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## PRESIDENTIAL ADDRESS

# REFLECTIONS—PROJECTIONS!

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It is hard to convey the feelings I first had two years ago when you elected me as vice-president of this prestigious organization. The thoughts expressed by Winston Churchill, on one of the many occasions that he was honored, come closest to my own feelings. I quote:

I must confess to you that I was overpowered by two emotions, pride and humility. I have always hitherto regarded them as opposed and also corrective of one another, but on this occasion I am not able to tell you which is dominant in my mind. Indeed, both seem to dwell together, hand in hand. Who would not feel proud to have this happen to him and yet at the same time, I never was more sure of how far it goes beyond what I deserve.\*

I would like to express my appreciation to all those who have made this past year so pleasant and enjoyable. Committee members have given considerable time to carry out the Association's business. The real work of the Association is done by Bill Maloney and our efficient secretary, Jim Cox, and I am particularly indebted to them. I would advise any of you aspiring to be president of any organization to pick one that Bill Maloney manages, and Jim Cox serves as secretary and to have Mort Buckley introduce you.

Over the past two years I have reflected on the question, "How did it happen?" I am sure many of you have asked this question as well. *Serendipity* is defined as the faculty of finding valuable or agreeable things not sought for, and I would have to acknowledge that serendipity best explains my presence here today.

As a medical student at Columbia's College of Physicians and Surgeons, I intended to pursue a career in internal medicine. It was only during a rotation on the surgical service, after I had completed my internship interviews, all in internal medicine, that I realized my real interest was surgery. I was

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unquestionably influenced by two chief residents on the surgical service who were excellent role models, Drs. Jim Malm and Keith Reemtsma.

With the help of Dr. David Habif, I was granted a late interview with Dr. Pete Rousselot at St. Vincent's Hospital in New York. I consider myself fortunate to have been able to spend the next five years in his program. Throughout my residency my interest vacillated between general surgery and various surgical specialties, until my fourth year of residency. After hearing a presentation by Dr. George Morris of Houston on vascular surgery, I decided that I wanted to be a part of this rapidly developing field. With the help of Dr. Daniel Mulvehill, a former member of this association, I was accepted into the Vascular Surgery Fellowship Program at Baylor University.

My first experience at Baylor was working with Dr. Stanley Crawford, and this alone was worth the trip to Texas. He was a gifted, practical surgeon who was a delight to work with. Dr. Crawford did a broad range of surgery, considering anything that bled to be in his domain as a cardiovascular surgeon.

My rotation with Dr. Michael DeBakey taught me many things, especially how much I had to learn, which seemed to be emphasized daily. He was an extremely well-organized man with work habits that surpassed anything I had experienced before. His ideas on health care provision, expressed in the 1960s, should have received more attention.

When I went to Houston it was to obtain training in vascular surgery with the intention of returning to New York. I had no real interest in cardiac surgery, that is, until I spent time working with Denton Cooley. The excitement of this burgeoning surgical field, the effortless manner in which Dr. Cooley operated, and the challenges presented were overwhelming. Dr. Cooley arranged for me to extend my program in Houston to gain more experience in cardiac surgery.

In April 1963 this Association met in Houston, and I had the good fortune to be invited to a breakfast with a group of surgeons. Serendipitously, I was seated next to Dr. John Kirklin. Although I did not know it, this breakfast and meeting Dr. Kirklin were to change my career. Shortly thereafter, Dr. Kirklin invited me to visit the Mayo Clinic, which I did en route to New York to finalize my plans to return there. After this visit Dr. Kirklin offered me the opportunity to spend a year working with him and his colleagues, an opportunity that I could not turn down. Without question, that was one of the most exciting and educational years I have experienced. That one year extended into seventeen years at the Mayo Clinic.

Dr. Kirklin was the most exacting, precise surgeon I have known. He had an unsurpassed breadth of knowledge of cardiac surgery and physiology, which he enjoyed sharing with those working with him.

Dwight McGoon was a superb and careful surgeon whose demeanor as a surgeon and a gentleman I tried to emulate, although I quickly realized that such an effort led only to frustration.

F. H. "Bunky" Ellis' interests were primarily the mitral valve, an area in which he did some excellent original research, and the esophagus, an area in which he is renown.

