DISEASES OF THE COLON & RECTUM

# Surprise Me: The 2007 American Society of Colon and Rectal Surgeons (ASCRS) Presidential Address, June 4, 2007

PRESIDENTIAL ADDRESS

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The American Society of Colon and Rectal Surgeons (ASCRS) is an association of individuals who have shared interests, experiences, and traditions since 1899. In the tradition of appreciation, I would like to thank the Society for more than a quarter of a century of personal experiences, led by 26 presidents, who have served as mentors to us all.

In 2007, the ASCRS membership totals 2,674—26 percent of whom are international. Currently, 9 percent are women, and I would like to thank Dr. Ann Lowry, our Immediate-Past President for her support this year. I wish her well as she enters the realm of Past Presidency. I also thank the 12 council members, 37 ASCRS advisors and representatives, 24 committee chairs, 428 committee members, 44 members of the *Diseases of the Colon & Rectum* editorial board, and our 19-member administrative staff at Executive Administration Inc. (EAI). In addition, I would like to recognize the 19 members serving the American Board of Colon and Rectal Surgery (ABCRS), the President, Dr. Herand Abcarian, the Executive Director, Dr. David Schoetz, as well as the 49 members of the Research Foundation, and the President, Dr. Walter Koltun. Finally, we recognize Dr. David Cherry, President of the Association of Program Directors for Colon and Rectal Surgery, for the 47 colon and rectal residency programs in this country.

In total, we have a 660-member workforce in our specialty, which is the engine that drives us forward. I thank members of the U.S. Armed Forces, in particular those ASCRS members who serve and allow us to live in peace in the United States while we perform our clinical duties.

Lester Rosen, M.D.

## WHY WOULD A SURGEON TALK ABOUT *SURPRISE?*

Surgeons are generally uncomfortable with surprises, particularly in the operating room, because we are occupied with the surprise of disease processes. The word "operate" means to follow a course of conduct, and therefore, extraneous intrusions are not appreciated by most surgeons.

In a leadership position, we often look to quality organizations in other fields. In the past year, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has adopted "surprise" as a mechanism of inspecting hospitals for quality.[1] Diplomacy, covered by the media, also has used "surprise" as an expression of process, in that President Bush,[2] Vice President Cheney,[3] Secretary Condoleezza Rice,[4] and Defense Secretary Rumsfeld[5] all have made "surprise visits" to Baghdad. The British Prime Minister, Tony Blair, also has made a "surprise visit" to Baghdad.[6]

This address, "Surprise Me" is based on shared experiences of ASCRS members who were encountered

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with "surprise" during the last quarter century and, more importantly, the organized response of the ASCRS to these surprises.

As Dr. Labow said in his introduction, I was born in Brooklyn and part of my education, both on the street and at home, was related to baseball. Therefore, it should come as no surprise that I might mention baseball along the course of this address. I quote Yogi Berra, who was born in St. Louis, extracting some lore of "Yogi-isms"[7] that he expressed or at least that were attributed to him. One of Yogi's favorite sayings to Hank Aaron was "If you keep the label up when you swing the bat, you can hit better."[8]

When one looks at the term "surprise"[9] in the dictionary, there are many synonyms. I have selected eight of them, which I will discuss consecutively, along with the ASCRS response to each one: astonished, flabbergasted, bewildered, illuminated, ambushed, bushwhacked, dumbfounded, and bamboozled.

## *ASTONISHED* IS "TO BE STRUCK WITH GREAT WONDER."

There is no doubt that the use of the computer, the internet, the World Wide Web, and even Web MD Magazine has affected patient care in a manner greater than any other innovation that I have seen during the past 25 years. What was the ASCRS response last year?

In October 2006 at the American College of Surgeons Meeting, we had a Website Retreat with the goal of defining educational modules. In the future, when a resident or an attending surgeon wants to review a subject, such as diverticulitis, by using as a foundation the ASCRS Electronic Textbook, there will be a website menu linking related articles from the journal of *Diseases of Colon & Rectum*, *Seminars in Colon and Rectal Surgery*, related Practice Parameters, annual meeting webcasts, and core subjects, all of which will cross-reference each other and relevant surgical videos.

Since early 2006, Drs. Nagle, Browning, and Billingham have been instrumental in our recent contract with OHO, a website redesign company in Cambridge, Massachusetts. An ASCRS website template will be finalized for the college meeting in New Orleans this October.

