

## No Time to Rest

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I am honored and humbled to be here today, as a representative of the society with which I have identified myself for the past 24 years. The honor of serving as President for the past 13 months has been one that I have taken seriously, because it reflects a trust that each of you have bestowed upon me. In the words of former American Society of Colon and Rectal Surgeons (ASCRS) President Harry Bacon during his 1949 presidential talk, "It is good to lose oneself in contemplation of the past and in reflection upon the achievements of those who have gone before us." I actually have the distinct pleasure of introducing the Bacon Lecturer tomorrow and am doubly honored in that Harry Bacon was a prime mentor in the 1940s for my father-in-law Dr. Richard Thompson during his surgical training at Temple, and the speaker chosen to give the Bacon Lecture is Dr David Hoyt, one of my mentors. Who would believe that this young lad from Ohio would go on to graduate from medical school at Case Western Reserve University and then to complete surgical training as a young man in California, much less become the executive Director of the American College of Surgeons! But that's the point...things change.

It has been a busy but very rewarding year, culminated by this meeting, but also highlighted by the Strategic Planning session we held right up the coast in Fort Lauderdale in conjunction with the 25th annual Cleveland Clinic Symposia in February, the results of which are being disseminated broadly this week and which will guide our society over the next 3 to 4 years. It is perhaps fitting that 1991, the year I completed my Colon and Rectal Surgery training at Ochsner, was the date of the first ASCRS strategic planning session, at which time a mission statement was first adopted. We have of course tweaked that over the years, and, although our vision has not changed, our Mission has evolved. For me, ASCRS always had a mission, as taught to me by my Ochsner mentors John Ray, Byron Gathright, and Terry Hicks, which is to always provide the best possible care without personal consideration of convenience or reimbursement. Of course, in truth, this was the same lesson I had learned from my earlier mentors.

Perhaps the worst part of the year, other than crafting this talk, was facing my email inbox every morning, for no matter how early I got up, the folks on the East Coast always beat me. Having noted that, I always got the last word in at night!

Truth be told, the job as President is a formidable one, but one that is supported far and wide by many other people whom I will take a few minutes to thank. I hope you will indulge me.

First, I would like to thank each of you, members and guests, for being in here rather than by the pool or beach on this beautiful evening.

Second, I would like to thank the Executive Council, with a particular call out to a select few who served as constant willing ears and minds (Drs Pat Roberts, Terry Hicks, and Charles Littlejohn)

I want to thank Brad Champagne as Program Chair and Joe Carmichael as Vice Chair, and the entire Program Committee (including super committee members Tom Read representing *Diseases of the Colon & Rectum*), Anne Lin, Dave Margolin (next year's program chair), and Terry Hicks (president elect).

I want to thank my partners for allowing me to depend on them even more than usual: Joe Carmichael, Steve Mills, and Alessio Pigazzi, and my staff, especially Teresa Watters, whose name anyone who has called my office recognizes, and a thanks to my entire department, all of whom marched forward despite my frequent absences over the past year.

I want to thank our staff from EAI/(Rick Slawny, Gayle Irvin, Gina Seegers, in particular), but also Kevin Bragaw, Linda Cullison, Lorrie Cooper, Karen Oster, and Kristi Conley and others behind the scenes (Truman, Kelly, Jeff, Jean), and Stella Zedalis.

It's a funny thing; as most of you know, Stella retired this year; well, in addition, Irene Babcock retired the year after I completed my term as board president, and back in California, my department administrator retired shortly after I became chair of the department. I prefer to believe these actions are coincidence or serendipity, but maybe my wife Bridget and my assistant Teresa are correct, and I truly am high maintenance!

My Mom is here today and I want to give her a special thanks for showing up and for just a few other things she

has done for me over the years, and my Dad is undoubtedly looking down from heaven with pride (I miss you Dad!). My parents taught me and my siblings the value of a strong work ethic, honesty, integrity, and, most importantly, the importance of family.

I have made a lot of decisions in my life, some good and some not so good, and I look at each one as a learning experience. Fortunately, the most important decision I ever made in my life, which was asking my beautiful wife Bridget to marry me, was a walk-off Grand Slam!

