Diseases of the Colon & Rectum

Presidential Address

Who, Why, What, and How?

David J. Schoetz, Jr., M.D.

Department of Colon and Rectal Surgery, Department of Medical Education, Lahey Clinic, Burlington, Massachusetts

I wish to extend my humble gratitude to the membership for the privilege of having served as your 97th president (5 have served twice); this represents a singular professional and personal honor. Particular thanks to the Executive Council for their sage advice during the year; they, in conjunction with our management team at EAI, have helped steer the organization through exciting and potentially difficult decisions and developments. I cannot omit my partners at the Lahey Clinic, who have allowed and endured my absences to perform Society business. Similarly, I am grateful to my friends and colleagues both inside the specialty and out, who have been more than willing to impart wise counsel and personal opinions regarding all manner of Society and specialty business. Finally, and first, I must thank my family and particularly my "appreciably better half" for encouraging and supporting my professional career over the years; without them, none of this would have been even remotely possible.

When one assumes the presidency, most of the past presidents assure you that your presidential address is the single most daunting task of the year; I agree. As one seeks inspiration for a topic of sufficient importance to be worthy of presentation, it occurs to you that this represents one of the few opportunities in your life (particularly if you have children) to present your personal passion for up to 25 uninterrupted minutes without any argument.

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Copies of presidential addresses of The American Society of Colon and Rectal Surgeons (ASCRS) and its predecessor, The American Proctologic Society, have been kept since 1908; they are passed from one president to the next. While reviewing them, I was struck by the impressive accomplishments of our specialty. Interspersed throughout this talk are quotations from

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Correspondence to: David J. Schoetz, Jr., M.D., Lahey Clinic, 41 Mall Road, Burlington, Massachusetts 01805

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"The Proctologist of the present and of the future.....must be in every sense of the word an intestinal specialist."

Figure 1. Presidential Address, Louis J. Hirschman, 15th Annual Meeting, 1913.

previous presidents that represent pivotal observations from our past. As is so often the case, our successes have been the result of identifying challenges and developing strategies to overcome them. These personal musings, combined with my career-long interest in surgical education, have resulted in the title of my remarks—"Who, Why, What, and How?" More specifically, WHO are we?; WHY are we here?; WHAT are the present challenges; and HOW will we address them?

The ASCRS is currently defined, rather expansively but accurately, as "the premier society for colon and rectal surgeons and other surgeons dedicated to advancing and promoting the science and practice of the treatment of patients with diseases and disorders affecting the colon, rectum, and anus."[1] Our specialty as we know it today is the end result of singular dedication of our forbearers to establishment of a curriculum that includes not only the anorectum, but the intestinal tract (Fig. 1). This has been accomplished in such a way that we have achieved respectability from organized medicine, surgical educators, and the public for our specialty. Coincident with the definition of the field, the early pioneers also fostered and nurtured relationships with such organizations as the American College of Surgeons, which have facilitated subsequent mutually beneficial accomplishments responsible in part for our current and continued success.

With the explosion of knowledge, the need for specialization and the development of a means for validating specialty training has long been apparent (Fig. 2). Establishment of The American Board of Proctology, later The American Board of Colon and Rectal Surgery, continues to represent, in my judgment, the single most important event in the history of the specialty; were it not for independent Board status, it would have been impossible to maintain our integrity in the face of tremendous pressure from academic surgeons convinced of our divisive nature. Since the granting of the first Board certificates in 1950, there

"Specialism has.....developed so rapidly in recent years as to suggest the wisdom of some type of future control of entry into limited zones of practice and some method by which....the profession and public may determine who may be trusted to perform services requiring special skill."

Figure 2. Presidential Address, Curtice Rosser, 35th Annual Meeting, 1933.

have been a total of 1,443 diplomates (Fig. 3). The process of board certification has been independently scientifically validated and continues to improve. The American Board of Surgery has affirmed the need for complete training in general surgery for colon and rectal surgeons. Nonetheless, the reasons for the original creation of an independent Board are at least as true today as when the founders of ABCRS were establishing and defining the Board certification process (Fig. 4).

