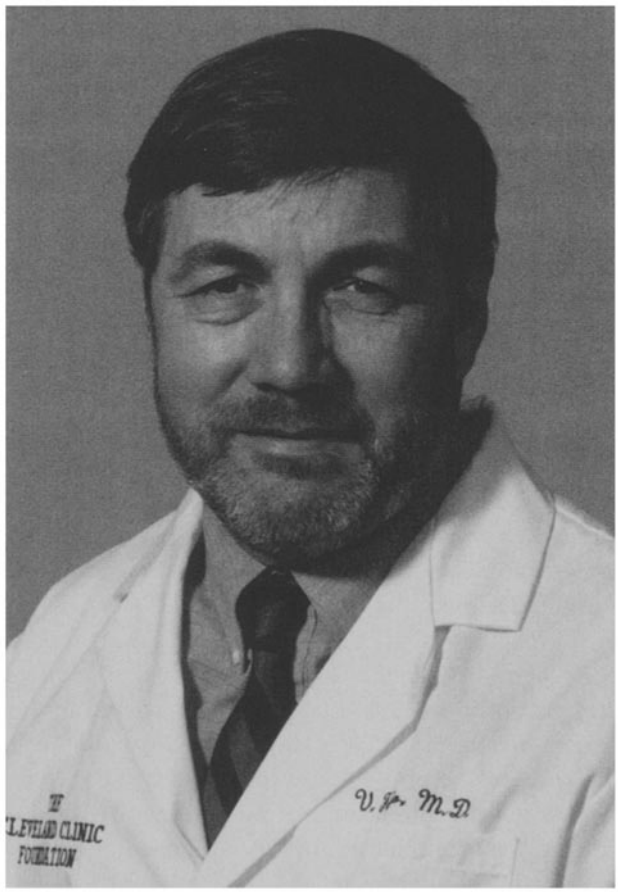
INTRODUCTION

To have been accorded the privilege of serving as your President for this past year has been a singular honor. My deep gratitude goes out to all who made that possible. . . my colleagues, my friends, and especially my family. Because this is, by tradition, a time when the speaker has a lot of latitude with his allotted time, I will take the time to single out a few colleagues and mentors for special mention. To my fellow Council members I give thanks for their advice and support during a year of change that has seen many events unfold. One of these, an historic event, will lead to a unification of The American Society of Colon and Rectal Surgeons and the Research Foundation to which I will refer later. My thanks are due to my mentors and fellow Australians Mark Killingback and Neville Davis for the encouragement they gave in my early years, especially for their acting as role models for me and so many other surgeons. Thanks also are due to my teacher, the late Rupert Turnbull, who taught—rather, who revealed—the added dimension to which advanced colorectal surgery could be taken. To my other late mentor, Noel Newton, the best surgeon I have ever seen, I acknowledge not just his guidance, but also his unflagging commitment to teaching the art and craft of surgery during a quarter century to anyone and everyone who wanted to attend his Sunday morning teaching rounds. It was he who steered me to Dr. E. S. R. Hughes, who in turn fired my enthusiasm to seek specialized training in



colon and rectal surgery. More than any others, these men have that marvelous ability to instill enthusiasm in their students. To my partners, especially Ian Lavery and my late friend and colleague David Jagelman, I am indebted for more than 20 years of friendship, a camaraderie that comes from being on the firing line together doing great things at one of the

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world's finest medical institutions. To my former fellows, I am grateful for having learned more from them than I could give back. But my deepest thanks go to my family, Victor, Jane, and David and most of all to my wife Carolyn, without whose support none of this would have been possible. The title of this presentation today is "Stay the Course." This conjures up a desirable trait, an ideal variably equating with determination, persistence, stick-to-it-iveness: an inexorable need to pursue a goal. The inferences is that this is not easy, that there are forces acting to sway the "stayer" from the course set, and that it might—or will—be easier to go along with these external forces. As physicians and surgical specialists, there are many factors affecting us today as we approach the new millennium. Health care reform is here. Let us look at some of these issues.

HEALTH CARE REFORM

During the first two years of President Clinton's administration, the proposed comprehensive health care reform came to naught. By November 1995, when a Republican Congress was voted in, representative sentiment had clearly emerged toward INCREMENTALISM, a slower, more deliberate piecemeal attempt at health care reform. This Republican-led reform, however, again proposed a comprehensive approach to the Medicare program, with a state goal of "saving it" while balancing the federal budget. Like Clinton's reform plan, this too "crashed and burned." These two gigantic comprehensive plans had three things in common: they addressed a wide range of issues, promised much, and there was practically no compromise with the opposition party.