After 24 years, I still wake up every day happy to see that she has stayed with me (I did marry up!) and our partnership has grown stronger, with one of the highlights being the birth and raising of our only child, our son Ilias, who is also here today. My wife has personally sacrificed a lot for me and for our family (and this year for the society), and for that I am eternally grateful; she really is our CEO (Chief Everything Officer) and I can tell you from watching her that it is not easy raising 2 boys! Fortunately, she is very balanced and brings me great strength and stability. Thank you, Bridget! Thanks also to you Ilias...we are very proud of you and I am so glad you are here!

In addition to my family mentors, I want to call out a few people who have meant a lot to me professionally – my other mentors after my family: Dr Robert Zeppa, who was like my adopted father during my general surgery training; Dr Hicks who has taught me so much, not only during my year at Ochsner, but every year since; John Ray and Byron Gathright (both former ASCRS presidents); Dr Ed Passaro from Los Angeles (a name perhaps unfamiliar to some of you, but a person who had great impact on me and academic surgery on the west coast); Dave Hoyt, whom I already mentioned; Charles Littlejohn, who, as a young Council member himself, took me under his wing and helped me get started in the Society; and then a number of people in the Society that I realize have done a lot for me even though they might not realize it.

As the 105th President of ASCRS, at this time, in the 115th year of our society's existence, I face the daunting task faced by every former president (save one who apparently declined the honor) – delivering a relevant and hopefully meaningful talk. Reading the previous talks (yes, I read them all!), I found that the first 33 or so were all about the justification for the existence of our specialty and society. Then, in 1933, Curtice Rosser first discussed board development/board status and indeed he followed through along with others (Buie, Hirschman, Martin, and other familiar names) and the Board incorporated in 1935, and then formal Board status with the American Board of Medical Specialties was achieved in 1949. During those years, many of the talks reflected those efforts. Over the next several years, the talks focused on education as a common theme, probably reflecting the reality that

organized educational efforts were still evolving in the US surgery arena as a whole.

Then, in the 1960s, there was a decidedly clinical bent to many of the talks.

Since then, a number of past presidents have given historical reflections, while others have championed causes near and dear to their heart. Still others have focused on problems of society, or the overall medical profession. This has been the most common theme in recent years, no small accident!

Some of our presidents have been quite prescient... most notably Dave Rothenberger in 1997 when he told us all to have an Open Mind, and to work to develop valid data systems to help assess quality. Indeed, quality is the theme of my talk, and in my mind there is no more important aspect of our current existence than quality and the *measure* of it. Jim Fleshman, in his Presidential address in 2010 on professionalism, said that we needed to encourage government to emphasize and focus on quality of care and broad coverage for patients. Well to that I say, *right on*, Jim...we got what he and we asked for, and it fits in very nicely with our society's strengths, which is to provide high-quality care for patients with diseases of the colon and rectum that has gone unmatched.

Sometimes change (or a threat even) is not recognized when it is occurring. Based on our Presidential talks, for example, not a comment was observed during the 1960s, even though in 1965 to 1966 Medicare and Medicaid were enacted as titles 18 and 19 of the Social Security Act, but who now doesn't recognize that as a dramatic change in our profession?

That is not the case currently, because all but the most insulated person recognizes the impact of the Affordable Care Act (ACA) and the threat to the status quo. There are certainly things to dislike about the ACA, and there are a lot of things to be uncertain about the ACA. At any rate, make no mistake, the efforts to emphasize and incentivize quality embedded in the ACA is long overdue, and we need to embrace it and embody it as we have for the past 115 years! Our society has always embodied the notion of improving the care of our patients regardless of our own economic stake (think Nigro protocol, colorectal cancer prevention, our diverticulitis parameter changes, etc). We have heard the term "disruptive innovation"...this is surely disruptive legislation.

No Time to Rest...the title could be a metaphor for my presidential year, as I balanced, and as my family balanced, the demands of the job along with my usual life/family/work balance, but actually the title is meant to reflect on how far we have come as a society and specialty, but to realize that, with the current environment, we indeed cannot rest on our laurels. We continue to make great progress as we have for the past 100 plus years! However, there is a growing public demand for improvement in

safety and quality, and for transparency, and this demand, while in its infancy, is surely building and even growing to be expected. The current sources of information are decidedly mixed in quality (STS/National Surgical Quality Improvement Program (NSQIP), Healthgrades, etc), but are ever present. If you have any doubt, try a Web search of a colleague or oneself to know that.

