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A View from the Bridge

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This annual meeting of the Society, the 94th in our esteemed history, is the first to be held under the Presidency of a Canadian. By coincidence, our meeting is being held in my own town, so I would like to extend to you a warm welcome to Montreal. (Bienvenu à Montreal. J'espère et reste d'ailleurs persuadé que votre séjour à Montreal vous sera benefique tant de point de vue scientifique que sociale). Our Chamber of Commerce proclaims Montreal to be the largest French-speaking city in the world, next to Paris. It is also 1,000 miles from the mouth of the St. Lawrence River, making us the world's most inland seaport.

What the Chamber of Commerce does not tell prospective visitors from the South is that when the British fought to claim the territory, King Louis of France shrugged off his loss by saying it was not worth his while to fight over a few million acres of snow and ice. We Canadians are still trying to live down the image of a glacial domain, which generates the Arctic blasts that from time to time invade the temperate climate normally enjoyed by the citizens of the United States. I hope that your presence here in the month of May will help dispel the still lingering notion that we are permanently ice and snow bound and that prompts the occasional visitor to arrive here on a hot summer day with skis atop his four-wheel drive recreational vehicle. And, may I add my wish that the warmth of our welcome with which you have been received will further cement the bonds that exist between our countries.

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For the year now ending, I have had the responsibility and the honor of heading this illustrious body of colon and rectal surgeons. As has been customary, the conclusion of my term calls for a swan song in the form of a presidential address, and I trust in the course of my remarks you will have no reason to regret the absence of defense along the longest undefended border in the world. If there should be among us today anyone with a perspective long enough to recall the annual meeting of 1931, I hope he will not wish himself back to that gathering of 64 years ago, when the record states laconically that no presidential address was given. I hope to give no reason this morning to inspire a wish to return to 1931!

When asked to provide the title of my remarks for the program, I was put in mind of a painter I know. His art dealer, concerned with the marketing of his paintings, was constantly after him to provide a title for each of his works. "It takes all I can do to paint the pictures," my friend replied "Let the people who buy them give them the titles they consider appropriate." That is not such a far-fetched idea as it may seem. What I have to say will, in the final analysis, register with you as you perceive my meaning. But I venture to suggest that I am presenting to you *A View from the Bridge*—because at the conclusion of my mandate, as President of our Society, I stand at the span between the past and the future of our professional experience. Collectively, as members of the medical profession, we work at that crossing that demarcates the realm of illness from that of health, and as concerned practitioners we are aware of the extensive changes that are in the making—to alter the shape of medicine as we have known it to the way it will be in the future.

To address the last of these concerns first, we are being challenged by a trend toward corporate domination and homogenization of our professional practice under the label of managed care. To put it plainly, the vulnerability of the individual patient is being exploited by the imposition of socioeconomic constraint on the specialist who is best equipped to deal with the serious illnesses that call for our skills.

The tightening grip being felt by both ourselves and those who come within the scope of our concern has led to the proposal of some dubious and vastly complicated formulas—among them President Clinton's ill-fated scheme that was supposed to lead to the Nirvana of universal health care in the United States. Although that Rube Goldberg structure collapsed of its own complexity, heaven only knows what strange devices will yet be concocted to meet the needs of a vast number of men, women, and children who are at the mercy of costs that continue to escalate, threatening to turn every medical encounter into a catastrophic financial disaster.

"Back to the Future" is the title a major primary care organization chose for a recent program on "today's healthcare crisis." In fact, what is happening in medicine today goes very much against some major trends in society and seems to harken back to an earlier time. We live in a world that has exalted specialization. In the news media, the dominance of a few national television networks and national magazines has given way to a proliferation of cable channels and targeted publications. In retailing, the grand old general department stores are being replaced by scores of niche-marketed specialty shops. In football, no one plays both offense and defense anymore, and in baseball some of the most sought-after players are now highly specialized closers who may come into the game to pitch to one batter. Medicine, on the other hand, seems to want to swim upstream against this tide and go back to the future.

What we are seeing in medicine, I believe, is not really a movement away from specialization. Specialization is still in. People do not want to go back to the days of the general practitioner anymore than they want to bring back *Life* magazine, *The Saturday Evening Post*, the single-wing formation, and Ted Mack's *Original Amateur Hour*. What we are seeing is not a desire to rid the world of medical specialists. It is a movement to cut out waste and inefficiency. The perception is that undisciplined use of medical specialists could lead to waste. It could and it has, but none of us wants to be part of that overutilization. We will be glad to see it cut away. Our only concern has to be that we not be swept away in a vast overreaction to a very real problem.

Much anxiety and concern has been expressed regarding the continued survival of our specialty. Is this gloom and doom justified? Of course not. The challenge of colorectal surgery in that area of medicine, which we have defined, refined, and brought to a high level of excellence, is to stand our ground. Yes, we need outcome studies, and we are getting them. A study to be reported at this meeting compares mortality rates for 2,805 patients who underwent colorectal surgery by 39 surgeons. The mortality rate for board-certified colon and rectal surgeons was 1.4 percent, compared with 7.3 percent for surgeons who were not board-certified colon and rectal surgeons.