So what now? Out of this morass came the possible emergence of incremental reform, similar to legislation proposed in 1991, but which was vetoed in the budget debate in the latter days of the Bush administration. This reform focuses on popular sentiment toward insurance reform, mainly portability of benefits and major modification, if not elimination of the pre-existing conditions reform. Senate Bill S1028, The Health Insurance Reform Act, sponsored by Senators Kasselbaum and Kennedy, is a bipartisan bill that has enjoyed tremendous support, especially in the Senate.

On the surface, this appears to be a much-welcomed proposal and benefit. The fine print (in this case not so fine, because fraud issues take up one third of the text of the bill) has a sting for physicians, manifested by some odious penalties, where the rules to be followed are subject to interpretation. These rules relate to such things as physician miscoding, with fines up to $10,000 for each instance of "incorrect" coding, even an honest mistake on insurance claims. If passed as it stands with these antifraud components not further qualified, this may prove to be a Pyrrhic victory for lawmakers. They, the legislators, will have passed a health care reform bill that they have almost despaired of passing, allowing them bragging rights to their constituents, leading into the next election. But this may be done at the price of access to physicians who may find the practice of medicine increasingly risky, medicolegally, as well as less fulfilling and see fewer patients, if not leave the profession.

Senator Kasselbaum's response to this criticism was that the bill is not intended to be severely interpreted, cold comfort indeed.

The companion bill from the House, HR3103, arose from three separate health committees and was passed on March 28, 1996. This eliminates pre-existing conditions, and ensures availability, portability, and renewability of health coverage. The inclusion of medical savings accounts and tort reform in this bill are opposed by President Clinton. Tort reform has been stagnating despite attempts to write passable bills, including the addressing of joint and several liability (the deep pocket syndrome) and limitations on noneconomic damages included in HR3103. So, Stay the Course!

With Presidential elections in the offing, along with a new Congress, the likelihood of a comprehensive health care bill being passed before November 1997 is small. This, of course, will have a very great bearing on us, as a society and as specialists in the field of colorectal surgery. What will be the effect on graduate medical education for surgical specialties? Along with slowing the growth of Medicare and Medicaid, the two largest federal health programs, which will occur to a greater or lesser extent with both major political parties, will come major cuts in indirect and direct medical education allotment. The most optimistic predictions are that pass-throughs will all decline drastically, and that allowable residency slots will be cut or slashed by upward of 45 percent for surgical services—this despite a lack of good data on what general surgery and specialist surgery manpower needs are in the future. Diane Schneidman reported on the Institute of Medicine's January 23, 1996, release that recommended the following:

1. No new medical schools.
2. Limitation of federal funding for graduate medical education by reducing first-year positions in

residency programs to approximately the number of medical graduates from U.S. medical schools.

3. Hospitals that depend on international medical graduates to serve poor patients were to get alternative funding.
4. Health Sources and Services Administration would provide regular reports on physician supply and demand.

The President's fiscal year 1997 budget released March 19, 1996, was followed by a further document, Health Care Reform for 1997–2002. This included a graded reduction from the current 7.7 percent to 6.0 in indirect medical education payments, capping the total number of residency slots and number of nonprimary positions currently reimbursed by Medicare. Also, a commission is proposed to develop policies that I will serve academic research and education, as well as make recommendations on the number, composition, and support of future workers. Other agencies such as the Prospective Payment Assessment Commission have proposed changes in Medicare teaching payments discouraging inappropriate growth. Meanwhile, in April, graduate medical education hearings by the House Ways and Means Subcommittee on Health led to recommendations that include limitation on funding to a resident's "first certificate" and mandatory service requirements to offset physician maldistribution.

Presently, the number of residency slots allowed has been determined by Residency Review Committees (RRCs), with representation from the AMA, The American College of Surgeons, specialty boards, etc. Essentially, these slots have been approved provided 1) "environmental impact" on other trainees in the institution is minimal and 2) the specific program can provide sufficient high-quality supervision and adequate and varied case numbers. Also, regulatory agencies have been subject to numerous legal appeals to counter RRC adverse action.