Although there are clearly some efforts that remain unproven or that have clearly focused on the wrong things, the efforts all reflect a growing requirement and expectation to measure and improve quality and safety. Our arena is particularly attractive to measure simply because, by the nature of our work, we have a disproportionate share of the surgical site infection events, a favorite target of assessment and measure.

How did we get here? Obviously, the current situation is nonsustainable. According to the Milliman Medical Index, a family of 4 now spends more on health care annually than they do on groceries. Other than the obvious conclusion that they don't shop at my grocery store, this is obviously a huge problem for much of America, and it certainly is affecting our overall economy.

Although we are not the architects of the current broken health care system (sic) in the United States, we have certainly been participants. We have profited individually and collectively from its structure (or lack of), and the system has resisted change. Part of the problem, of course, is that, by its very design, there has been little incentive to make any fundamental changes; in fact, it has consistently rewarded quantity independent of quality, and has actually rewarded complications with financial gain, especially at the hospital level. The other observation that has been widely noted is the great variation in care and in utilization. We can also look to NSQIP for validation of the great variation in outcomes, which persists with risk adjustment. Is this the worst kept secret in our field? We have not given this ample attention, and it's truly the elephant in the room! As custodians of our patients' health, we must do better. The changes, which will be (and will need to be) significant, have to come from 1 of 2 sources, our hospitals/medical centers (as the deep pocket) or from our government/payors. In point of fact, it will be incentives at the payor level that influence the hospitals to spend the money they need to that will impact safety. Let's spend a few minutes on a parallel industry that has had great success. Yes, as you might have guessed, I am talking about the aviation industry; but lest I lose the audience who might worry I will digress into a conversation on checklists, time outs, and teamwork or Crew Resource Management, fear not. Although those efforts are indeed useful to us, as they were to the airline industry, they are not the primary reason for their safety record achievements. I have done quite a bit of research on airline safety for this talk, which I will share with you now.

Let's step back a bit (say to the 40,000 foot level). The aviation industry is actually just about as old as the field

of abdominal/colorectal surgery. The early flight pioneers were like our early pioneers, unafraid to try new and bold maneuvers. Of course then, as now, when a pilot made an error or equipment malfunctioned, they often went down with the ship.

Like our world, the aviation industry also has 4 main players: the airlines themselves, the pilots/crew, the passengers, and the government. Surgery has our hospitals/ambulatory surgical centers, the surgeons/surgical team, the patients, and the government/other payors.

In 1926, the Air Commerce Act required that pilots be examined and licensed (our board equivalent), that accidents be investigated (still no parallel mandate in medicine), and that safety rules and navigation aids be instituted (it took us a good bit longer on this, because we were self-governed). Despite this, from 1929 to 1951, airline accidents were fairly common, even though flights were not. The rate of accidents that occurred over that time, if not reduced to current levels, would equal 7000 crashes/year in 2014! The evolution of flight safety continued through the 1950s and 1960s with a series of mostly mechanical improvements, and the widespread introduction of the jet had one of the most dramatic impacts on flight safety (6-fold reduction). We have similarly seen an evolution of technology that has brought safety to our operating rooms. Simulation, begun in the 1950s, has been richly developed in the aviation industry, and we similarly need to embrace it. Why has it not happened in surgery? Simple, no mandate and no deep pockets. This is 1 area in which we can have influence, because we need to push for this to be mandated, at least in training programs and for hospitals to pay for it (government is not likely to!). Not just for novices or trainees, but also as a method of warm-up, especially after any period of nonactivity. For sure, our current simulators are still second generation, but they will improve. Terms like fidelity, haptics, and content validity need to become part of our everyday/weekly lexicon. At our hospital in California, we have recently opened a surgical warm-up room located in our operating room (expensive real estate!) for that purpose.

Despite all these efforts, the airline industry's safety record was far from where it is today. In 1985 alone, more than 2000 people died in dozens of crashes, including 520 when a 747 crashed in Japan. In 1996, another series of crashes prompted the federal government to set a goal of cutting accident rates by 80% over 10 years. If this sounds familiar, it is akin to Don Berwick and the IHI (Institute for Healthcare Improvement) 100,000 lives campaign, which, by the way, has nearly eliminated central-line infections.

