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*Diseases of the*  
**COLON & RECTUM**

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*Presidential Address*

Reflections

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OVER THE PAST several years we have seen more gloom for the practice of medicine than ever before. Things seem to be going completely to pot. Malpractice litigation is rampant, the government is trying to regulate how we practice, our fees are being challenged, we "don't get no respect" from the public. The media, legal profession, and even Uncle Sam are all hostile toward us, we are competing more and more for patients, even by advertising (which used to be unethical), and more of us are retiring younger than ever before.

In view of all this, it seemed to me that it might be interesting to pull out the old crystal ball and predict what the future has in store for us. Because it is the old crystal ball that is doing the reflective speaking, no one can blame me if it is wrong or controversial, but at least it will give us something to think about. Will it be good? Will it be bad? Let's see!

It has been reported that there is a reduction in the quality of medical school applicants as compared with the past. Is that bad? Is a 4.0 average an indication of the ability of the student, once he graduates, to evaluate a patient by combining cognitive knowledge with the skill and intuitive sense required to make a good judgment? Of course not! Most of the doctors in my age category would never have been accepted by medical schools today (many of us had only B+ averages in college), yet medicine has not suffered as a result. And it will not suffer in the future! We will see an entirely new breed of physician in the

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future, one with less concern for monetary gain and with more compassion and regard for the total welfare of the patient than ever before. I think we will like the new breed, maybe because it will remind us of the old breed.

Gender ratio will change. Thirty years ago, about 5 percent of medical students were women; now it is up to 35 percent. Before long, as older doctors die off or retire early, over half of the physicians will be female. This will present a problem, because some female doctors will have children. This will demand heavily on their time, forcing them into primary care rather than surgical specialties and possibly into part-time practice. It is predicted that by the year 2000, there will be an oversupply of physicians numbering 140,000, but the figure does not take into account that many might be part-time women practitioners. Things may not be as bad as they appear.

Because general surgery is not appealing these days, 70 percent of general surgical residents are taking additional training in super specialties. Colon and rectal surgery is very popular because it offers minimal night work, comparatively steady hours, and the opportunity to perfect technical skills and to keep up to date on new developments. This is evidenced by the number of highly qualified applicants for colon and rectal surgery residency programs, many of which must be turned down because of a paucity of slots available. This is disheartening.

Funding of these programs will become a problem

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Read at the meeting of the American Society of Colon and Rectal Surgeons, Anaheim, California, June 12 to 17, 1988.

because the government is reneging on its pledge to even partially fund this sixth year and before long may drop this funding entirely. Funding by the training institutions will be more of a burden than most will wish to bear. There are two solutions to this problem: reduce the number of programs, which we must not do, or fund the programs ourselves, which we must do. Most of those who have or wish to have programs will have to fund them out of their own pockets, by paying residents' salaries and their malpractice insurance. Actually, this arrangement will be better. The residents can be given much more responsibility in the office, which will make them a part of the practice, and therefore pay for themselves. As a result, they will be better trained. This arrangement will appeal to hospitals, which can still enjoy the prestige of being a training institution without the expense. The Residency Review Committee for Colon and Rectal Surgery has always recognized a deficiency in outpatient training in many programs, and for most programs, this will become a thing of the past. The crystal ball speaks!

What will happen to our incomes? They will go down, down, down! The colon and rectal surgeon who now has had an income of \$250,000 a year will see it drop 30 percent to \$175,000 a year in the next five to ten years. Budget cuts and the tremendous escalating unexpected cost of the AIDS epidemic, with its anticipated 450,000 victims by 1993, will create a massive negative impact on the medical economy forcing great cuts in physicians' fees, and hospital and other medical costs.

The resource-based relative value scale will be adopted, not because it is any good, but because it has cost so much to develop. Surgeons do not like it, but the AMA and medical specialties are in favor of it because it favors cognitive services. It will be revised so often over the years that the original will not be recognizable.