Since the development of training programs in colorectal surgery, in concert with a strong Residency Review Committee, the numbers of training programs have grown remarkably and responsibly slowly over the years (Fig. 5). There has never been an attempt to overpopulate with colorectal surgeons, a decision based on our own perceptions of demand for our skills combined with a clear recognition of political reality. Most of what we do also is done by other specialists, rendering manpower predictions impossibly inaccurate (Fig. 6). By focusing on our own development and avoiding confrontation with others over the issues of "turf," we have evolved into the recognized preferred provider for anorectal conditions, rectal cancer, surgery for inflammatory bowel disease, and laparoscopic colorectal surgery. Demand for our services continues to increase based on our own abilities and accomplishments, resulting in what I have repeatedly referred to recently as "the golden age of colorectal surgery" (Fig. 7).[2] I maintain that to date as a specialty we have an extraordinary record of achievement.

Despite these impressive accomplishments, there continue to be challenges to our continued success that will require the same skill of our predecessors to identify and overcome (Fig. 8). Many of these revolve around educational issues; it is not possible to deal

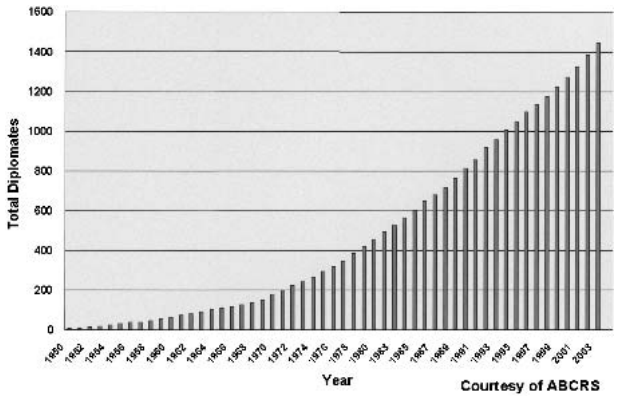

Figure 3. Diplomates of the American Board of Colon and Rectal Surgery since its inception (data courtesy of the Board).

"As a specialty it has rapidly assumed the importance which is its due in spite of the opposition it has experienced from the general surgeons who have seemed to look upon it as an unwelcome invasion of their field."

Figure 4. Presidential Address, Dwight H. Murray, 12th Annual Meeting, 1910.

with all of them in exhaustive detail. Consequently, I will focus on those that I believe represent the most substantial immediate threats to our specialty, along with some suggestions for dealing with them.

At a time when college graduates are confronted with a difficult job market, pushing them to choose more and longer graduate school pursuits in hopes of delaying the inevitable while gaining a competitive advantage in building a career, the interest in medical school has been decreasing. From a peak of 2.7 applicants for every position in 1996, the number declined to 1.9 per position in 2001, where it has remained (Fig. 9). Medical school and residency is perceived as too long, too arduous, and too expensive; several private medical schools have breached the $40,000 per year tuition barrier. More than 80 percent of medical school graduates are substantially in debt, with the mean debt burden of graduates of private medical schools exceeding $123,000.[3] Compound this with the general realization that physician earning power is dwindling in a hostile and overregulated environment, and is it really a surprise that fewer college graduates choose medicine as a vocation?

Of much greater potential significance for colorectal surgery is the declining interest among medical students in general surgery as a career; it is the general surgery residents who make up our residency applicant pool and future close professional colleagues. Recent failure to fill general surgery residency positions has resulted in general surgery being characterized as "newly noncompetitive" as a field (Fig. 10) compared with some specialties that are consistently noncompetitive, including family practice and internal medicine, or consistently competitive, such as orthopedics and urology; still others, such as radiology and the currently most popular radiation oncology, are becoming more desirable, or newly competitive.[4] As one reflects on these data, it is not only the "controllable lifestyle" specialties that are attracting greater student interest—higher reimbursement rates help as well. This diminished interest has challenged academic general surgery to examine the reasons for this lack of desirability in an attempt to redirect the "best and brightest" back to general surgery. Not unexpectedly, the duration of training combined with the perceived excessive work requirements that often preclude a life outside of the hospital have been identified by medical students as the most substantial deterrents to pursuing a general surgery career. Perceptions on the part of students that we are increasingly unhappy with our practices and are apt to be even less so in the future not only the result of further decreased monetary reimbursement but also unresolved issues such as malpractice liability reform also are cited by students as impediments to enthusiasm in pursuing general surgery.