Outcome studies are important, and we need to increase our understanding of how to function in a managed care environment, but we also need to stand up and make the case for our specialty in plain English. We need to speak up with the people who count on us for leadership—our patients, our allied health professionals, our office and hospital staffs, our local communities—friends, neighbors, and relatives. We can make our case without outcome studies or other statistical data. When a patient asks any one of you if he or she should seek treatment for a colorectal problem from a generalist or a colorectal specialist, do you have any problem answering? I should think not. Is it not true that we bring more experience to the treatment of colorectal problems than other surgeons or primary care physicians could possibly have? Will we not be much more able to recognize unusual diagnoses? And will the patient not be more likely to receive the most appropriate treatment for the condition from a specialist who sees the same thing every day than from a generalist who may not have seen such a case in a month? Will we not be more likely to know from practice and experience when an operation is necessary, which operation to perform, and how to do it? Are we not the surgeons best equipped to handle diseases and disorders such as colon carcinoma, ulcerative colitis, Crohn's disease, diverticulitis, hemorrhoids, and other anorectal problems? Will the care of a colorectal specialist cost more? Most likely, it will not. It may very well cost significantly less. In a study of operations on large and small bowel to be reported later this week, it was found that patients treated by colorectal specialists had shorter lengths of hospital stay and lower costs per case. So, is the case

closed? It should be if we will all just speak up. The audience is waiting.

Concern about the survival of our specialty is not a new phenomenon. I traced the Society's history back to 1910, and I can assure you that prophets of doom have had their say throughout the years. But have we disappeared from the face of the earth? Indeed, the exact opposite has occurred with continued growth and potential for yet more growth. If we just continue to do the good work that goes hand in hand with ongoing research, the teaching of our specialty, the pursuit of further breakthroughs, the conquest of illness and the saving of lives, if we just stick to what we do best, the specialty of colorectal surgery will continue to grow and gain recognition and respect. We must remain cognizant of the fact that there is no substitute for human care and compassion. When all is said and done, the quality of patient care is still the most important concern. The founders and builders of this Society have given us a position of leadership in our specialty, and what we do with this position of trust in a rapidly changing world has much to do with our future progress.

Sixty years have elapsed since colon and rectal surgery was board certified as a specialty. As the data will attest, there is a track record of which we can be truly proud. We have achieved significantly lowered mortality rates in our area of surgery, and postoperative complications have been dramatically reduced. My perspective as a Canadian, who has a brother practicing in the United States and who has had such wide-ranging access to American colleagues, prompts me to compliment you on how far you have come in securing the recognition of colorectal surgery as a certified specialty. In no other country has comparable recognition as yet been won.

To cite the experience in Canada, in such a context, is perhaps to invite your sympathy—because to this day there is only one officially recognized program here for postgraduate training in colon and rectal surgery. And it is a program accepted for accreditation by the Royal College of Physicians and Surgeons of Canada, but without certification. I should point out that the lack of additional programs is not because of any absence of interest or effort on the part of my Canadian colleagues. Some university faculties with both insight and foresight have permitted and even encouraged the development of colorectal specialists, whereas others have been reluctant to do so and resisted initiatives to establish colorectal surgery as a center of excellence.

As I have noted, recognition of the specialty in the United States is much further advanced than it is in Canada. But even in the United States, colon and rectal surgeons comprise only 1.3 percent of the overall membership of the American College of Surgeons. They do, however, represent a disproportionately large group of participants—the highest percent of any specialty in the Annual Clinical Congress—and they consistently attract the largest audiences during the general sessions at postgraduate courses. So even in the enlightened, progressive United States there is room for further progress.

I appreciate that in the year now concluding you entrusted the leadership of our Society to one who works within a health-care delivery system that has been widely held to be hostile to the interests of the medical profession. My position as a Canadian physician has, nevertheless, permitted me to demonstrate that the specialty of colorectal surgery can be successfully upheld as a nonexpendable one, however, pressing the drive to control costs—and from this bridge between the Canadian and American experiences, I can attest to the viability of our position. It has admittedly been challenged by some but has not been banished on this side of the border and will not be untenable in the United States. We need only hold on to our principles, insist on quality as the main element in the surgical armamentarium, and demonstrate our commitment to patient care, then we will gain the recognition we seek. Specialization needs no defense before this body. You know it to be a natural consequence of the ever widening scope of medical activities joined with an entirely laudable desire on the part of individual practitioners to master some phase of the tremendous whole and thereby make oneself a more effective instrument of society. This is exactly what the population and government want and, undoubtedly, will demand.

I keenly appreciate the heightened responsibilities that these changing and troubled times place on us. In fulfilling the duties of the Presidency, I have, during the past year done my best to help guide the Society through some unchartered waters. Let me now give you a brief report of some of our activities.

