

Presidential Address

Reaffirmation of fealty— To serve all

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Washington, DC

I want to express profound thanks to my colleagues, Fellows of the College, for the high honor given me to serve as the 76th President of the American College of Surgeons. This honor makes me realize the great responsibility this office imposes. I accept the responsibility and its accompanying challenges and pledge to do my best to uphold the high standards and traditions of the College. Although this is a great personal honor for me and gives me the opportunity to give further service to the College, this occasion symbolizes much more than that. It also serves as a catalyst that I hope will lead to increased diversity in College activities, which can only add to our strength, commitment, and dedication. It is with great pleasure that I welcome the 1,682 new Fellows of the College to participate fully and actively in College activities. My comments are directed to the entire Fellowship but especially to you—the Initiates of 1995.

At the 48th Convocation Ceremony, which occurred on October 8, 1964, during the 50th Clinical Congress in Chicago, my friend and colleague, Edward E. Cornwell, Jr., MD, FACS, and I, marching together in the procession, became Fellows. James T. Priestly, MD, FACS, became President. In his first official act as 45th President of the College, he told the 1,160 assembled Initiates that “one of the prices that you must pay for gaining Fellowship in the American College of Surgeons is listening to the Presidential address. Happily for you, this is your last requirement for admission to Fellowship.”¹ And I must add—perhaps unfortunately for you—31 years later this requirement remains.

Although it is not usual in a Presidential Address to mention one’s parents, I feel impelled to do so this evening. My mother and father grew up on farms—my father in East Texas (Elysian Fields near Marshall), and my mother in northern Alabama (Gurley near Huntsville). Both attended one-room schools until the eighth grade. Then, because of their great desire to receive an education, they both left their homes to finish high school and college and subsequently became teachers and principals in public schools (father—high school, and mother—elementary school). As parents they emphasized that with a good education and

hard work combined with honesty and integrity, there are no boundaries. My presence here this evening gives credence to their principled beliefs.

I owe so much to so many people and am especially pleased that my family, friends, and colleagues are here tonight. Their support and encouragement have been crucially important to me during the course of my career. I, too, have fond memories of my association over the years with colleagues in several surgical and oncologic societies. Although surgery is a demanding profession and we have major obligations to our patients, I urge the new Initiates to find—indeed, to make—time to spend with their families and friends. Having strong interpersonal relationships is essential for a fulfilling and enjoyable life.

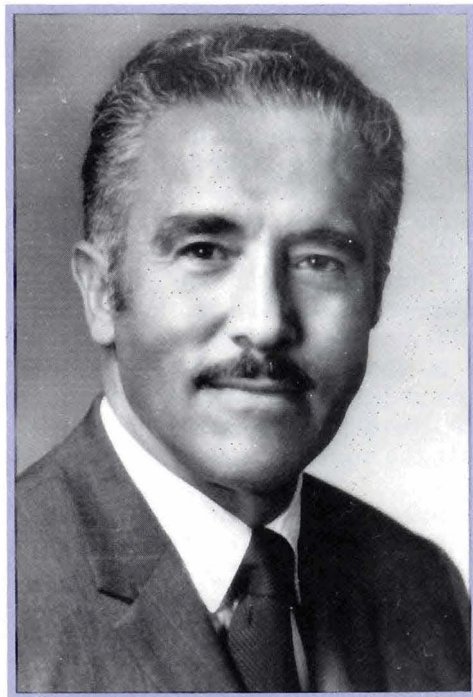
I am particularly cognizant of the wonderful teachers I have had over the years and am steadfast in my belief that it is an honor to be a teacher. The role of teachers is to instruct, to inspire, to stimulate, to stretch the imagination, and to expand the aspirations of others. Their impact on my life has been incalculable. On occasions such as this, prudence dictates that no mention be made of specific teachers because egregious oversights can occur. But with your permission, I shall flout tradition and name a surgical teacher who had a major influence on my general surgical training at Freedmen’s Hospital (now Howard University Hospital). In recognizing this teacher—Burke Syphax, MD, FACS (a member of the surgical faculty for nearly 60 years), whom we call with respect and admiration Master of the Abdomen—I pay tribute to all of my teachers from my public school days in Quincy, FL, to the present who have given me knowledge, inspiration, and support over the years (see photo, p. 13). When one observes Dr. Syphax evaluating a patient with a difficult abdominal problem, you can differentiate his true radiance from the penumbra of others who are often found wanting. There is no surgical teacher from whom I have learned more. My almost half-century association with him has been one of the most enriching and rewarding experiences of my professional life. I am particularly

honored that he, now approaching his 85th birthday, is present here tonight.