The government will set up a fee schedule from this scale for Medicare and Medicaid and laws will be passed mandating physicians to accept them as full payment. Insurance companies will go along with this and force the physicians to participate. The only way a patient will be able to pay a nonparticipating physician is out of his own pocket, and he will not want to do this.

It appears that there will be the same pay scale for different specialists doing the same procedure. Because everyone will be a specialist (you will not be able to practice if you are not), it is hard to argue with this. To make this less cumbersome, the turf problem will be solved. Second opinions are not working and will disappear. It is hard to believe all this, but the crystal ball speaks!

Members of the AARP, the American Association of Retired Persons, 20 million strong, with powerful political clout, are saying, "Why save all your life for retirement

and have a medical catastrophe wipe out all of your savings?" The Medicare deductible is too high. About 40 percent of the elderly live in or near poverty level. The cost of nursing home care today is \$25,000 a year. By the year 2000, there will be 5 million people over 85 years of age. It will not be long before the AARP forces the government to completely cover all medical expenses for the elderly including catastrophic care, nursing home and other custodial care, cost of medication, transportation to and from medical facilities, social service attention—all medical care! What will suffer? Technology and the doctor's pocketbook!

Advances in medical technology, even today, are at the mercy of officials who decide which development is worthy of Medicare reimbursement. Review is cumbersome and cannot keep up with technologic discoveries. As a result, devices and procedures that have been shown to be safe and effective are not available for use, and development of others is impeded because of fears that they will not become economically profitable. Ultimately, investors may decide not to back a promising experimental device because it may not gain Medicare and eventually Medicaid and, in the future, insurance company approval. Their decisions will be influenced by cost. Medical technology advances will slow down. The crystal ball speaks!

Will the practice of colon and rectal surgery change? Decidedly yes!

Colonoscopies, one of the biggest income producers for gastroenterologists and colon and rectal surgeons, will be done by technicians or physicians' assistants. They will also do the biopsies, polypectomies, and fulgurations. Outlandish? Not at all! Sigmoidoscopies have been performed successfully for a long time in several institutions by nurses.

These changes will occur for two reasons. First, the newer endoscopes, with distal tip cameras that allow image transmission to a video screen, open up all kinds of local as well as distant educational opportunities, because images can be transmitted by phone lines and satellite. Teaching is easier, faster, and more exacting than ever before. The skills of a physician will not be necessary for each case—one physician endoscopist can oversee several technicians just as an anesthesiologist roams through several operating rooms checking on the nurse anesthetists who are giving the anesthetics.

This saves dollars, which is the second and really the primary reason for this inevitable approach. A physician will charge \$500 to \$800 for colonoscopy with an extra fee for polypectomy, whereas a salaried technician can do the whole thing for \$100 more or less—a tremendous saving! The crystal ball speaks!

Barium enemas will soon be past history; new scanning techniques will discover colonic disease painlessly

and most likely more accurately than colonoscopy, which is not the case today.

No longer will the physician be the first to see the patient. The history and physical examination will be performed by a salaried physician's assistant and the results fed into a computer; possible diagnosis and studies to be performed will be retrieved. These will be done by or under the direction of the physician's assistant, the results fed back into the computer and, lo and behold, out comes the final diagnosis and how to treat the problem! Then the patient and all of these data will be presented to the doctor who will have the final say. This is much cheaper and possibly more accurate than today, but still subject to human error because humans program the computer. The crystal ball speaks!

What about the malpractice problem? It will not go away and probably will get worse. Attempts at tort reform have been almost worthless. In the year 2000, instead of one of seven surgeons sued a year, as it is today, the number will probably double. Defensive medicine will continue in spite of computer assistance and the cost of this will come out of the physician's pocket.

In contrast, British physicians under the National Health Service, socialized medicine, are rarely sued, probably because the care is free and contingency fees are considered unethical by the legal profession. Many British attorneys try to avoid malpractice suits. The real reason is probably a philosophical one. The British believe that the world cannot be totally right, accept the problem, believe that some problems cannot be dealt with, and have a natural conviction that doctors, being human, are imperfect. America is a "perfectability-of-man" society—if there is a problem, it can be solved, and doctors should be perfect!

