

Challenges

by *Henry T. Bahnson, MD, FACS, Pittsburgh*
President of the American College of Surgeons

It is an impressive sight to view from this vantage point a large percentage of the nearly 1,700 newly initiated Fellows of the College and the wives, families, and friends who have helped to make possible your initiation into this Fellowship of Surgeons. My congratulations to you all! It is mainly to you that my remarks are directed.

It is awesome and sobering to recognize my obligation in the coming year to uphold the traditions of the College on the foundations laid by my distinguished predecessors. Election to this office was a surprise to me, but I am truly grateful. From my personal association with the College for the last 30 years and from lessons learned even earlier about the College through my preceptors, I know that uncommon good fortune allows me to address you as President.

As Fellows, the College expects you to participate in its affairs as we pursue our common purpose: to raise the standards of surgical practice and improve the care of the surgical patient.

The College has always faced the problem of maintaining leadership sensitive to the needs and voices of its many constituents. There is special concern for the young surgeons who are the future leaders of the organization. Addressing these needs has been made more difficult as surgery has been fragmented and as new techniques and knowledge have resulted in superspecialization.

The final authority of the College is entrusted to 18 Regents who are elected by the Governors and represent surgery in all of its areas. The President constitutes the nineteenth Regent. I have not been a Regent until now, but I have been privileged to attend Regental meetings for three years as a College officer. This has provided me with a somewhat peripheral view of the workings of the Board of Regents, even though the opinions of officers and staff are sought and considered. Final decisions are made by the Regents and that is where the buck stops.

Occasionally an officer who has been a Regent might have to be reminded that he no longer has a vote. I relate this not to complain that I have been excluded from voting on final decisions but rather to express faith in this oligarchic approach to the challenge of managing an organization of more than 46,000 surgeons. Knowing the individuality of surgeons as you and I do, one might think the task impossible at first blush. But a large measure of the success of the College resides in the characteristics of the Regents as practicing surgeons, recognized leaders in their field, officers of their respective specialty societies, and writers of foremost textbooks in their specialty, and above all the salient fact that no one of them campaigned for office. This fills one of Plato's requirements for the best government, that officials should be those who do not seek office.

Although the final authority of the College rests with this compact group, every effort is made to obtain input from Fellows and to foster wide involvement of Fellows in College affairs. I urge each of you to become involved through your local Chapter, the Governors, the more than 300 committees, and the annual Clinical Congress. No matter how great your contribution, I am sure that you, as I, will get more from the College than you give to it.

No small measure of the success of the College is due to the dedicated staff who are constantly meeting challenges and striving for excellence. I have worked under or with the Director of that staff, Dr. C. Rollins Hanlon, for 37 years. I hope you will permit a short digression about him. One of my earliest experiences with him involved a paper that was important to me, on which, after doing my best, I asked him to comment. It came back so overwritten with red ink that I could not see the black. On this Presidential Address, after many years, I have savored again the mixed sensations of Rollo's incisive editing. His Jesuit education and erudition and his wisdom and perception are evident in the Director's Memos, which appear regularly in the *Bulletin*. At every meeting of the Regents, a dic-

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tionary is available to be sure he is correct in his often esoteric usage of language. To date, Rollo hasn't been tripped and is batting close to 1,000.

Defining the challenge

Webster gives a number of definitions for "challenge," the title of my address. It is a calling to account or calling in question; an invitation to engage in a contest; a summons to action, or effort; medically, it is the substance or act that calls forth the body's defenses; in hunting, it is the opening and crying of hounds at first finding the scent of their game; militarily, it is the examination of one who attempts to pass proscribed lines; politically, a claim that a vote is invalid.

The special meaning that I use is found only in more recently published dictionaries, that is, more recent than my college and medical school ones, because the word has acquired a new, subtly different meaning: The quality of requiring full use of one's abilities, energy, or resources. This definition casts a different light on the meaning of the word "problem," which is something thrown forward for solution. Challenge thus is viewed as a stimulus calling forth the best and highest. It is this meaning that I intend in my title.

Twenty years ago when I accepted my present position at the University of Pittsburgh, I recognized, as have many of you in your own niche, that I was settling down to do a job for which I had been preparing. Initially, I felt overwhelmed by problems at hand. Later, it seemed more helpful to view them in another light more attractive to a surgeon's temperament. So I began to speak not of problems but only of challenges.

To illustrate a facet of challenge, let me comment on an experience that I recently shared with a Regent, Bill Donaldson, and the new Second Vice President, Ben Eiseman. This experience was an expedition with some younger men who were facing what they considered one of the great remaining challenges on the earth. To them, this was not a

problem but a challenge to bring out their best effort. It was to climb Mt. Everest from its unclimbed and virtually unexplored east face in Tibet.

Socioeconomic challenges

My thoughts were winnowed and part of this address was written during that time. I plan to use a few vignettes of that experience as I speak about more serious socioeconomic challenges facing the College and facing you as practicing surgeons.

I will speak about several interrelated issues: control, compensation, and competition. I consider these major challenges calling forth our best effort.

One of the oldest and most important accomplishments of the College has recently been threatened by action of certain commissioners of the Joint Commission on Accreditation of Hospitals (JCAH) who represent the major voting blocs in the JCAH. They circulated proposed standards for hospital staffs that would have removed the distinction between fully licensed physicians and limited licensed practitioners. These changes were proposed because of a fear of litigation alleging restraint of trade. The effect upon patient care, implicit in the inclusion of limited licensed practitioners in the hospital staff, was recognized and acted upon by the College's Director, Doctor Hanlon, and by the Regents, Governors, and many Fellows.