The National Medical Association (NMA) celebrated its centennial this past August in Atlanta—the city of its founding in 1895. Daniel Hale Williams, MD, FACS, of Chicago, a founding member of the NMA, was inducted into Fellowship in the American College of Surgeons in 1913, the year of its founding.² The surgical community is indebted to Claude Organ, MD, FACS, and Margaret Kosiba, RN, for chronicling the contributions of NMA members in their classic book *A Century of Black Surgeons—The USA Experience*.³ As a member of the Surgical Section of the NMA—my first membership in a surgical organization—I recall with pride the great support I received from the two Directors of the College with whom I have worked most closely—C. Rollins Hanlon, MD, FACS, and Paul A. Ebert, MD, FACS. With no desire to become maudlin or treacly, I simply want to record the fine spirit of cooperation these two surgical leaders have shared with me. Just as the Surgical Section of the NMA spawned me, various Fellows have other organizations to which they have allegiance, and their views and ideas must be heeded by the College. Diverse surgical groups meet during the Clinical Congress, recognizing some common bond or theme that binds them into a functioning cohesive unit. What is most important, however, is that they all are members of the College and eager to participate in College activities.

For me to give this address and not speak about the Great Mace would be an act of rank impertinence. My relationship with the mace seems primeval. I feel a certain filial gratitude toward it and a furtive sympathy for those who have yearned to clasp it—even for a moment. My words about this historic emblem represent an act of fidelity and a testament of respect.

In 1983, the Board of Regents made the decision to commission a new reproduction of the Mace that would be carried in the procession during the Convocation Ceremony. The project was completed in June 1984. As the newly elected Secretary of the College in 1983, I had the



Dr. Burke Syphax

honor to carry this mace in the 65th Convocation Ceremony in San Francisco—an honor that was my privilege for nine years (1984-1992). Having had the opportunity to be its proud bearer on these occasions has been a moving experience and one that I shall never forget. Recognizing what the Mace represents is humbling to me—surgical history is implicit in its resplendent elegance.

The mace was a gift to the American College of Surgeons from 54 British surgeons who had worked side by side with their American counterparts during World War I and with whom they shared a dedication to high ideals. It was designed to symbolize the ties that unite Great Britain to the United States and Canada and to represent the close union that exists between British and American surgery. The presentation committee consisted of Sir Berkeley Moynihan, KCMG, CB, of Leeds, England, as its chairman; Sir William Taylor, KBE, of Dublin, Ireland; and

Albert Carless, CBE, of London, England (see photo, p. 15).^{4,5}

Berkeley George Andrew Moynihan was chief of surgery at Leeds, born without advantages, but with high intelligence and great dexterity of hands; by application, charm, and hard endeavors, he made himself the person of his times who embodied the art and science of surgery—especially surgery of the abdomen. He made his presence felt in any company. The force of his personality commanded attention and his charm of manner when he wished—and he usually did—was virtually irresistible. Having been knighted in 1912, he was elevated to the peerage in 1929, the first surgeon since Lister in 1897, and only the second surgeon in history so honored.⁶