We have been working on the development of an appropriate design for outcome studies that will demonstrate persuasively the results that can be achieved with judicious use of colorectal specialists, and, thereby, establish the pre-eminence of our specialty. Designing these outcome studies can be difficult. How do you define patient satisfaction? Is it relief

from pain and healing of disease? Or should it include such factors as convenient parking, commodious waiting-rooms, and free coffee? Outcome studies that put free parking on a par with the remedial treatment of fecal incontinence must give way to the consideration of what really counts in making people well.

Another important activity has been assuring the appointment of personnel best qualified to secure the full accreditation of our Society as a body that grants credits for continuing medical education. The ASCRS is only as strong as its credibility. We want to be absolutely sure that what has been so dearly and meritoriously earned over the years will be properly safeguarded.

I am also happy to report that we have established a committee for the review of colorectal cooperative clinical trials. We are confident this new committee will help to encourage our members to pursue and participate in research to broaden the scope of our effectiveness.

We have developed a comprehensive manual providing practical guidelines for members to follow in their dealings with managed care organizations. In the critical area of our relations with the corporate healthcare conglomerates, our members must deal from the strength that is inherent in our collective position as a body that is confident of its place in the medical universe, committed to progress and sure of its worth.

Over the past 12 months I have had the pleasure of traveling extensively to represent the Society at scientific conferences and professional meetings. Working closely with our Executive Director, Jim Slawny, I have made presentations to the appropriate industry organizations to obtain all possible support for our publications, meetings, and educational activities.

In all this, I have been richly rewarded by the confidence you have placed in me. It has been a crowning professional experience, for one who came out of the Canadian Midwest almost 30 years ago, to embark on a professional adventure that has given so much meaning to my life. One of my predecessors as President recalled in his address the inspiration he received from a village blacksmith. It was the blacksmith, he said, whose industry and integrity led him to choose the calling of surgery. I would like to take a leaf from his book and acknowledge my own beginnings on a farm in Northern Saskatchewan where I learned humility by milking the cows. That I came in the course of time to the practice of medicine, followed my star to become a Professor of Surgery at the university, Sir William Osler elevated to eminence in the education of physicians has been a great fulfillment for me. Now, having served as your President, I have to say how much I owe to all who illuminated the path I have traveled and to all of you who have so significantly contributed to my enlightenment.

What is past is prologue. To what our specialty has achieved over the past 94 years, much remains to be added in the years ahead.

We have much to learn from our colleagues in the international community of colorectal surgeons. As medicine shares with other spheres of life a new sense of global togetherness, the Society helps us maintain worldwide contacts through the International Relations Committee, on which it has been my pleasure to serve. Certainly we have to put the problems faced by medicine here in North America at the top of our list of priorities, but we will deal with our problems no less effectively if we see them in the context of an emerging world body that can help to promote our efforts and broaden our horizons. We must continue to reach out to embrace the experience and expertise of colleagues in other lands around the globe.

My friends, I cannot conclude without telling you a story. I recently encountered a very distinguished member of our profession who, at the age of 85, is Professor Emeritus at one of the great American schools of medicine. To illustrate the ongoing changes in his field, he told me a story that may be part fact and part allegory, colored by his brilliant imagination. He described a visitor who had come to see him not long before. This man had graduated from medicine some 25 years earlier. He had returned to a class reunion and now wished to greet his old teacher, whom he had not seen in so long a time. He was brought into the Professor's office and asked by the secretary to have a seat. The Professor was on the telephone and would be happy to speak to him when he finished. The visitor sat down. Seeing some papers on the Professor's coffee table he was amused to recognize the very examination he had passed a quarter of a century earlier. "Would you believe it?" he later told his former teacher. "They are asking the very same questions I answered when I was in med school 25 years ago!" "Don't let it bother you" the old Professor replied. "The questions are still the same, but they have long since changed all the answers!"

We live in a world where the answers to age-old questions are constantly changing. The information base is being continually updated, as man continues

to explore new approaches with the aid of new instruments that are both the ends and the means of scientific inquiry. It is our challenge to keep in step with the new findings, the new methods, and the new techniques that are continually coming on-stream. If we stay on top of things and refuse to settle for yesterday's answers, the surgical specialization that is our contribution to the healing arts will never be painted into a corner by advocates of don't-rock-the-boat and let's-not-open-the-door-any-further conservatism. We can, we must, and we will.

I am, as you can tell very well by now, decidedly optimistic about our future. Colon and rectal surgery has been a great specialty for me in Canada. It is developing and expanding in Australia, the United Kingdom, throughout Europe, Asia, and Latin America. Inevitably, there will be resistance to progress from some who feel threatened by new developments, but I have not stopped believing for even one moment that we shall overcome, and we shall continue to be recognized as a specialty among specialties. Our national responsibility is divided between an obligation to those who will be the future custodians of our specialty and one which has for its objective the advancement of knowledge in all subjects relative to our specialty.

The march that our predecessors began almost a century ago will continue, and, thanks to the strength and promise of this organization, the road ahead will be straighter and less tortuous than it was for those who went before us.

Thank you.