Drs. Fleshman, Lowry, and Birnbaum will be working on a pilot for the first web-based education module that I mentioned, using "Socrates," a software program developed by Dr. Jeff Gold from the Society of Thoracic Surgeons. Dr. Gold's vision was to create a "dashboard" where a resident can review new online educational models, those they have completed, their case logs, CME programs, progress of MOC, and other landmarks in their training, such as development in simulation of skills for laparoscopic surgery. In addition, Dr. Schoetz, Executive Director of the Board, is developing a central question bank as a shared question repository for the ABCRS and ASCRS. Written and oral board examinations, recertification examinations, and CARSEP will all be stored and utilized in a secured section of the web.

Yogi Berra once failed a test by getting almost every question wrong, and his teacher said, "Don't you know anything?" Yogi responded, "I don't even suspect anything."[10] With the use of the repository and educational models, we suspect that our board examination process will be facilitated for both preparation and testing.

I congratulate Dr. Robert Madoff, the newly elected Editor-In-Chief of *Diseases of the Colon & Rectum*. In 2006, there were 871 submissions to the Journal, 210,645 articles were downloaded in 2006, compared with 135,000 in 2005. The Journal has been retrodigitalized, back to volume 1 from 1958, when Dr. Buie said, "We begin."

## *FLABBERGASTED* IS "TO OVERWHELM WITH GREAT WONDER OR DISMAY."

We have all been flabbergasted by specialty training, which reveals the secrets of anatomic tissue planes surrounding the colon and rectum, how they are affected with disease, surgically removed, and reconstituted anatomically. We anticipate known postoperative complications with standard or creative treatment heralded by safety. This should be the answer to "Why do you want to be a colon and rectal surgeon?"—frequently asked during resident interviews.

Colon and rectal surgeons are experts in the pelvis, both in the broad female as well as the narrow male pelvis. The pelvis was a favorite subject for Georgia O'Keefe, a Southwest painter in the 1940s. One of her paintings[11] notes the obturator foramen and how clear the blue sky appears contrasted to the white bony pelvis, suggestive of the improved view that the surgeon experiences during laparoscopic surgery through the port cameras.

The transition from performing open surgery to laparoscopic surgery will be facilitated by training young surgeons who have established laparoscopic backgrounds in open techniques. There will be open surgery fellowships. The ASCRS response to open or laparoscopic surgery this year is credited to both Drs. Read and Ross, our Program Chairman and Association Program Chairman, respectively. Their St. Louis program balances basic and advanced laparoscopic surgery with a symposium on open radical resection. In addition, Dr. Judith Trudel will oversee "Pelvic Floor, Views from the Other Side," which demonstrates the synergy of urogynecology and colon and rectal surgery in preparing to operate on associated pathology in the same patient.

I also recognize our Administrative Director, Mr. Jim Slawny, for having the EAI team facilitate corporate support that brings the newest technology to our membership.

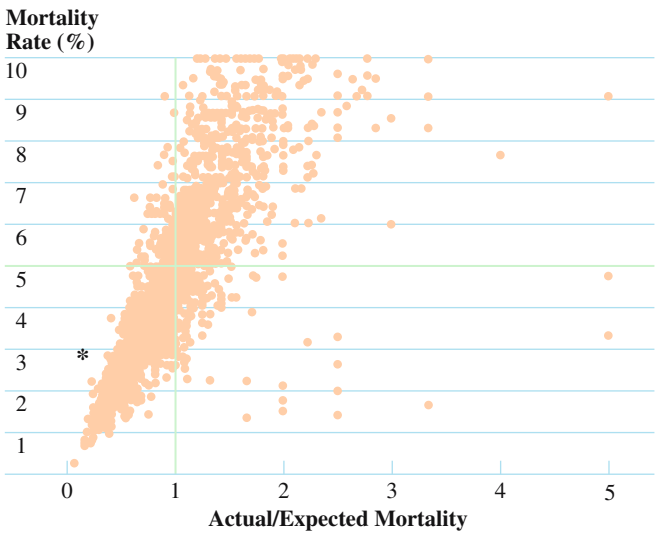
## *BEWILDERED* IS "A SURPRISE WITH CONFUSION."

A five–year-survival chart from the National Cancer Data Base (NCDB)[12] on colon and rectal cancer cases between 1998 and 1999 that have been followed for five years is shown. Unfortunately, despite colon and rectal cancer screening, we still see more than 45,000 people annually with rectal cancer, and those who have positive lymph nodes currently have only a 50 percent chance of surviving five years. However, this has improved considerably since I began practice in 1981.