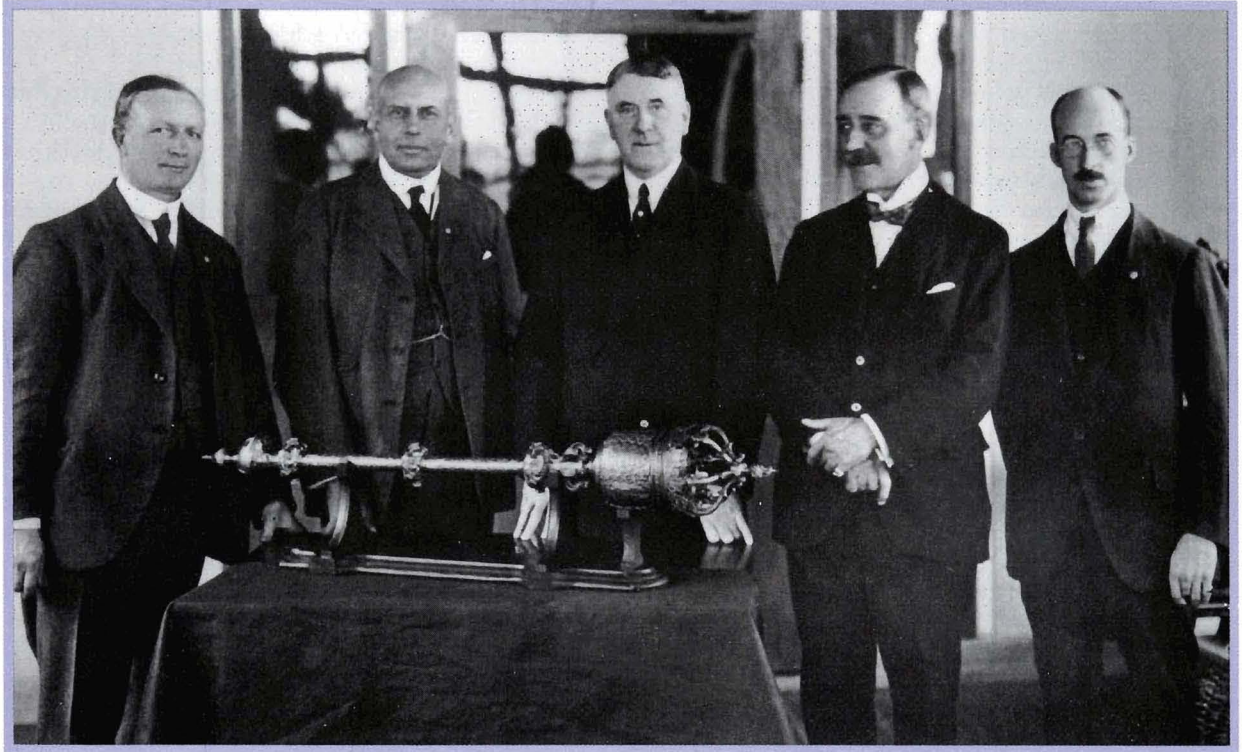
The mace was presented by Sir Berkeley Moynihan to the then-President of the College, George E. Armstrong, MD, FACS, professor of surgery at McGill University and surgeon-in-chief of the Royal Victoria Hospital during the College's annual meeting in Montreal on October 15, 1920. Accompanying Dr. Armstrong on this occasion was Dr. Francis A.C. Scrimger, a staff surgeon at The Royal Victoria Hospital, who was the winner of The Victoria Cross in World War I, which is the highest award given in the British forces for outstanding valor. The dedication inscribed on the mace reads: "From the Consulting Surgeons of the British Armies to the American College of Surgeons, in memory of mutual work and good fellowship in the Great War, 1914-1918." The mace was a symbol of that shared devotion to eternal principles, love of justice, joy in liberty, and hatred of oppression. Moynihan also stated, "We pray that you may regard it as a symbol of our union in the harsh days of trial; as a pledge of our devotion to the same imperishable ideals; as a witness to our unflinching and unchanging hope that members of our profession in the two lands shall be joined in brotherhood forever in the service of mankind." In accepting the mace, Armstrong replied, "The scientific fire represented in this gift welds together another link in the chain that shall forever bind us together in the great work of promoting the highest possible standards of surgery as well as peace and good will among men."⁴

Just as the lower portion of the head of the mace is decorated with a band that is intended to symbolize water or the ocean that both unites and separates America and Great Britain, the various surgical specialties of the College are separated to pursue specific specialty interests but united in their goals to provide the very best in patient care. Working together for common goals is the essence of what the College represents.