The irony in this is that although governmental edict will mandate reductions in available training posts, probably even if nongovernmental funding of such posts were made available, the mechanism of such reductions will undergo close governmental scrutiny for possible breach of antitrust laws. Addressing this issue at the 1995 AMA-sponsored convention of Specialist Society Presidents, AMA legal counsel for Antitrust Action gave numerous examples of how the Specialty Boards, RRCs, and Societies may *not* make the cuts. In the end, the quality of the program, however that is defined, will be a major deciding factor. One of the few other ways was to use the Oregon technique on final-year medical students. Simply put, this technique, so I am told, is a form of reverse negative advertising. During the 1970s and particularly the 1980s, Oregon was subject to large-scale migration of Californians, to get back to a simpler, healthier life and lifestyle. Ads and stories were planted in the California news media (by Oregonian representatives) to disparage Oregon in general. By telling medical students how bad things are in specialized surgery with managed care organizations, HMOs, and regulatory actions and in colorectal surgery in particular, there may be fewer applications, making cuts in training positions less necessary to our specialty. This, of course, is the reverse of what our Society, our specialty, and our Board has been advocating. With leadership provided by the Program Directors Association begun by Dr. Goldberg, of Minneapolis, we have seen the policies work. The policy, or strategies, include the exposure of young surgical residents to the role models of our membership, our annual educational programs, and the promotion of academic tracks for leaders in the specialty. So now we have a paradox, a schizophrenic need possibly to cut slots yet to promote the specialty and recruit the best and the brightest. STAY THE COURSE. We all know what the right thing to do is: recruit the best! And for no better reason than that our patients and our patients' offspring should have access to the best specialized care now and in the future. To rub salt into the wound, the subspecialty areas, those beyond the traditional five-year postgraduate period (leading to Boards eligibility like Colorectal Surgery) and which are currently funded through HCFA pass-throughs of specific institutions, will be affected severely, *no matter which political entity controls Congress, as one reads current proposals.* So, STAY THE COURSE. If we were hand wringers, lamenting but doing little to improve the fate of our current and future trainees while we shore up our defenses against personal financial discomfiture, doing nothing to maintain and promote our subspecialty, then I say we would deserve what we get from government and third-party payors. Each of these threats and challenges need to be met and answered to pay back our inherited debts.

Make no mistake; we surgeons, the beneficiaries of the hard work, talent, and foresight of our surgical forbearers (our well diggers, as Dr. Veidenheimer calls them), owe our young colleagues and future colleagues, especially, equal staying power and effort to secure the specialty to Stay the Course. We ARE our brother's keeper. How do we do this?

Lobby our Lawmakers

We can do this as individuals, as Society members, as part of organized surgery through the college, or as part of organized medicine through the AMA. Recent reassessment of the future of Medicare funding by Medicare trustees indicates that the new date for bankruptcy of Part A Medicare (without major reform occurring *now*) is 2001, not 2002. Payroll taxes from younger workers cannot keep up with the needs of retirees. By 2010, even with Medicare reform with either party's program, a further crisis will occur as the baby boomers start to retire. This makes the present reform plan analogous, in some pundit's opinion, to rearranging the deck chairs on the Titanic.

It is disturbing that these efforts are, therefore, not likely to be very effective in leaving residency slots uncut. This is one area in which we can all agree that "minimally invasive surgery" or minimally intrusive reductions is desirable. Given the proposed cuts or lessened annual increases in the Federal budget for Medicare, a base of popular support from the public, this "surgery" is likely to be traumatic to our specialty. Congressional members, however, are strongly influenced by voters. Appeals to these Representatives to preserve education and research budgetary allowances on the basis of providing the best-trained physicians may be a more successful strategy.

Lobby Our Patients

As patient advocates, we can and should seize opportunities to inform our patients what a specialist in colorectal surgery is. Imagine the patient's child or grandchild needing specialized colorectal surgical care, say, sphincter-saving resections of a midrectal cancer, complicated Crohn's disease in a youngster, the niece with severe colitis who is looking for ultimate stoma avoidance as well as health, or the daughter rendered both incontinent and having a cloaca after a traumatic delivery. Where do they suppose the future skilled surgeon-scientist will come from if current dollar savings mandate care through a managed care organization panel of surgeons who have yet to acquire the necessary skills?

Look to Other Organizations such as Patient Advocacy Groups

The American Association of Medical Colleges includes members from many elite and prestigious organizations, who often have the ear of their area Representative as well as national leaders. The credibility of AAMC is high and may help blunt draconian changes in the system. Other groups to which specialist societies may look include the Access to Specialty Care Coalition. A major concern for both Democrats and Republicans still is that with Medicare their constituents can still get access to the best medical/surgical practice. Thus, these lawmakers will want to write into law protections for Medicare and nonMedicare recipients against panels refusing access to the "best." At a societal level, we will need to keep a close check on manpower. The issue of how many colorectal surgeons are needed out there is a difficult one to answer. It is up to us to show our stuff.

