Thoracic and cardiovascular surgery. Presidential address

FD Loop

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PRESIDENTIAL ADDRESS

THE FIRST LIVING AND THE LAST DYING

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I appreciate the introduction and the honor of this presidency and reply that the reason for my apparent success is found in an epitaph Andrew Carnegie suggested for his tombstone, "Here lies a man who knew how to enlist in his service better men than himself."[1] When one looks back on a career, all the memories of intensity and stress and responsibilities tend to fade, but the memories of the successes shared with patients and colleagues remain forever. I wish to thank those colleagues, medical and surgical, past and present, who have worked with me, some for more than 30 years.

A man alone is in bad company. I can only wonder why I had the great, good fortune to find Bernadine, my wife, companion, great friend, and great love. She is certainly responsible for my *aequanimitas.* We have wonderful families: Alison, Fred, Kendall, Bartlett, Marie, and my mother, who is an exceptional woman and at 98 years old still waits up for me. I have also been favored by the ability to work in a unique and eminent field of surgery and now to be president of this Association. I believe that my life has been like a clear day in the high Sierra, and with all the sharp ridges and steep gorges, it has been an exhilarating experience being part of this profession. The season now is autumn, but I still see sunbeams every day, for which I am deeply grateful.

The title of this address is found in the writings of Master Surgeon Ambroise Paré, a Frenchman, military surgeon to kings, who lived during most of the 16th century. In addition to compiling a large clinical experience, he wrote a monumental 10-volume work on anatomy and surgery.[2] Those who read medical history may remember that he concluded many of his reports, "I dressed him, and God healed him." In Paré's day, 400 years ago, gunshot wounds and surgical amputations were considered poisonous and were cauterized with boiling oil, which turned pain into agony. Paré discovered that abolishing cauterization decreased inflammation and infection, thus saving many lives and advancing surgery during the Renaissance. His observations were far ahead of the times. Paré concluded after a lifetime of surgery, "Science without experience yields not great assurance."[3] Years ago, when I read some of his works, I found these lines:

> The heart is the chief mansion of the soul,
> the organ of vital faculty,
> and the beginning of life,
> the fountain of vital spirits,
> and so, consequently, the nourisher of vital heat,
> the first living and the last dying.

From the Cleveland Clinic Foundation, Cleveland, Ohio.

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Since a presidential address is necessarily reflective, it occurred to me that Paré's phrase, "the first living and the last dying," may be applied not only to the heart but also to elements of our character, the profession, our specialty, and our academic societies. The traits that mark each one of us begin early in life and develop throughout our careers.

From the beginning of our medical training, we are involved in *scholarship*: You may call it education or learning, but whatever term is used, knowledge is one of the earliest fundamental requisites of our being, and the pursuit of knowledge exists throughout our lives. In surgery, the two dominant forces are advancing technology and the exponential growth of medical information. Surgical training is only the start. The present store of knowledge has a half-life of 3 to 5 years.[4] The problem we face in continuing our education is not that we forget what we have learned; instead, it is the struggle to acquire new knowledge. New knowledge is the real wealth today, far more than material assets.

There are many incentives for scholarship—for vigilance and humanism and personal renewal. We may be dissatisfied with current results or we try to stay ahead of technical obsolescence, which unfortunately coincides with advanced age and isolation of practice. The ultimate motivation is to achieve a higher standard. Bad surgery can be very expensive treatment. In the future, greater pressure from educated consumers, risk-bearing contracts, and litigation will allow even less tolerance for poor outcomes.

The detached thoracic surgeons will excuse themselves from further scholarship on the grounds that they are not teachers. But they will have overlooked a greater responsibility apart from self-education, and that is educating the patient. C. H. Mayo wrote that the patient is safest in the hands of a person engaged in teaching medicine. To teach, the doctor must always be a student.[5]

Since presidencies also confer a degree of academic freedom, my opinion is that this vast and changing field is not conducive to a shorter length of training. I am not advocating inertia or resisting change. If we could shorten general surgery training by a year and standardize cardiothoracic surgical training to 3 years, that would be fine. The point is that our training programs are challenged by older surgical candidates, by the unprecedented pace of technological innovations, new operations, and emerging adjuvant therapies. As an editorialist recently wrote, the constraints of time and the stress placed on development of technical skills result in the education of the resident lagging behind the training.[6]

Quality in medicine begins in residency. Shorten the residency and you may devalue the specialty by encouraging lesser qualified persons to enter a field that demands exceptional talent, maturity, and rigorous training. We cannot teach wisdom or experience, but educators provide the critical substrate, the foundation essential for hard-earned experience, and especially skill which has to be mastered in a relatively short interval. Our specialty is the epitome of natural selection and meritocracy, and it should stay that way.