Each year the mace is carried before the Fellows. It was borne by a senior noncommissioned officer from one of the U.S. Armed Forces who was arrayed in full dress uniform, complete with medals, until 1953, when that duty was shifted to the Secretary of the College as being more collegial than military. Today when I see the Secretary bearing the Great Mace and leading the annual procession at the Convocation Ceremony, I experience some withdrawal symptoms and a simmering yearning for days bygone, knowing this honor once was mine, yet content and serene knowing that you—the Fellows of the College—will ensure the continuation of this noble tradition.

Many colleagues have spoken eloquently and continue to speak about the concerns that have relevance for surgery such as health care reform, professional liability, quality assurance, graduate medical education, alternative health care delivery systems, AIDS, fragmentation, physician reimbursement, and turf problems. We must continue to speak out forcefully and pragmatically on these and other issues so vital to our Fellows and our patients.

Education of Fellows for the benefit of our patients is the prime reason for our existence. The interdisciplinary nature of the educational offerings at the Clinical Congress remains an integral part of the annual program and ranges from an examination of advanced surgical techniques to consideration of the most sophisticated computer-assisted devices. These and many other programs and services the College offers surgeons are the magnet that will bring more qualified surgeons into Fellowship, surgeons we are proud to represent. Educational, socioeconomic, and



Principal surgeons involved on the occasion of the presentation of the Great Mace to the American College of Surgeons in Montreal, October 15, 1920. Left to right: Sir William Taylor, Dr. George Armstrong, Sir Berkeley Moynihan, Mr. Albert Carless, Dr. Francis Scrimger.

membership services of high quality are of direct value to Fellows and make Fellowship more attractive.

The Washington Office of the College plays a major role in representing the socioeconomic interests of the Fellows. The College has always supported universal access to high-quality care for all patients. Financial issues related to access must be addressed and solved by public and private interests as well as by physicians and surgeons. Many of the patients served by our Fellows are uninsured or underinsured. As surgeons, we will continue to serve this population while being involved as much as possible in legislative efforts to correct this inequity for these citizens. Traditionally, surgeons have provided free care for poor and economically disadvan-

tagged people. This exemplary paradigm of surgical tithing must be maintained.

My practice and research interests are devoted primarily to surgical oncology. I am proud to be a member of this specialty and of the training I received at Memorial Sloan-Kettering Cancer Center. However, I am first and foremost a general surgeon—a member of that great discipline, general surgery, that forms the foundation of all surgery and which must be preserved. General surgery is now recognized as one of the four so-called stress specialties (the others are physical medicine, geriatric medicine, and psychiatry). The 1989 report from the American Medical As-

sociation's Council on Long-Range Planning and Development noted that, while a 6 percent increase in the number of general surgeons is anticipated by the year 2000, a 16 to 19 percent increase in the projected use of general surgical services is predicted.^{7,8} Speaking of the importance of general surgical training for the surgical specialties, James Snow, MD, FACS, an otorhinolaryngologist and former Regent of the College, stated, "The discipline of general surgery remains the unifying force in surgical practice, education, and research, upon which all of the specialties in surgery depend."⁹ This powerful statement places general surgery in proper perspective.

The Surgical Resident Masterfile was initiated by the American College of Surgeons in 1982, and surveys have been conducted annually since that date. The masterfile contains current and historic information on all physicians enrolled in accredited surgical residency programs in the United States, regardless of their country of origin or their ultimate medical specialty. The information collected in the survey includes: surgical specialty, curricular year in training, institution sponsoring the residency program, gender, citizenship, name and location of medical school attended, and year of graduation from medical school.