Look to Ourselves

If graduate medical education beyond board certification in General Surgery is threatened (and it will be) it is time to look at alternative means of maintaining subspecialty training in Colorectal Surgery. I don't pretend to know the answers. Alternatives do include return to preceptorship, fund raising to develop a corpus from which salaried slots can be maintained, junior faculty appointments, and individual sponsorship by hospitals, corporate entities, and specialist societies.

Important as it is, governmental reform of health care pales in comparison with the unprecedented market-driven changes in delivery of health care in the past 10 years. Attempts to slow the process, this irresistible force, have been unsuccessful.

A bewildering array of acronyms such as MCO and HMO now has become part of our lexicon. All surgeons would love to say, "Just let me look after my patients." How times change. We have six surgeons in our colorectal group that functions in a multispecialty, academic group practice. One of the many reasons we all joined the group was not to be bothered by article work, billings, insurance companies, or even whether to seek approval for providing indigent care. In the past two years, we have hired not one but three "financial advisors/counselors" to help our small department steer our patients through an incredibly complex approval and billing system. Last year our department forfeited $200,000 in payments because of a technical hitch, *i.e.*, lack of *written* preadmission approval, despite obvious disease being present (*e.g.*, cancer) that required obvious treatment (surgery) that could be done expeditiously without entailing a further visit from out of town or out of state. Yet we, our group, have no one to blame but ourselves for work-

ing in the mid-1990s with a 1980s mentality. An expensive lesson indeed; one that has led to further hurdles, hoops, and general impediments to be negotiated by patient and physician, where quality of care has nothing to do with the process. It would seem our role as physicians and patient advocates is being "marginalized," another new word for this era. Yet, one has to agree with Frederick Hansen's recent article in the February 1996 Bulletin of the American College of Surgeons, "What does your future hold: Capitation or decapitation?" in which he advises surgeons to leverage their clinical knowledge and expertise to gain control over payment systems, "or else they must become employees of the money handlers," and that "in a free market system, the power goes hand in hand with the money." It has been pointed out that physicians' fees are only 20 percent of the costs of medical care. Yet physicians are responsible for 80 percent of total costs by directing resource utilization. Half the fees relate to overhead; thus, physicians' fees amount to about 10 percent of the costs of medical care. This direct payment is the area targeted for adjustment by government and private payers alike. However, physicians vary in their efficiency of resource utilization. This can be quantified as an index that may range from say 0.6 (very efficient) to say 1.6 (inefficient) where the unit 1.0 represents average nonfee resource consumption. In a scenario relating to a physician's net annual compensation of $200,000, the efficient and inefficient physician may cause a payor's costs to range from $1.3 million to $2.9 million. How important it is that payors of all types focus on these types of nonfee costs. Lest it be said, as it has, that physicians are more concerned about a second automobile than about providing cost solutions and that these specialists are protecting turf, there is an obvious solution. We specialists can demonstrate the value-added component of specialty practice by cost or outcome studies of patient satisfaction. In study after study, managed care organizations show Priorities 1 through 8 as being price, price, price. Number 9 is patient satisfaction, because this will determine return of that satisfied patient's premium dollar for next year. And somewhere in there, number 10 or higher, is quality, so we strive for cost containment by demonstrating that in the care of the *whole* surgical patient we can be effective and efficient. We must become informed, spend the time and money to study what is happening in health care, attend the courses, become educated, and forge the necessary alliances.

What about quality? One cannot do justice to any discussion on this issue in the time available. Our focus, as surgeons and as a Society, has been to look at outcomes. Our work as surgeons is what defines us, and outcome assessment has been a measure of this work. The outcomes "thing" does not necessarily mean the same thing to everyone. For some payors, patient satisfaction is the all-important outcome. Even the experts disagree on the significance of functional quality of life outcomes. But one might predict that sooner or later, logically, results will mean everything.

This was the theme of my colleague, Norman Hertzer's Presidential Address to the Society for Vascular Surgery. We have seen numerous examples of outcomes in colon and rectal surgery where specialized care given by experienced surgeons has resulted in superior outcomes. Phillips, reporting in the 1980s, noted a wide range of survival rates in the treatment of rectal cancer, dependent on individuals and units of volume of the procedure. Bill Heald has demonstrated one of the lowest rates of local recurrence of rectal cancer by the acquired expertise and large individual experience obtained in a specialized unit. The subject of volume performance standards and hospital credentialing is a complex and controversial issue. But in certain areas, rectal cancer for one, there can be little justification for a surgeon to do two or three cases a year.