I also am bewildered by the variation in mortality with colon surgery. Figure 1 shows the 231 Pennsylvania Hospitals' Colorectal Surgery mortality data from 1992 to 2003.[13] Each square represents the mortality rate in an entire year of surgery at that hospital. In this figure, 2,541 points are shown, which resembles the shape of a comet; to be at the head of the comet, one must be at a 3 percent annual adjusted mortality rate or lower, which is less than one-fifth of all hospitals. I am aware that the Lehigh Valley Hospital's Division of Colon and Rectal Surgery's mortality rate, where I work, is at the head of the comet, and it remains a challenge to explain why consistently for 11 years we have had this reduced mortality rate; however, specialist colorectal surgeons with a residency training program must be considered in the assessment.

The ASCRS response to improved survival with rectal cancer will hopefully be answered by Centers of Excellence for Rectal Cancer. I have asked Dr. David Rothenberger to head an *ad hoc* committee to look at the feasibility of a Rectal Cancer Center of Excellence, and this week we have Dr. Lars Pahlman, who will speak to that issue. We want to recognize Dr. Pahlman as the current President of the European Society of Coloproctology.

**FIGURE 1 Colorectal surgery mortality data from 1992 to 2003 from 231 Pennsylvania hospitals.**




The ASCRS is working with the American College of Surgeons on a case log reporting system, a practice-based learning system, which allows surgeons to compare outcomes on a confidential basis. Dr. Tom Read has been working on this for some time, and I encourage all of our surgeons to participate. I believe that most colon and rectal surgeons' practices will have mortality rates in the "head" of the comet.

## *ILLUMINATED* IS MY PREFERRED SURPRISE—AS "TO BE ENLIGHTENED."

Kock,[14] from the University of Texas, teaches us that learning by surprise enhances cognition. We know that anything we have learned from a response to danger remains with us perpetually, such as catching a bee and suffering the consequences. Kock describes this as a Darwinian or primal learning response, and this is supported by neurologic research that suggests that the startle reflex in elderly people with dementia is usually one of the last reflexes to disappear.[15] Brown and Kulik[16] have written on "Flashbulb Memories of Surprises." A *flashbulb memory* is a photograph that preserves the scene as the flashbulb is fired; we all remember the JFK assassination in the moving convertible.

A surgeon's experience creates these flashbulb prints that are difficult to modify. These memories are probably associated with the surgeons' reluctance to give up or adopt techniques or methods with which they are familiar for new ones, such as pelvic drains, nasogastric tubes, adaptation to early discharge of patients, and implementation of laparoscopic surgery.

The ASCRS' response to understanding the reluctance for change has been to continuously update Practice Parameters, which are now evidence-based, and the Standards Committee, led by Dr. Neil Hyman, has been very active. This year, we approved Parameters for Crohn's disease, constipation, incontinence, and anal neoplasms. In addition, the Society has published its own ASCRS textbook, and I am pleased to say that 1,200 copies have been sold since February. We are looking forward to *Evidence Based Reviews in Surgery*, coming from Canada, and our ASCRS website will be linking to these reviews, edited by Dr. Robin McLeod.

I am pleased to report that we will be illuminated in perpetuity with the "The American College of Surgeons' Abcarian Lecture" at the fall meetings of the American College of Surgeons. We congratulate Dr. Herand Abcarian on this honor.

As to my own flashbulb memories, I would certainly like to personally thank Stella Zedalis and the other members of EAI for their day-to-day support. I will fondly remember opening up my e-mails to see 20 to 30 addresses with their respective names!

## ARE THERE *NEGATIVE SURPRISES?*

Kierkegaard,[17] who lived from 1813 to 1855 in Copenhagen, said, "Life must be understood backwards, but lived forward." The saying reminds us that we improve our skills, at times, from bad experiences and results. This quote ideally portrays operative interactions between a surgical resident and an attending surgeon, where the resident is moving forward with the Metzenbaum scissor, and the attending surgeon is thinking backwards from past experience and using the "suction" or forceps to thwart maneuvers that could be unsafe.

## *AMBUSHED IS* "ATTACKED FROM A CONCEALED POSITION."

Every surgeon has been ambushed by the recurrence of Crohn's disease proximal to the ileocolic anastomosis. In a sense, our surgery is easily burglarized by Crohn's disease. Although the postoperative anastomosis is a natural model to study Crohn's, we have no etiology or cure. I hope that in the future, young surgical researchers will find the cause. My mentor, Dr. Leon Ginzburg, discovered ileitis in 1932. His initial hint was to concentrate on the process of granuloma formation.