The total number of residents enrolled in surgical residency programs has remained the same since this study began in 1982. Variation within the study period has been small (4%). Numbers of residents in general surgery and urology have declined slightly, and other surgical specialties have shown small increments of growth. For example, there were 8,683 general surgical residents (834 women) in 1982-83 versus 7,788 (1,206 women) in 1992-93, a decrease of 895 positions in the 11-year period. The percentage of women in general surgical residencies increased from 14.5 percent in 1982-83 to 22 percent in 1992-93.¹⁰ In his thoughtful and reflective 1990 presidential address to the American Surgical Association entitled "Who Killed General Surgery?", John Mannick, MD, FACS, concluded that, "Although there were problems, general surgical training is still alive and well in our

country, and the American Board of Surgery and the Residency Review Committee have a reasonable chance of keeping it that way."¹¹

Responding to the voiced concerns of the Fellowship, the College has made great strides in its representation of general surgeons with its expanded Advisory Council for Surgery, which speaks with vigor and authority for general surgery within the College ranks and externally before congressional committees and other groups such as the Physician Payment Review Commission (PPRC), AMA/Specialty Society RVS Update Committee (RUC), and the Health Care Financing Administration (HCFA).

The Spring Meeting of the College is devoted to general surgery—a major plus for the general surgeon. In addition, the College has: (1) revised and expanded CPT codes for general surgery; (2) recommended the creation of committees on (a) emerging surgical technology and education and (b) informatics; (3) received input from general surgeons nationwide through the Group of 100; (4) assessed the role of the general surgeon in health care reform; (5) studied adequacy of surgery in rural areas; (6) provided regular reports of interest to general surgeons in the *Bulletin* and in *General Surgeon News*; (7) sponsored seminars on CPT coding for general surgeons and on managed care; and (8) supported granting of privileges in endoscopy, critical care, and vascular surgery to general surgeons with adequate training. All of these actions by the College are laudable and are continuing. However, we must not become complacent with what we have achieved but must maintain and enhance this robust dynamic posture in order to further strengthen the fundamental discipline of general surgery. It can be stated with assurance that the measures the College has instituted do augur well for general surgeons. It also must be noted that the College has undertaken and maintains many similar activities for its Fellows in all of the other surgical specialties. This is as it should be because the College has the obligation to represent the entire Fellowship with the same dedication and commitment.

The College's Fellows Leadership Society pro-

vides monies to expand our scholarship and fellowship programs, helping to fund bright young scholars to allow them to pursue research activities early in their careers. Support for funding scholarships, fellowships, and research career development awards can pay handsome dividends that may have enormous benefit for improved patient care.

Surgical research remains important—it is the constant search for new knowledge and the expansion of old knowledge. Candor in research is essential. Speaking of truth brings to mind Roger Bacon (1214-1296) of Oxford, a philosopher of encyclopedic knowledge. In his *Opus Majus*, Bacon anticipated the methods of modern science and experimentation and enumerated four stumbling blocks to truth: (1) the fragility of unworthy authority; (2) the inherent error of undisciplined observation; (3) the influence of custom or popular prejudice; and (4) the concealment of ignorance in a display of apparent wisdom.¹² Cognizance of these principles can aid researchers in their studies, for dishonesty is antithetical to the very basis of scientific endeavor. Surgical research can, and must, be conducted in an honest manner.

High ethical standards have always been an integral part of the College's philosophy. The ethical issues confronting the Fellows have become more numerous and amorphous, often defying "right and wrong" answers. In addition to providing high-quality surgical care, we must listen to our patients and to the entreaties of our conscience to make the best decisions for our patients.¹³

As the seminal force in the founding of the American College of Surgeons, Franklin H. Martin, MD, FACS, despite sometimes great odds, forged an organization of leading surgeons that has assumed the role of primacy in surgical education, practice, and ethics in our country and with influence that extends throughout the world. He was prescient in his belief that such a group of surgeons was necessary—even vital—if surgery were to be elevated to a level commensurate with its responsibility to its patients.¹⁴ We must never forget the role of so many leaders

who were major participants in the early success of the College. C. Rollins Hanlon, MD, FACS, spoke eloquently of these contributions during the Clinical Congress opening ceremony in 1988.¹⁵ In attempting to recapture the past, we are not trying to do so in some idealized way, to make things what they never were or to escape the trials of today. Rather we are looking instead for a common theme that will render us even better able to serve our patients.