Closer to home, we have seen a report from Lester Rosen of variations in colon and rectal surgical mortality with use of a state-legislated database. There was a significantly lower mortality rate for colorectal surgeons (1.4 percent) compared with other institutional surgeons (7.3 percent). For admission severity Group II, comparable mortality was 0.8 percent and 3.8 percent. This difference was 5.75 and 16 percent for admission severity Group III, this following a similar trend. Other comparative studies attesting to the favorable outcomes of colorectal specialized surgeons or units include studies on anorectal surgery and length of stay in major large-bowel procedures. It is my belief that perseverance in accumulating data on the outcomes of our treatment, especially for those areas that differentiate the surgeon who has a major *vs.* an average or small experience, will provide data that speaks for itself. Whether this area best lies in outcomes assessment *vs.* outcomes research still remains to be clarified.

We have observed changes happening with managed care panels, in which exclusion of colorectal surgeons has occurred, with leaning toward the generalist. This is

reputed to be a cost-saving measure. It also is a subtle or not so subtle denial of access. Specific examples include an Ohio-based HMO whose advertised plan for coverage of colorectal surgery includes six surgeons. One confines his work to proctology. Four are general surgeons who not only don't have any added colorectal training, but who have no special practice component that could be called colorectal. And the sixth name on the 1996 panel from which patients can choose their surgeon is dead!

So what can you do? Chances of influencing the HMO/MCO to change this practice are slim. Only two possibilities exist as I see it. One is to educate these groups or show evidence that, not only can physical outcomes for the patient be better, it can also be cheaper by avoiding substantial nonfee expense items such as excessive testing and, especially, readmissions for treatment of complications.

The other possibility is more attention getting for HMOs, and that is regulatory. Current oversight of quality control or assurance of all these plans and organizations is limited. Increasingly, government and elected representatives are interested in their role as watchdogs of the public good, doubtless stimulated by patients and patient advocate groups to see that patients' benefits are being looked at. The most prominent of these issues recently has been exposure of the "gag" clauses in contractual arrangements between providers and managed care groups. These have provided penalties, including removal from panels, for physician daring not just to criticize defects in a particular plan's coverage that patients thought they had but also simply to apprise patients of what alternative treatments exist for particular conditions. Thus, when patients find that an alternative treatment, say, an expensive alternative treatment, is not allowable or payable under the plan, there is a likelihood they will be dissatisfied, if not remove themselves from further premium payments.

These, then, are possible answers for the surgeon who is faced with exclusion from certain panels as they relentlessly pursue generalism. Namely, the providing of information to patient advocate groups, to patients themselves, and to government when access to experienced, specialized care is being denied. It may well fall to specialty societies such as ASCRS to be part of this information dissemination and education of the respective groups. In the long run, however, a win-win-win solution is the best, in which the patient, the insurer, and the surgeon benefit by provision of expert and experienced care to the patient at a total cost to the insurer that shows value.

Earlier, I referred to events of this past year in which your Society leadership had been involved. One of these was the union of the Research Foundation with The American Society of Colon and Rectal Surgeons and its Council. For many members there has been confusion about the relationship of these two groups, confusion about the mission and purposes. Extensive staff meetings and discussion during the past year in particular, has seen resolutions emerge that have produced a solidarity, reunion, and a new beginning. With active support and representation by Council and with the planning of a major capital campaign, the re-energized Research Foundation of ASCRS will provide a vehicle for fund raising to support basic and clinical research of disease and disorders encountered by many colorectal surgeons. With shrinking federal budgets for research and allocations that leave unfunded many projects in our areas of study, we have to look to ourselves and our own devices to provide resources for such endeavors.

These are difficult times for physicians. Yet, one is reminded of the aphorism that "character becomes forged in the crucible of difficult times." We must and we will become educated about where health care reform is going. This takes dedicated time and effort. A paralysis of will, a temptation of inertia has to be resisted, attractive as this may seem when the course seems uncertain. If there is one certainty, it is that change is here and ongoing. We have witnessed the obscene profits made by CEOs of certain managed care organizations. Before we complain excessively, let it be said that we lose the high ground in the debate when the focus is mainly on reimbursement issues rather than on our position as patient care advocates. We must Stay the Course over the universal truths. These universal truths include the patient and a caring physician, a physician dedicated to advancing and promoting the science and practice of treating patients with disease of the colon and rectum. If that sounds oddly familiar, it should. It is the mission statement of our Society.

Despite the difficulties and uncertainties of medical practice today and marginalizing of the profession, I have to agree with the statement I read somewhere: "My greatest wish at this time would be to be a young surgeon starting out, despite the dangers. . . . " Again, I thank the Society for the privilege of the Presidency. Thank you.