Dr. O. T. "Jim" Clagett was an extremely versatile surgeon, at ease working in the abdomen as well as in the chest. He became a close friend, confidant, and advisor during my years at Mayo.

The experience I had at the Mayo Clinic has strongly influenced my thinking regarding the practice of medicine and surgery. The high degree of administrative organization provided the physician an unencumbered opportunity to pursue his professional activities. The clinic is governed primarily by physicians with a strong supporting cast of able administrators, with both groups having respect for the other. In my opinion, this is the ideal way in which to run a medical institution.

In 1980 I returned to Washington, the city of my birth, where my family still resided. I have enjoyed the challenges of an entirely different environment at Georgetown University Medical Center. Again, I have been fortunate in having an excellent group of colleagues in our department and the loyal support of staff.

As you may have noted, of the nine surgeons mentioned as mentors, six have been president of this Association and two have been president of the Society of Thoracic Surgeons. In addition, I have enjoyed the friendship, support, and advice of several other members of this Association. It is readily apparent that it is not what you know but whom you are fortunate enough to know that is important.

It is sometimes assumed that those living in the Washington area have an insider's view of what is going on politically. Let me assure you that I have not found this to be true. The political approach to health care reform is understood, or misunderstood, equally well inside and outside the beltway. My current assessment of our profession and its responsibilities in the future is a result of my own personal experiences, feelings, and certain biases.

I would like to comment briefly on five areas that the profession must **address** if we are to meet the challenges of change.

1. The structure of academic health centers
2. Alliance with our patients
3. Medical decision making
4. Data analysis and application to practice
5. Elimination of excess in the system

The primary stated objectives of the recent health care reform effort were to provide insurance and access to medical care for all individuals and to control what has become an unsustainable rate of increase in health care cost. The reform efforts were unsuccessful in achieving these objectives, perhaps in part because efforts were made to introduce changes in a system that provides the best quality of medical care anywhere. Some degree of success might have been achieved had the focus been on the real issue, which is health care *finance* reform. Despite the failure of the reform effort, it has had a major impact, stimulating important changes in the health care system. It is unlikely, however, that these changes will **address** the two most important issues—cost and insurance coverage.

The failure to adopt any health care reform proposal may prove particularly detrimental to academic health care institutions. Changes that are taking place in the absence of planned reform do not provide support for the additional educational expenses incurred by these institutions. In addition, many of our academic medical centers are structured in such a way that they cannot compete effectively in the changing marketplace. Decentralization of administrative responsibilities and individual department autonomy is inefficient and makes decision making slow and cumbersome. Our academic medical

centers need to redefine themselves so that they can respond with speed and decisiveness in a unified way and position themselves so as to have the ability to take and to manage risk.

In a capitated reimbursement system, efficiency and cost effectiveness can best be achieved if all disciplines share the same objectives regarding quality and cost containment. In my opinion this would best be accomplished by aligning various clinical services administratively on the basis of their clinical practice, research interests, and educational programs. An administrative grouping of cardiac surgeons, cardiologists, and others involved in the care of patients with cardiac disease, working together within the framework of jointly developed practice guidelines, would be more effective in today's environment than the traditional structure that exists. Clinical practice structured in this way might cause us to rethink the way in which we train our specialists in these areas.

Over the past three decades, many changes in the practice of medicine have contributed to a deterioration in the close relationship that formerly existed between physicians and patients. Some of these factors relate to technology that has moved the patient away from the physician, others relate to third parties that have come between the physician and the patient, and unfortunately some are driven by economics. These changes have occurred during a time when society has experienced increasing cynicism toward and decreasing respect for all professions.

Although physicians have greater capabilities than ever before, use and abuse of these capabilities has led to the public perception that the medical profession is responsible for the marked increase in health care cost and, thus, has led to a loss of confidence in us. Our profession is viewed like any other business and thus requires management, control, and restriction. We must change this perception and develop a close alliance with our patients if we are to alter the current direction of health care changes. Physicians and patients have common goals, and we should work together to achieve them, recognizing that resources are limited.

Medical ethics have dictated individual patient advocacy by physicians without consideration of cost or other limitations. Now that the public has determined that cost no longer can be ignored, physicians must advocate for their patients within the limits of their responsibility to society as a whole. Decisions regarding the allocation of resources must be made by physicians and informed patients, not by for-profit corporate entities.