As Fellows, we must do all we can to ensure that the College represents all surgeons. The 94 Chapters (67 in the United States, 2 in Canada, and 25 foreign) of the College play a vital and perhaps the most important role along with the different advisory councils in encouraging participation of all specialty groups. Strong liaisons between the 19 Regents and the 258 Governors are essential for the Governors play a major role in expressing the concerns of the Fellows. This close relationship must be maintained. The College is the official body that brings us together, forges our future, and binds us one to the other—representing all of our concerns and desires. As surgeons we are inextricably bound, and, thus, we should act for the common good of our patients, recognizing that different specialty opinions must be heard, discussed, and acted upon. But above all, after our deliberations, we must remember that the College represents all surgeons and their views.

The Congress is currently working on a plan to reform the Medicare program, motivated, at least in part, by the projected insolvency of the Medicare Part A Trust Fund. The trust fund is the portion of the program that is responsible for paying for hospital and nursing home—but not physicians'—services. Moreover, under the current budget resolution, Congress must identify \$270 billion in Medicare savings over the next seven years. Some of these "savings" are likely to translate into reduced Medicare expenditures for physicians' services and physician training programs. We also hear about growing Congressional interest in providing more choices for Medicare beneficiaries beyond those that are available under the traditional Medicare program.

However, Medicare's physician payment policy is not the only area of concern. Policymakers also seem inclined to reduce Medicare payments for graduate medical education—the major source of Federal funding for physician training programs. This plan is motivated by concerns about the Federal deficit and the excess supply and specialty maldistribution of physicians. However, even today, Medicare does not pay its share of the full costs of many surgical residency programs, because full Medicare funding is limited to a maximum of five years (with Medicare paying only half of its share thereafter), while it takes years longer to train many types of surgeons. Now there is talk of further reducing Medicare payments for residency programs lasting more than five years. The American College of Surgeons supports the concept of limiting the number of physician residency positions and setting broad goals regarding the number of generalists and specialists to be trained. However, the College has repeatedly insisted that any mechanism for addressing physician supply issues must explicitly include a policy of adequate funding for all residency positions through the entire course of the training period. Instead, the Congress now seems poised to adopt a policy that may encourage an arbitrary and possibly less optimal training period for surgeons.

Congress is discussing mechanisms for providing more choices for Medicare beneficiaries. However, in many cases, these choices could mean reduced access to specialty or surgical services and limited choice of surgeon. Already, many of the kinds of health plans that Congress wishes to make available to Medicare beneficiaries make use of gatekeepers, generalist physicians, or non-physician primary care providers who essentially control patient access to the services of medical and surgical specialists. Many of these plans require patients who make it past the gatekeeper to select from a limited number of surgeons and other specialists. Further, given their age and health status, Medicare beneficiaries may well need greater amounts of surgical and other specialty care than the non-Medicare population. Thus, it would not seem prudent for the Congress or the Administration to adopt policies that would reduce Medicare beneficiaries' access to surgeons and other specialists.

My point with these comments is not to take issue with policymakers' interest in meeting the health care needs of all Americans or in reforming Medicare. Instead, I believe that some balance must be restored to these discussions, lest we find ourselves creating new problems, or imposing inappropriate—presumably unintended—barriers to the receipt of surgical services and other kinds of health care. The American College of Surgeons stands ready to work with the Administration and the Congress to address a wide range of health policy concerns. We fully intend to play a constructive role, in the same way we did a few years ago during consideration of Medicare physician payment reform. At a time when no other major physician group would support Medicare expenditure targets, we endorsed the concept as a means of addressing concerns about the volume of physicians' services. Our recommendations were ultimately adopted in the form of Medicare volume performance standards (MVPSSs).

The College continues to support the concept of performance-based incentives to restrain growth in the volume of services provided to Medicare patients; we also continue to support separate MVPS and fee schedule conversion factor for surgical services. However, we have made it clear to policymakers that, *if they are intent on establishing a single fee schedule conversion factor, such a policy change should include a transition period in order to minimize disruptions to surgeons and their patients.*

The surgical community intends to do its best to respond to policymakers' concerns and to improve the quality of care that is available to our patients.