In my opinion, the best solution to these particular challenges at the student level reverts to the reasons that we ourselves chose medicine as a broad field of study and surgery as a specific career path. Having the opportunity to interview and occasionally counsel both college and medical students, I have yet to identify one who does not offer the same altruistic enthusiastic reasons for considering medicine that I recall from my much younger days. Although it may be progressively harder to remember why we do what we do, we would all do well (myself included) to reflect on and reaffirm our dedication to our profession and recall the intense personal job satisfaction that few others, if any, can enjoy with equal regularity. Complaints about the financial and regulatory environment must always be placed in proper context so

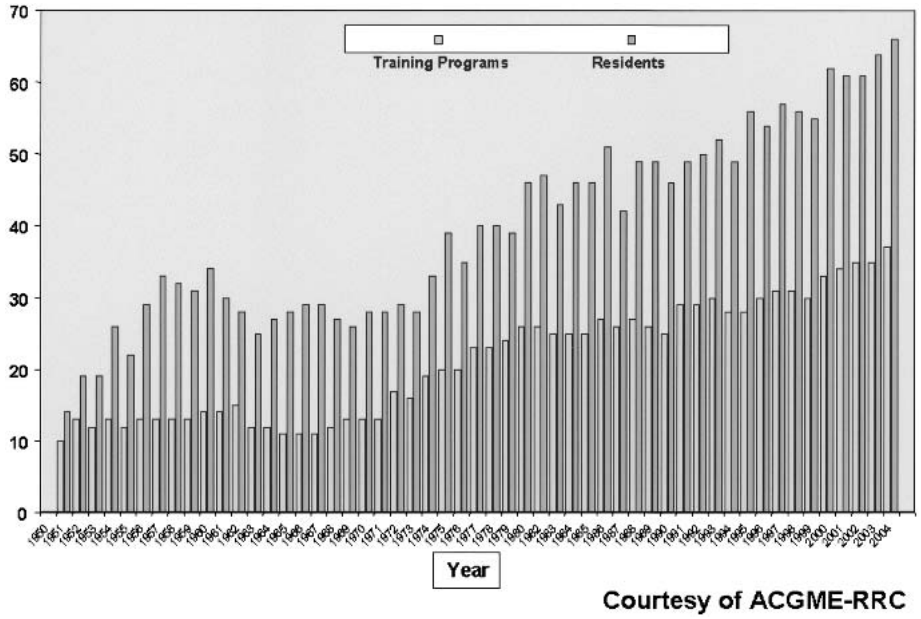

Figure 5. Training programs and residents per year, colon and rectal surgery (data courtesy of the Residency Review Committee).

"Our concern….is the creation of proctologists of quality rather than quantity and of quantity only when that quantity can be of the best quality."

Figure 6. Presidential Address, Descum C. McKenney, 28th Annual Meeting, 1926.

"With our population growing rapidly, particularly in the number of older persons, there will be an increasing demand for specialists….."

Figure 7. Presidential Address, Neil W. Swinton, 1969.[2]

"Probably the most serious task which confronts us today is the problem of education."

Figure 8. Presidential Address, Louis A. Buie, 30th Annual Meeting, 1928.

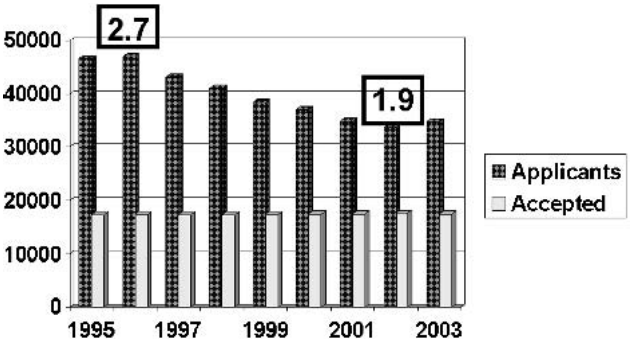

Figure 9. Applicants per position in medical school.

that students are not negatively affected. Just as many of us were steered into our careers by the example of others, we must provide similar guidance to young people wrestling with career decisions; the fact that more colorectal surgeons are working in academic departments in medical schools provides a larger platform for conveying this message.