We all have been ambushed by the continual rise of medical malpractice premiums.

The ASCRS' response to being ambushed can be addressed by several initiatives. First, I congratulate Dr. Victor Fazio on being appointed as the first surgeon to the National Scientific Advisory Council of the Crohn's and Colitis Foundation of America (CCFA). I am certain that he will bring ideas to that organization with a surgical point of view. I anticipate support from the ASCRS Research Foundation to specifically encourage research to discover the etiology of Crohn's disease, particularly following resections for potential cure. Annually, we have inflammatory bowel disease symposiums to stimulate discussions, and this year Dr. Steve Wexner will host, "Expert Exchange on IBD."

I would like to acknowledge Drs. Kofsky and Eisenberg from the state of Pennsylvania, colon and rectal surgeons who became "quasi-Philadelphia lawyers." Through their progressive lawsuits, the Pennsylvania Underwriting Association reclassified colon and rectal surgery, which decreased the CAT surcharge, which nearly doubled our state premium (Kofsky, Philip, "David and Goliath," personal communication, January 2006).

I believe that tort reform should be directed at the state level, and perhaps this is a role for our regional societies; I have written to Dr. Unti to look into this.

## *BUSHWHACKED MEANS* "ATTACKED AFTER A POSITION IS CLEARED."

We have all experienced the impact of the reduction in resident exposure to surgery within the 80-hour limited work week. A solution is "Chunking of the Colorectal Surgical Resident"! Chess grandmasters rely on stores of knowledge of game positions, organizing knowledge in "chunks," like a musician practices chords.[18] If one looks at an actual game board of chess for a measured period, using players rated from less than 1,600 to more than 2,350 (as a grandmaster), they can consecutively recall pieces from approximately 5 for the novice to more than 20 as we near grandmaster level. However, if chess pieces are placed randomly on the board and studied, there is no difference in the identification of where the pieces were, thus showing that "chunking" of knowledge from many played games has improved performance. Will surgical techniques passed through subsequent generations of surgical residents be affected by decreased exposure in the operating room? Will there be a generation gap? How do we "chunk" the resident?

One ASCRS response has been to develop a "Director's Corner" at this year's meeting. Dr. Milson's symposia described the necessary learning components of surgical videos for residents to watch on webcasts or to download to their MP3s to further their learning. Additionally, these videos will be helpful for emerging colorectal specialists in other countries. In my own institution, Dr. Roberto Bergamaschi is working on simulation models in laparoscopic surgery. These models have "mesentery" and "colons" that can be tied and resected, respectively. The computer can visualize the trail of knot tying and compare a very broad-based knot with a rather compact knot performed by an expert, and residents can note their progress, perhaps in the Socrates' type-model that I mentioned previously.

A blue-ribbon committee chaired by Dr. Bruce Wolff, from the ABCRS, is currently looking at potential modifications of colon and rectal residency programs to keep up with the changes in technology and reduction of resident working hours.

## *DUMBFOUNDED* IS "SURPRISE WITH BRIEF CONFUSION."

All surgeons were initially *dumbfounded* when we became exposed to the RVU, or Relative Value Unit, which converts to dollars paid to surgeons. Work expense, practice expense, and malpractice expense make up a

formula of payment that is affected by geographic and conversion factors. In addition, Medicare had set a target to control growth and physician spending, called a "sustainable growth rate" (speed limit). In 2002, there was a 5.4 percent reduction in payment. However, in 2003, 2004, 2005, and 2006, there were subsequent legislative acts proposed to prevent reductions, namely the Medicare Modernization Act, Omnibus Appropriations Act, Deficit Reduction Act, and the Tax Relief and Health Act, respectively.

The ASCRS's response to these legislative issues is to support the American College of Surgeons, which informs governmental organizations of surgical concerns. Dr. Guy Orangio, Chair of our Socioeconomic Committee, monitors government regulations with Dr. Anthony Senagore, who has spent considerable time on the Practicing Physicians' Advisory Council (PPAC), which advises the Centers for Medicare & Medicaid Services (CMS) on physician payment. We congratulate Tony on his nomination as President-Elect.