Practice patterns are changing and new health care delivery systems, such as managed care, are being developed with astonishing rapidity. The College has provided surgeons and their patients with information that can help them deal with this new environment.

In December 1994, the College published in the *Bulletin* a "Statement of Recommendations to Ensure Quality of Surgical Services in Managed Care Environments." That document sets forth

the College's recommendations for ensuring that high-quality surgical care is maintained in managed care systems through proper documentation and data collection to be used in measuring outcomes, the quality of life, and patient satisfaction. The statement also recommends that surgeons participate in training primary care physicians to make timely referrals, and that surgeons serve as the patient's advocate to ensure prompt access to the appropriate range of surgical care.¹⁶

In January 1995, the College published a statement in the *Bulletin* entitled, "Statement on Managed Care and the Trauma System." That statement sets forth certain principles regarding patient transfers, reimbursement, continuity of care, data collection, and other issues that trauma systems and managed care systems should agree upon to ensure the best possible trauma care.¹⁷ Since 1993, the College has offered and continues to offer managed care workshops to help surgeons learn how to cope with the increasing prevalence of managed care.

In early 1995, the "Group of 100" (chosen largely at random from Fellowship rosters of the states and with particular emphasis given to selecting general surgeons in small communities and rural areas) met with the College's Advisory Council for Surgery and expressed great concern about interference in their practice in the managed care environment. They believe that surgeons must become more knowledgeable about managed care contracts in order to maintain high quality care for the surgical patient and to retain the honored bond between surgeons and their patients. Further, some surgeons have found themselves excluded from participation in these managed care groups. While it is not the role of the College to serve as arbiter for local problems, conflicts, and disagreements, the College does maintain the moral, if not the legal, imperative to give its imprimatur on behalf of the Fellows to ensure that all are treated fairly.

With the multiple and often complex issues constantly facing the College, maximum participation by the Fellows is necessary for its strength and survival. The College has a continuing commitment to involve all segments of the Fellowship in College activities and must be vig-

ilant in seeking new ways to use the broad range and vast array of talents that exist in the women and men within its Fellowship. The initiation several years ago of the Young Surgeons program was a positive effort in this regard. To do our job well, we must foster the concept of maximum Fellowship participation.

I emphasize that the College must continue to make a concerted and sincere effort to identify the talented men and women who comprise the Fellowship and can help us confront the multiplicity of problems facing our profession today. These Fellows are already in our midst, and we must find them. With such action, the College emphasizes the role of diversity in its ranks. Furthermore, the time will come, as come it must, when a group of Fellows will be waiting to talk with the President of the College to discuss some business issues. As the Fellows are being ushered into the conference room, the secretary will announce, "The President has just arrived. She will see you now."

As Fellows, we plight our troth to surgery. We are most confirmed in our love for this noble and honorable discipline when there is a reaffirmation of fealty to the principles upon which the College was founded in 1913—dedicated to the ethical and competent practice of surgery and the provision of high-quality care for the surgical patient. Fellowship in the College is ennobling and has a certain allure and talismanic prestige, but duty, accountability, and responsibility with great obligations to our patients and our profession accompany this privilege. Problems facing the College must be confronted boldly. We will make some mistakes, sometimes grievous ones, but we must never err in our purpose and our resolve—always maintaining the requisite faith to do what is best for the patient. Respect and trust are not given in perpetuity but must be earned each day of our lives. We must avoid the inertia of the discontent that resembles some insidious illness gnawing at our souls and eroding our spirits.

We must continue to have a noble vision undefiled by sentimental thoughts of the good old days, for those are times bygone. While cognizant of the past, we must plan for the now and the

future, for these are changing and exciting times for us and surgery remains an honored profession. We must be able to elicit something that is obvious to discerning observers, and that is a seriousness of purpose in our actions—which, when it is not a mood but a passion, is a formidable force.