In many ways, doctors in this country are not perfect. Six to 10 percent of licensed physicians are chronic alcoholics. Inclusion of those with mental instability and narcotics addiction means that 10 to 20 percent of practicing physicians have suffered from impaired functions at one time or another. The public and politicians do not like to hear this, and before we know it, doctors, like athletes, will be subjected to periodic drug testing. The crystal ball speaks!

There is also the matter of competence. Consumers are under the impression that we, as physicians, do not weed out our bad apples and, to a large extent, that is true, because politics and fear of litigation make it difficult.

Thus, two things will be required for all physicians in the future to evaluate competence: recertification and compliance with standards of care.

With recertification, the doctor's competence, knowledge, and practice are reviewed in mid career; the consumer wants this. We know that there is no real correlation between a doctor's ability to pass a cognitive

certifying or recertifying examination and his competence. Unfortunately, many of those who fail are excellent physicians, and some who pass are incompetent.

What is competence? Competence is the ability to recognize shortcomings and seek help in areas with little expertise, judgment in the application of information, honesty in offering appropriate treatment to a patient without regard for monetary gain, caring for patients when not convenient or profitable, the avoidance of drug use, the maintenance of emotional stability—especially under stress, and working in harmony with other physicians. None of these can be evaluated by examination. If a physician fails, he or she loses privileges in hospitals, loses his or her license, fares badly in malpractice litigation, or is refused payment by third parties—even though he or she may be treating patients with skill, competence, and compassion.

Standards of care are already in the process of being set up. They will be vague for a while, but in the next 10 to 20 years will be stiffened to the extent that we will be practicing close to cookbook medicine. Periodic inspection of doctors' office practices, hospital practices, or anywhere else doctors practice will determine whether or not compliance with these standards is being carried out satisfactorily. Woe be to the doctor if they are not!

Double boarding will disappear and you will be what you are. The American Board of Colon and Rectal Surgery will have its own examination without requiring the passage of any part of the American Board of Surgery examination because our residency structure will change from five years of general surgery and one year of colon and rectal surgery to two or three years of general surgery and two years of colon and rectal surgery—there will be no need for the extra time, and lack of funding will not allow it. We will not be absorbed into gastrointestinal surgery nor will we be relegated to a special skill in general surgery. Why? Because our specialty is strong, our Society and Board are strong, we have shown we can provide superior care, and we have firm referral patterns from both patients and other physicians wherever we are located. People have become used to us and have confidence in us. Politicians will favor us because the people favor us. The crystal ball speaks!

So things, although they appear bleak, are not. We can handle the future. We must resist our tendency to resist change. We must realize that these changes are inevitable and roll with the punches. There is no perfect solution and we must accept that, just as the British have done. We must be willing to modify our life styles and to continue a superior job of caring for patients in spite of this adversity. We cannot let down in our efforts to train young adults in our specialty; we must establish more residency programs and be willing to fund them ourselves, which will be no real burden.

We must encourage our young adults, after completion of their residencies in Colon and Rectal Surgery, to resist the temptation to do general surgery. Although this is appealing because of early financial gains, in the long run it will not pay off. It has been shown over and over again that those who stick to colon and rectal surgery reap great satisfaction and joy in their practices. In every instance that I know of, doctors who do this become highly successful and, after a few short years, are seeking an associate. Those who do not do this hurt not only themselves but also the specialty in which they were

trained. I cannot emphasize this strongly enough. Do not do general surgery!

As a final note, this is our Society. This is where we learn, exchange ideas, make lasting friendships, and can work effectively politically. The more active each of us becomes, the better for our future as a specialty. We are a close-knit group and, if we stick together, we will survive. Times are difficult and will get worse but, in spite of this, we can continue to offer our patients the best in the care of colon and rectal disease. The crystal ball speaks!