After the pursuit of knowledge, another distinguishing feature of our professional life that forms at a very early age and may be apparent throughout life is *leadership.* Leadership comes naturally to most thoracic surgeons. The demands of the specialty are so great that there is a natural selection of bright, practical, decisive individuals, and it is these characteristics, this elitism based on excellence of performance, that comprise leadership.

There are three reasons why leadership is critical to medicine. First, we are beginning an era of physician-directed health care. Second, we are in the business of results,[7] which demands leadership for database formation, bench-marking, and the translation of knowledge into clinical application. Third, leadership is important today to assure that medicine does not devolve into a commodity that stifles innovation. Neither competition nor cost containment will ensure the maintenance of research and education, which are the foundations for further advances in therapeutics. Surgery is still the crucible of the research laboratory.

The single greatest lesson I have learned in management is that medical centers should be led by physicians. It is easier for a physician to learn business management than for a businessman to learn medicine. Leadership is the same quality whether it is leadership of an academic medical center, or heading a department or a group of physicians, or even running a commercial business. The effective leader knows the field, provides direction, protects the guiding principles, and articulates a vision based on integrity and trust.

When the trustees of two large New York hospitals recently attempted a merger, the respective medical faculties rebelled, citing cultural differences.[8] Someone used the word "vision," and newspapers quoted a psychiatrist who said, "In my line of work, only schizophrenics have a vision and we give them medication." Well, maybe under those circumstances the vision was cloudy, but whatever you call vision, it helps to know your priorities and where you are headed personally, professionally, and preferably in hand with the organization wherein you practice.

Leadership is basically common sense and example. The challenge is to build a creative environment and, at the same time, communicate reality. Good organizations want performance, not conformance, in a culture

whose goals are leadership, active practices, academic achievements, intellectual growth, and accountability for cost, service, and outcome. The concept of monolithic leadership is flawed because, in medical organizations, performance is the result of collective leadership. And most of the talent is on the shop floor, not in the executive offices. Great physicians and great scientists create great medical centers. Lay hospital administrators generally cannot understand or mentor doctors, but a physician-driven culture is able to understand doctors and medicine and better interpret the medical market.

This having been said, service institutions tend to have performance problems because they are not businesses. The fact of the matter is that we are not in the business of business; we are in the business of medicine. And this business is best run by physicians who are totally aligned with the medical center where they practice. The synergy among doctors, hospitals, research, and education has the potential to strengthen the individual physician and to establish an ideal creative environment. Some would say that amounts to surrendering individuality to the organization. Not at all. Medical interdependencies enrich the clinical experience and make the individual physician wiser, more efficient, and secure. The aligned group acts as a unit, manages the support team, serves as a repository of knowledge, and yet the individual physicians can remain remarkably independent. It is the collective genius of an organization that differentiates one medical center from another.

Our strategy at the Cleveland Clinic has been to invest in physicians and their leadership. This is the intellectual capital where value in medicine resides. Sometimes the best specialty medicine is the most expensive health care initially, but frequently it becomes the least expensive treatment over time and, thus, a better value. Value in medicine is far more important than money. You cannot put a price on hope, wisdom, skill, and compassion. On the other hand, investment does not mean doling out dollars irresponsibly. There must be a measurable return on investment, perhaps improved performance or better clinical outcomes. Money cannot buy friends. All it does is give you a better class of enemy.[9]

I am discussing characteristics and endeavors that begin early in our lives and usually last throughout our careers. Along with *scholarship* and *leadership*, another trait inherent in our profession is *courage.* "'Tisn't life that matters," one of Hugh Walpole's characters says, "'tis the courage you bring to it.'"[10] Most of us spend a lifetime in surgery and courage is a prerequisite, because in addition to boldness and acceptance of responsibility, courage means discipline and tenacity. To render the kind of service we provide as surgeons, our main asset is ourselves. The best surgeons do not forget their mistakes, and they compete mainly with themselves to get better every year. Try to be better than yourself. It is a lot more stimulating and rewarding than competing with colleagues.

As a hospital executive, I see, unfortunately, a decline in courage among doctors of medicine. Sometimes it is disguised as apathy, materialism, self-preservation, or moral mediocrity, or perhaps influenced by absence of collective spirit, the fear of change, the litigation juggernaut, or market destabilization.

Nevertheless, more and more throughout medicine, we fail to stand up for our principles. Appeasement replaces courage when physicians cower to accept fee schedules, rules, and regulations that are counterproductive to good medicine. Now is the greatest time for courage because we are threatened by a neo-socialism and do not recognize it. We are entering a period of regulation by fear and litigation in which fiction replaces fact. While the Washington rhetoric features market forces and emphasizes the private sector, instead, socialism is being reinvented quietly and medicine is the major target. The new budget and portability acts have secondarily funded intrusive, investigative, and intimidating bureaucracies. The food of these bureaucrats is paper and their blood is ink.