## *BAMBOOZLED* IS "A DECEPTION THAT CAN BE UNINTENTIONAL, BUT SOMETIMES THE OUTCOME CAN BE HELPFUL."

From January 1, 1992 to December 31, 2003, managed care in the state of Pennsylvania led to a decreased length of stay from 13.5 days to a little less than 10 days for 187,381 consecutive patients who underwent colorectal surgery.[13] This was a significant decrease, and I have dubbed it PFPWP, which is *Pay for Performance Without Pay*; mainly hospitals and insurers have profited from this initiative and outcome.

At times, surgeons feel bamboozled as they are principally blamed for the rising cost of healthcare and leaders in Washington have made attempts to socialize medicine so that the government can pay the bills and control health care. In reality, there has been a "socialization of medicine"; and by socialization, I mean to "convert or adapt to the needs of society."

Because of the effects of aging, joint and organ replacements, surgery for obesity, medical treatment for alcoholism, drug addiction, and treatment of sexually transmitted diseases, which has changed from a course of penicillin to a lifetime of antiviral medications, we are consistently treating all ills known to man. Certainly, I am for this, but socialization is what drives up healthcare costs.

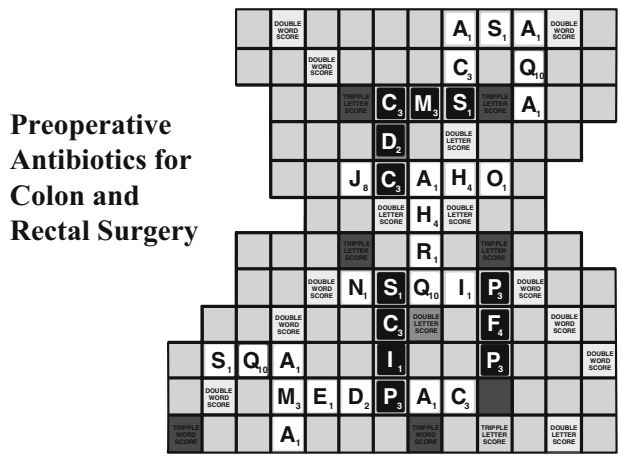
Although necessary to decrease surgical errors, I am skeptical that the new pay-for-performance initiative will decrease the rising cost of healthcare. We are familiar with basic performance measures, such as time-out for patient identification, operative site marking, and appropriative timing of antibiotic administration. Starting in July 2007, a 1.5 percent bonus is payable in 2008 if the surgeon adheres to health performance codes.[19] Performance measures are coming from a variety of places, including CMS, JCAHO, and the AMA Physician Consortium for Performance Improvement. These measures go through a vigorous process for approval at the National Quality Forum (NQF), and they can be implemented through the Surgical Quality Alliance, chaired by Dr. Frank Opelka. Many of these organizations are interrelated, and to understand them, I think they are best seen on a Scrabble Board (Fig. 2). For example, the CMS and the Centers for Disease Control and Prevention (CDC) have worked together to form the initiative called Surgical Complication Improvement Project (SCIP).[20] If a surgeon appropriately starts and stops antibiotics in a timely fashion, there will be a pay for performance bonus. The American Society of Anesthesia (ASA) and the American College of Surgeons (ACS) have developed the Surgical Quality Alliance (SQA), which has been charged with the coordination of surgeons' response to these initiatives.

The ASCRS's response to these activities has been to appoint people to serve on the appropriate committees, and we are grateful for Dr. Baxter's participation at the National Quality Forum, as well as Drs. Lowry, Hyman, Ricciardi, Morris, and Temple's participation at the SQA level.

In summary, I come here today to tell you that "the ASCRS is engineered to function in response to Surprise."

...And we are growing, as 46 fellows and 56 members will be added to our society. The International Council on ColoProctology Committee, chaired by Dr. Newstead, is developing a registry of all international societies and their meetings, and on Sunday, there was an International Consensus Workshop in St. Louis, which looked at global standards for the practice in colon and rectal surgery. The ASCRS has an approved membership category of International Fellow.

**FIGURE 2** **Interrelationships of various organizations.**



Some "Addresses" try to predict the future, but certainly I cannot predict future surprises, or they wouldn't be a *surprise*. I leave you today with a tale about Mrs. Carmen Berra,[21] who said, "Yogi, you were born in St. Louis, played for the New York Yankees, but lived in New Jersey. Where do you want to be buried?" His answer, "Surprise me!"

Thank you very much for the opportunity to serve as your president.

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