Interactions with general surgery residents produce a much greater opportunity to affect ultimate career choice and professional development. One of the current challenges to training residents is the ACGME-mandated 80 hours regulations. Relationships between faculty and residents have been substantially strained by these regulations for reasons that are elusive at best. Could any of us who trained in every other night programs, routinely spending 110 or more hours per week in the hospital, honestly maintain that current residents should do the same? It is imperative that we remember the rationale for restricting resident work hours and focus on the potentially positive aspects of these regulations. The original impetus for

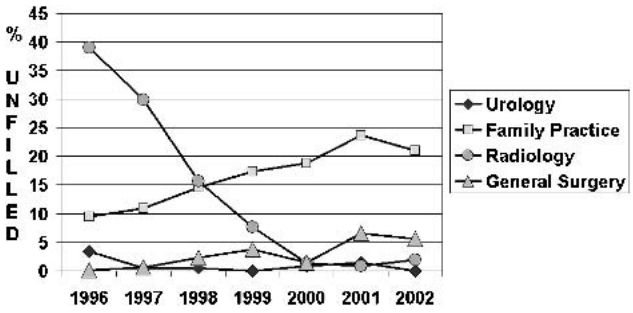

Figure 10. Percentage of unfilled positions in different residencies over time.[4]

these rules was a situation that had much less to do with exhausted residents and more to do with the need to improve the overall educational environment. Residents are primarily students, learning to practice their chosen specialty; they were never supposed to replace orderlies, phlebotomists, and transport technicians and thus be a source of cheap labor that improved "bottom-line" financial performance within the hospital. The fact is that we as surgical educators tacitly facilitated development of this potentially abusive situation by persistently neglecting the obvious. When combined with the excessive public reaction to the oft misrepresented report from the Institute of Medicine concerning medical errors and patient safety, the purchasers and consumers of health care have demanded "untired" (and therefore presumably safer) residents. In the short run we have no assurances that we will be able to provide a satisfactory overall educational experience that produces a more capable physician at the end of the training experience. Furthermore, procedure-based specialties cannot predict the effect of implementation of these restrictions on the ultimate duration of training, because volumes of procedures have previously been used as surrogates for competence. The new regulations are previously having positive effects on recruitment of residency candidates; since the adoption of the 80-hour rule, general surgery training programs in 2003 and 2004 have filled 99 percent and 99.8 percent of available positions.[5] Unfortunately, in my opinion, we are devoting too much time and creative energy to counting hours and minutes while losing sight of the fact that what we are challenged to do is provide new and better educational opportunities and train better doctors; to do this will require collaborative input from skilled educators and the residents themselves because they will have to assume greater responsibility for their own self-directed learning.

Having been involved in a colon and rectal surgery training program for 23 years and having read applications for residency positions as well as having interviewed hundreds of applicants, it is my strong belief that general surgery residents choose additional training in colon and rectal surgery almost exclusively because of a sustained positive interaction with at least one colorectal specialist during residency; this often has been referred to as a "mentoring" relationship. We must remember the origin of the word mentor to truly fulfill the mentor's mandate; in Homer's *The Odyssey,* Odysseus, suspecting that he would be away from home for an extended period of time, relied on Mentor to raise his son. Being a true mentor is more than providing a positive example; it implies a deeper influence and special parenting type of relationship that extends beyond the period of residency. Hopefully, the importance of this relationship stimulates those who have been mentored to do the same for others. In preparing these remarks, I was pleased to look back at the former colon and rectal residents for whom I was fortunate enough to have participated in their training. From 1982 to present, the Lahey Clinic has graduated 48 colon and rectal surgeons: 34 of 48 are involved with general surgery training programs and 7 of these are university-based; 13 are faculty of colon and rectal surgery training programs, 6 as program directors. I challenge other surgical educators to look back at their own programs in a similar way; they will be at least equally gratified by their accomplishments. One of the great strengths of our specialty has been its unwavering commitment to continued excellence in education; this will need to continue with renewed vigor for the foreseeable future as we redefine the parameters of surgical training.