The wizard in Washington is trying to establish universal health care through regulations. Many well-intentioned people believe that our problems will be solved by government rather than by individual responsibility and self-sufficiency. An increasingly larger dependent population is gradually being enrolled into government health care.

Congress affects the legislative and regulatory requisites often unwittingly, because the members are uninformed. The legal profession may strengthen society, but writing regulations that affect science and medicine has not been one of their distinguished contributions. Few members of any congressional committee have enough background in technology, medicine, or science to legislate in this area, nor are they interested in acquiring such knowledge. In a technologically based society, this legislative climate of ignorance is inexcusable and potentially fatal. While American business achieves success through greater specialization, health care is being pushed backward toward general medicine. There is no possible protection from technology except by advances in technology.[11]

Yet, a very influential minority is intent on regulating good medicine out of existence by promoting atrophy of

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the private market. Once they have squeezed physician reimbursement, the regulators will turn to suppressing medical advancements at a time when we have an aging population, more prevalent chronic disease, and empiric treatments for life-threatening illnesses. No other profession faces the nationalization of a private enterprise.

So, what should we do? We know that open-ended inflationary funding is gone forever. Singular branches of medicine complaining to Congress tend to be uncoordinated and ineffective. The legislators already know what we are against, and none of it will help them get reelected. The problem is that no one knows what we are for. We need to make a positive case understandable to the American public. We can call this case the five freedoms of health care. One can easily double this list, but its a start.

The first would be freedom of a specialty to manage itself without being accused of protecting its guild. If work force studies indicate that we train too few or too many, or otherwise indicate a subspecialty maldistribution, it should be our business to change it.

The second is freedom of choice for patients and doctors, a freedom that has eroded over the past 20 years. Patients want the right to select their doctor and we must be their advocates. At the same time, the physician should be free to negotiate payment with the Medicare patient. As it stands, the penalty of expulsion is so severe that this option is untenable. No other profession is prevented from negotiating fees based on the ability to pay. The American Medical Association and The American College of Surgeons support decontrolling prices and allowing patients to spend their dollars to purchase health care services outside the Medicare program. Members of Congress and federal employees may contract privately outside their own Federal Employees Health Benefits Program. Why not Medicare?

Third, physicians should have the freedom to focus on patient care. Distractions to practicing medicine are increasing. We suffer documentation oversight from innumerable federal, state, and private regulators, all with different standards and requirements, largely established by anonymous bureaucracies with little or no knowledge of what they are regulating and little accounting of their activities. We are guilty until proven innocent.

The fourth is patient freedom from financial ruin. No one should become bankrupt taking care of an acute illness. Instead of regulations that often promote medical inefficiency and increased cost, Congress should legislate mandatory insurance for catastrophic illness—mandatory for those who buy insurance and subsidized for those who are truly disadvantaged.

The fifth is freedom from unrelenting pressure of capricious lawsuits. Liability reform should apply not only to medical malpractice but also to product liability and access to biomaterials. Incentive to sue can be reduced by placing limits on awards for noneconomic damages and, as other countries do, having the loser pay the court costs.

These five freedoms place the patient first and protect the specialty. Thoracic and cardiovascular surgery is ninth in size among 11 surgical specialties, which may actually be to our advantage for organization, standards, flexibility, and innovation. We are very progressive compared with other quaternary specialties. But our status requires unity and resolve. Historically, physicians do not organize well, but any splinter activity today would be poorly timed. This is the wrong time to have a house divided. We should not compromise our ideologies or our competitive spirit, but we have to start thinking politically to survive. Remember, you do not get what you deserve in life; you get what you negotiate.

We have 3000 active surgeons who can speak on these subjects. We need a coordinated information strategy to speak out on the value of the specialty and of medical and surgical achievements. We must provide perspectives about the value of specialty care, medical advances that affect quality of life, and the outstanding benefits of modern medicine. We are not against government, and we are realistic about the cost of today's health care and the pressure it brings to bear on employers, the government, and the individual. We need the public, payors, and patients to recognize that the length of training, the skill, education, and judgment required for highly technical specialty care, and its attendant responsibilities, are different from those of routine medicine.

This is a peculiar time: the brokers, the money changers, the payers are in charge, not the provider or receiver of health care. This is an incredible phenomenon. There is no parallel in law, architecture, the arts, other professions, or even in most industries. Commercialism in medicine is relentless and, if it persists, will erode trust between physician and patient, and economics will drive ethics even more than it does today.[12] Although profit in health care is essential to provide better services, running a strictly profit-maximizing corporation is different from a medical operation whose first priority is an obligation to the patient. Money is necessary for success, but it is not the reason for the enterprise.