As an example, medical care decisions for the incompetent patient are moving away from the profession and the public toward third parties. If we do not take the initiative in a responsible way, these standards may be applied to all medical care, including the care of the competent patient. Decisions regarding the standards of futility, quality of life issues, and the extent of resource allocation are difficult to make, but we must **address** them or others will. We have to recognize that when life cannot be extended with dignity, the use of resources for the meaningless prolongation of dying is neither necessary nor desirable for the profession, the patient, or society.

It is imperative that we become more expert in health services research and outcome analysis. The value of what we do must be determined objectively with improved methods of data collection and analysis. The variable application of certain operations in different geographic areas suggests that these procedures are being overused or underused, and we are uncertain about which is the case. We must evaluate new technology in terms of its value in improving health and not allow its widespread use until

its effectiveness is substantiated. We are all aware of procedures that have gained acceptance without demonstrated value. I suspect that currently certain technology is being widely used that does not contribute in a cost effective way to the quality or duration of life.

The appropriate treatment of coronary artery disease is an example of an area in which we are deficient. Even though various interventions have been used for several years, their relative value is unclear, and opinion and practice vary widely.

Currently we lack the data needed for objective decision making about the direction, magnitude, and nature of our major investments in health care. Quality of care and value for dollars spent must be documented, not by government or payor, but by physicians as part of their responsibility to society. I am encouraged by a major gift to The Thoracic Surgery Foundation for Research and Education in honor of Dr. Ralph Alley to support this type of research.

Past methods of reimbursement have contributed to excesses in the system; for example, recent changes in the provision of health care have resulted in a major excess of hospital beds, which are costly to the system. The Washington metropolitan area has approximately 4000 hospital beds, and on any given day approximately 1200 are empty. Elimination of this excess is not easy, but it is the responsibility of the medical profession to participate in the solution to this problem. Our past system, which has promoted excessive investment in high-cost facilities and wasteful patterns of practice, provides a degree of optimism that simultaneous cost control and improved quality are possible.

These efforts will be effective only if lower quality, inefficient providers are allowed to fail, either by closing entire facilities or dropping specific services. Competition should be encouraged, but only if it recognizes quality and efficiency. Any incentive in the system should be based on quality rather than quantity of services. If we can lead the way toward solutions in these areas in a manner that places the patients' best interests foremost and is not considered as professional self-interest, we can do much to restore our relationship with the public and restore professionalism to our profession.

Proposed health care reform, as with any change, has produced a flurry of entrepreneurial activity. Today health care is being packaged, marketed, and sold for a profit, with unproven methods of practice, often with financial incentives to restrict care, and with little regard for patient or physician satisfaction. I believe it is unconscionable for corporate interests to derive excessive profits from health care and inappropriately deprive the health care system of millions of dollars that are badly needed to meet the previously stated objectives of insurance coverage and cost containment. Any profits should be invested in improving patient care, not returned to shareholders. It is equally inappropriate for the entire medical profession not to recognize that society has said that the rate of increase in the cost of health care is unacceptable and not to accept the responsibility of leading the effort to contain cost and maintain quality as well as patient and physician satisfaction. Can these goals be accomplished? I think so, but compromise and change will be necessary and success can be achieved only if physicians and patients can strengthen their alliance with one another.

I am optimistic about the future because I feel certain that many capable people are interested in working to resolve the problems that exist and to meet the objectives that I have defined.

In addition, I am encouraged by the 45,000 young people who applied to medical school this year, the

greatest number since 1978. I feel certain that they will bring new ideas and enthusiasm to the profession as it faces some of these problems. We should continue to encourage the best and brightest of our young people and not discourage them with cynicism brought on by changes to which we have difficulty adapting.

On my first day as an intern in 1957 I met a very senior surgeon. On learning that I was beginning a surgical internship, he offered his sympathy and assured me that surgery had had its day and that I was embarking on a dead-end career. As I look back I am glad he did not convince me. I would have been deprived of the privilege of being a surgeon, the gratification that comes to all physicians from caring for patients who entrust their lives to us, and also the honor of being at this podium today.

## Footnotes

Read at the Seventy-fifth Annual Meeting of The American Association for Thoracic Surgery, Boston, Mass., April 23-26, 1995. [+](#)

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\*From "This Superb Honor," an acceptance speech delivered by Sir Winston Churchill at Westminster Hall, London, November 30, 1954. [+](#)

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