We must always give our patients the best possible surgical care. In addition, we must be involved in the political arena in surgery, but we must never forget our responsibility to our patients, for when they present themselves to us for care, we must meet the challenge. We must maintain the necessary skills and knowledge to render the best care possible. As Fellows of the College, we have a continual need to commit ourselves to excellence, and, having done so, we must expend all efforts to achieve this goal. Goals can be achieved consistently only when they have been defined. We should be willing to compromise to reach our goals but we must never compromise on principle. This concept must remain inviolate.

We should reject the thesis of health care providers who give health care to “clients” or “customers.” We are surgeons, and we treat patients. There is no closer, more reverent, or more honored bond than the one that exists between surgeons and their patients.

In caring for their patients, surgeons must be mentally and physically robust to give the best patient care. We must have physical stamina, emotional intensity, and mental acuity. One of the most avidly sought and highly elusive qualities for the surgeon is impeccable judgment—arguably the highest accolade that can be given to the clinical surgeon. Making the correct decision represents a delicate amalgam of intelligence, knowledge, experience, analysis, and restraint. For surgery is much more than a technical and cognitive exercise, and these are important—it is also a discipline to be lived.

I have spoken of several topics this evening and want to emphasize five of the most important ones for the College that will help define our mission as surgeons in the increasingly challenging days ahead: (1) To work with the Congress and the Administration on a wide range of health policy concerns, including Medicare reform; (2) To assist surgeons in making the managed care sys-

tem responsive to the needs of patients and surgeons, thus ensuring the highest quality surgical care; (3) To maintain the integrity and viability of general surgery—that fundamental discipline that forms the basis of all surgery—while at the same time representing all other surgical specialties with equal fervor and concern; (4) To identify the many talented Fellows—men and women in the Fellowship—and increase their involvement in College activities; and (5) To use the moral force of the College, when applicable, on behalf of the Fellows in their quest for just and fair treatment. The College has done much in these areas, as the record will show. I am suggesting that we must continue to be active in these areas and do even more.

We must never forget that the object of our affection is the surgical patient. If we ever forget that, then this Convocation Ceremony and Clinical Congress will amount to naught, because it means we will have forgotten the most important person—the patient. As we gain more experience in our profession, the romance of the neophyte tends to dim, and what we can and cannot do are brought into sharper focus. It is with this realization that we know how important it is to give our patients hope, not some unrealistic hope, but a hope that is realistic because almost always there is something that can be done to make a patient better. And when you grant patients hope, you grant them one of the greatest of all human joys, and that is the joy of anticipation—that perhaps, just maybe, there is something that can be done to help them.

As we go about our work, it is important to maintain something the Romans called *gravitas*—stamina, patience, and judgment. Also important in our actions is that high standard of surgical discipline, equanimity under duress, which will allow us to maintain the requisite tranquility to give our patients the best possible care. As a surgeon treating patients, I have seen the human condition in peril; I have seen the stubborn persistence of hope when under ordinary circumstances there should be no hope; I have seen patients who seem to regard life as a divisive and fractious experience devoid of hope

and dream; I have seen an exhibition of faith that comes from those of strong moral fiber; I have seen the anguished eyes of patients that seem to ask questions with the dignity of mute entreaty; I have seen the desolate faces of patients shorn of the pretense of better days ahead; and I have seen demonstrations of courage that defy description. And when I see these things and more, I know that I must be more caring, more sensitive, and more compassionate toward those patients who are committed to my care. And perhaps for surgeons, Sir Berkeley Moynihan stated it best when he said, "Surgery after all, is an affair of the spirit; it is a fierce test of man's technical skill sometimes, but in a grim and long fight, it is above all a trial of the spirit; and there are few things that cannot be conquered if man's heart is set on victory."¹⁸ And our hearts are set on victory.

As we come to the end of this 79th Convocation Ceremony and 81st Clinical Congress, it is time for a reaffirmation of fealty to the principles we hold dear and to be ever mindful of the creed emblazoned on the College Seal—"Omnibus per artem—fidemque prodesse" (To serve all, with skill and fidelity). May it remain so forever. Ω

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