That year (1996), 340 people died in 2 crashes in the United States. The Federal Aviation Administration (FAA) and pilot groups have worked together since then to share concerns through a series of voluntary programs, and airlines agreed to participate after assurances that the infor-

mation would not be used to discipline or fine them. An FAA Web-based (NSQIP-like) system was created in 2007, and this Aviation Safety Action Program includes shared information from 44 separate carriers. These reports are reviewed by a committee made up of pilots, airline representatives, and the FAA. This has spawned an attitude that allows errors and hazards to be identified before accidents occur. These “nonjeopardy” reporting programs have become ingrained in their culture, while the cultures in many/most medical centers are to “cover” for each other (team/bunker mentality), and incident reports are often perceived as punitive rather than constructive. Even when used, often disproportionately by our nurses, the response is often minimal. Even our morbidity and mortality conferences, started by Codman in 1914, have not evolved much.

In the airline industry, near misses are an area of intense concern, but, until very recently, they barely got noticed in medicine, with comments like “better lucky than good” being commonplace. We have all said that, haven’t we? The airlines also instituted a Flight Operations Quality Assurance program. This system captures electronically and automatically every alarm, every event or system that occurs outside predefined parameters. In the past, these were not reported, because they were dealt with immediately and no harm/no foul was the usual mindset. (In that way, pilots are much like surgeons; once a problem is solved they are inclined to press on to the next task, rather than get bogged down with paperwork and reports.) The Flight Operations Quality Assurance system is not an optional reporting, it automatically captures these outlier events and they can be then analyzed for significance. These are the real main efforts that have made the safety of US airlines what it is today, the use of these processes and that of failure analysis, akin to a root cause analysis. We have all observed the extent of failure analysis as evidenced by the recent efforts to find Malaysia flight 370.

Eighty-five million passengers traveled on US airlines or foreign airlines serving the United States in 2012. There are more than 28,000 commercial flights/day in the United States alone, and that number is expected to double over the next 20 years. The safety record (if not their HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores!) is impressive. Contrast that with the 51 million inpatient procedures done each year (CDC data (CDC.gov)). Consider how many lives are lost each year because of medical errors;

just choose your number. (Is it 50,000 or 100,000 as the Institute for Medicine says? Or more, as the lay press would say? It’s certainly not as low as the number of airline fatalities, which are at an all-time low over the past 10 years.) Is Nero fiddling while Rome burns? Are we just messing around with our seat belts, missing the big picture? I think we largely are. We can and must do better. The real issue is that our hospitals have not been held to task for safety...preferring our method of “one offs” over any type of “expensive” system fix.

Even when asked to support a safety program like NSQIP, they often will decide it is too expensive, all while taking in handsome, sometimes obscene profits. The other culprits, of course, are the insurance companies, who until recently were oblivious in their fat profits and happy to continue to raise rates to ensure their stockholders profits while ignoring the core issues.

We must be engaged as active participants, not passive and not obstructionists just to avoid change, which none of us like. In these tumultuous times, our litmus test should be a simple one; is this good for the patient? Not “is it good for me?” because, although that might be successful in the short term, any such success will be short lived.

Again, this is not new for us, because our society has long been at the forefront of quality and safety efforts, with such current leaders as Cliff Ko, Frank Opelka, and Arden Morris.

Where do we go from here? The aviation industry had multiple problems and through a process of identification, ownership, and collaboration they have made measurable progress. This did not come easy, and it is noteworthy that the pilots through their union initially objected to many of the changes. We need to learn from their mistakes as well as their successes, and adopt our own philosophy of identification, ownership, and collaboration. The ACA will expose all of our outcomes and safety records and will and should make each of us look inside and decide what and where our scope of practice is, and help us redefine it based on our strengths and training and *not* on any economic pressures. In the airline industry, the captain goes down with his ship, while, in surgery, we have said in the past that we are captains of the ship. Well, it’s time to take the helm and ensure that the ship stays afloat, or we will indeed go down with it.

We have much to be proud of, but there’s much more to do and no time to rest on our laurels.

Thank you.