The last challenge that I wish to highlight is the Maintenance of Certification process, or MOC. Reliable consistent measurement of competence has been, and continues to be, the "Holy Grail"; all of our past efforts have been tangential, with the assumption that achievement of enough related milestones somehow equates to a "competent" practitioner. Satisfactory completion of approved residencies, performance of sufficient numbers of cases, board certification, and subsequent recertification and accumulation of sufficient CME credits have been used as indicators of continued commitment to self-education and quality care. Again stimulated by consumers and purchasers of health care, this time with considerable assistance from the ACGME Ph.D. educators, an unprecedented long-term educational experiment has

ACGME Outcomes Project
General Competencies

- **Patient care - all aspects, including prevention, integrated care plans.**
- **Medical knowledge.**
- **Professionalism - Role modeling, ethics, industry relationships.**
- **Systems-based practice - understand and utilize resources in system; collaborate with team.**
- **Practice-based learning - identify areas for improvement, learn from errors.**
- **Interpersonal and communication skills.**

Figure 11. ACGME core competencies.

been launched in all residency training programs called the ACGME Outcomes Project (Fig. 11).[6] At the present time, all specialties must incorporate these six competencies into their special requirements and curriculum. Lectures and lessons must be provided on the more obscure competencies to enfold them into the goals and objectives of each residency. Assessment tools must be created and/or adopted within each teaching institution and individual residency program to measure the progress of each resident in these six areas. The reason that I have referred to this as an experiment is that there are no data supporting the speculation that this initiative will create a better physician. One of my favorite current questions is how do we teach professionalism to residents and program directors so consumed by adherence to the counting of hours that patient care clearly suffers through lack of continuity and inadequate sign-out?

To amplify the potential problem, the American Board of Medical Specialties has joined the ACGME in endorsing the general competencies and demanding from each specialty the creation of a Maintenance of Certification process to replace the current recertification examination. Our Board must coordinate with the Society, which is the primary educational arm of our specialty, to provide a comprehensive process that includes continuing medical education, regular objective self-assessment, outcomes reporting and prospective practice characterization, as well as a written examination. This process, which must be continued on a regular ongoing basis during an extended period of time, will be more time and resource intensive for each individual than the present recertification examination system. Currently, the American Board of Surgery does not recognize reciprocity by recertification in Colon and Rectal Surgery; because we presently require, with the agreement and endorsement of the ABS, complete training in general surgery for our trainees and certification by the ABS for certification by the ABCRS, we must carefully monitor the future of general surgical training paradigms as various four plus two-year or three plus three-year schemas are explored and ultimately adopted (Fig. 12). Completion of an abdominal surgery or gastrointestinal surgery residency may in the future be substituted for current comprehensive but perhaps outmoded general surgery residencies. Perhaps more threatening is the belief by some that it will be impossible for a busy practicing surgeon who does not limit his/her practice to colorectal surgery to maintain current simultaneous certification in both fields, leading possibly to the temptation to consider becoming a subservient Board or even relinquishing our Board altogether to make the MOC process achievable. I submit that we must never consider compromising that which has resulted in our present position of prominence; rather, we must again concentrate our considerable talents on the development of an MOC process that allows simultaneous maintenance of certification in both general surgery and colorectal surgery. If that means doing both without reciprocal credit, so be it.

In closing, let us renew our continued commitment to clinical excellence and education; more importantly, let us impart this dedication to those who fol-

"General Surgeons are not our antagonists, they are our colleagues who are in the last throes of a struggle against the steady advance of specialization."

Figure 12. Presidential Address, James A. Ferguson, 1970.[7]

".....our specialty has risen to its present eminence during difficult times, and although the present time is filled with uncertainties, our future is brighter than at any time in our history."

Figure 13. Presidential Address, Patrick H. Hanley, 1976.[8]

low us (Fig. 13). This formula has proven successful in the past, when survival of our specialty was far less assured. Now that we have achieved the position of preeminent providers of highly specialized care of diseases of the colon, rectum, and anus, we must direct our considerable talents toward providing an exemplary educational experience for medical students and residents while preparing them for lifelong, self-directed learning and dedication to highest quality care.

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