When Henry Ford started his own company, he reflected on what he first learned about business,[13] "Thinking first of money instead of work brings on a fear of failure," he observed, "and this blocks every avenue and makes man either afraid of his competition

or afraid to change his methods. Yet, the way is clear for anyone who thinks first of service—of doing the work in the best possible way."

We have come a long way from that era. Today, the only thing that is not for sale is character. We need a united and effective voice to send a clear, forceful message to legislators and opinion makers. We need transforming leadership, with courage to fight for pluralistic health care. We need surgeons who are strong, on stage and off. The price of freedom is responsibility. Responsibility, first, for awareness of health policy and support for government relations initiatives in our specialty. All advice should be accompanied by a check. We are obliged to help solve hospital compliance dilemmas and to assess our new technologies. For the first time in our history, we have responsibilities in addition to patient care and research. For the first time in our history, we are indeed a fate-sharing vessel.

Most of us believe that medicine is not a commodity. Sooner or later, we will all be patients and we know that when we are sick, we do not want politicians, lawyers, or bankers to dictate the treatment. We want the best and most experienced doctors with the latest information to be responsible for our care—the best attainable quality for the lowest justifiable price.

"I am too busy to get involved," you say. "Just let me operate; this will pass by; the economy is good; the politicians can handle it. Besides, if l do anything, I risk my own security." Those who think this way are those in society who do nothing and always wait for things to get better. Let me tell you how wrong this is by giving you one apocalyptic story. In the late 1950s, the new Soviet Premier, Nikita Khrushchev, came to America. He met with reporters at the Washington Press Club. Since he did not speak English, the questions were written down and translated to him. The first written question was, "Today, Mr. Khrushchev, you talked about the hideous rule of your predecessor, Josef Stalin. But, Nikita Sergeyevich, you were one of Stalin's closest aides and a colleague during those years. What were you doing at that time?" Khrushchev's face turned red. "Who asked that? This is not signed. Stand up," he shouted. No response. Even louder, he screamed, "Who asked that question?" The audience was stunned, embarrassed, and silent. And after a pause, Khrushchev said, "You're very quiet. That is what I was doing."

We cannot safely ignore that anecdote. Our voices carry the authority of the present, but we are the temporary stewards of an ancient art. A good friend of mine once observed that surgery, like music and language, is a primordial enterprise of man.[14] It has no founder, no date or place of origin, and no recognizable pattern of growth. Born in the dim past of the human race, surgery has been synthesized over long centuries. This enterprise of thoracic surgery resembles a grand mansion with many large and sunlit rooms. At all times, parts of the mansion are under reconstruction, inspired by the hazard function of the occupants and other shifting episodes of human existence. The rebuilding is not possible without the preexisting structure. We are nothing without our predecessors, yet for the times we are obliged to be more. We have by now evolved from a mechanical art to more than an intermediate science, and with each advance the enterprise has been more satisfying for patients and doctors. And the drama is still unfolding.

There is no technical field today ahead of thoracic and cardiovascular surgery—no surgical field in which science is moving as fast. In fact, The American Association for Thoracic Surgery was established to investigate and to reach and verify conclusions from true and useful research, without fear or favor. Investment in science is the single best bargain in America today because it serves mankind like no other endeavor. This medical profession, this marvelous surgical specialty, provides a vantage point from which we can see and even participate in change, participate in scientific discovery, and in accelerating progress. If that were not enough, we actually help people. We are part of a real humanism that has few equals.

I have now almost finished these metaphorical associations of *scholarship*, *leadership*, and *courage* that relate to Master Surgeon Paré's passage, *the first living and last dying*. In closing, I wish to address one more attribute, and that is *faith*, a phenomenon that profoundly affects our surgical careers. Faith tends to begin early and often develops further during our professional lives, and it is probably the last to die, if it ever does. Faith is deeply personal and variable and hard to explain. But there is a common faith that we as doctors share. I conclude my remarks today by describing faith as I believe is best written by a great surgeon, Dr. George Crile, Jr, in his autobiography.[15]

> No physician, sleepless and worried about a patient, can return to the hospital in the midnight hours without feeling the importance of his faith. The dim corridor is silent; the doors are closed. At the end of the corridor in the glow of the desk lamp, the nurse watches over those who sleep or lie lonely and wait behind closed doors. No physician entering the hospital in these quiet hours can help feeling that the medical institution of which he is part is in essence religious, that it is built on trust. No physician can fail to be proud that he is part of his patient's faith.*

Thank you for this honor.

*Crile G Jr. The Way It Was. Kent [OH]: Kent State University Press. 1992. Reproduced with permission.

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