As a result of challenging the proposed changes, alerting and informing the physicians through leaders of the College, and repeated warnings in the Director's Memos in the *Bulletin* of the College, a groundswell of opinion developed among the membership of the American Medical Association. To date, this strong force has prevented acceptance of the proposed changes. However, the challenge remains because new proposals have been written and sent out to the profession for review. These revised proposals leave to each hospital the decision about admitting privileges for limited licensed practitioners and even allow some hospital privileges for individuals not on the staff. This appears to diminish

the onus on JCAH for restricting the privileges of limited licensed practitioners, but it increases sharply the potential legal exposure of the individual hospital.

The challenge to the American College of Surgeons has increased because the American College of Physicians has reluctantly elected not to press for maintenance of standards to the same degree as our own College. The Board of Regents has unanimously recommended that the College and the Fellows continue to oppose the proposed changes now being circulated for comment.

Compensation and competition

Perhaps I am unduly concerned about challenges related to compensation and competition, but a few events that have occurred in Pittsburgh recently reflect the situation elsewhere in the nation and make me believe that we have begun a new era in the practice of surgery.

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First came prospective payment to hospitals for Medicare beneficiaries, which is based not, as in the past, upon cost or charges (which are different) but rather upon assignment to one of over 400 diagnostically related groups (DRGs) for which a fixed sum is to be paid. Congress has been asked to adapt the same DRG principle to payment for professional care by 1985.

Second, the Pittsburgh Program for Affordable Health Care was formed by major industry, the medical profession, Blue Cross, unions, hospitals, the university, and the community. The stated goals

of the group are to reduce inpatient utilization by ten percent and to decrease by 800 beds the area's medical and surgical bed capacity. Note that government is not involved, but industry, providers, and payers are.

Third, trustees of Presbyterian-University Hospital, the central teaching hospital of the Pitt medical school, hired consultants to assess the advisability of establishing a Preferred Provider Organization (PPO) to offer discounted services, professional as well as institutional. The advice of the consultants was that it would be prudent to proceed. One of over 65 PPO's already established in the United States is based in Pittsburgh.

Fourth, the same university hospital formed a corporation, a holding company designed to use its profits to help support the nonprofit hospital. All of the hospitals in Pittsburgh are assessing the advisability of joining one or another multihospital unit, following the pattern of consolidation of the hospital system so nicely described by Paul Starr in his timely book, *The Social Transformation of American Medicine*.

Fifth, a prestigious major Pittsburgh hospital ran a full-page ad in *Time* magazine advertising its services with special attention to its Life Flight transportation service.

Sixth, Blue Cross denied payment for an inpatient operated upon under general anesthesia because it decided that the operation could have been done in an outpatient facility.

Seventh, a for-profit hospital chain has opened the first of five freestanding walk-in Urgicenters in one of the moderately affluent districts surrounding the central city. The dynamic president of this chain has been a visiting professor at the Pitt business school. He aims to provide in health care, coast to coast, as uniform and reliable a product as a McDonald's hamburger. One must question whether hamburgers and medical or surgical care are comparable.

I have reviewed the determination of the federal government to diminish its contribution to health care and to make that contribution more cost-

effective, the similar effort by local payers and providers, the consideration by a major teaching hospital of providing discounted services in order to increase its market share, the open marketing by another teaching hospital, the shift from hospital inpatient to outpatient care, and the increasing prominence of for-profit hospital corporations. All of these are signs of a radical change that is occurring in delivery of health care and the practice of surgery. I sense an increased swiftness in these changes that tempts me to say "never before in the life of the College . . ." But when I read the addresses of former Presidents, I realize that changing times have always been with us.

Quality and cost

The medical profession is partly responsible, in a positive way, for the conditions that led to the present crunch. Good health care has been accepted as a right by the American people, and we have, with only partial limits on expense, proceeded to make our medical care the best in the world, but at the same time one of the most expensive. Now we question whether we can afford to continue on this course.

The changes are not all bad. A three-year trial in New Jersey of DRGs and prospective payment has shown that they may accomplish in cost containment what prior programs could not. However, anticipation of the program has made hospital directors bite their fingernails, despite the fact that the program will be phased in over three years. The federal government expects to save \$14.5-billion with the proposed program. That means that income to the nation's hospitals will be reduced by \$14.5-billion. A number of hospitals that cannot meet the increased competition and tighter cost control are expected to close.

Fears that teaching hospitals and medical schools will be adversely affected are justified, although such fears have been partially allayed by legislative recognition of the special role and costs of teaching hospitals. The Health Care Financing Administration has been receptive to recommendations related to

this issue. After all, good surgery is cost-effective, and this is what we should be teaching.

The burden of this initiative of the federal government has been placed upon hospitals, which account for the largest percentage of the health-care dollar; but physicians and surgeons must be prime actors in the effort to maximize quality at the same time that we minimize the cost of care.

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Thus two important obligations of this challenge fall on us: to join with hospital administrators in efforts to make the program work and to assure that what is taken out of hospital costs is the chaff and not the wheat. Economies can surely be made. It is up to us to assure that they are in the right place. There will be a deterioration of patient care unless physicians play an active role with hospital administrators and in peer review.

The many proposals, overshoots, retrenchments, and new departures in the last two decades may cause some to despair. I feel confident, however, that surgeons will try again, just as they recoup after a surgical failure, learning thereby to do better the next time. In this connection, I want to read one of my favorite quotes by a mountaineering friend, Galen Rowell, which was written after the Americans failed in their climb of K-2 at Mt. Everest in 1975. They had experienced all sorts of trouble with the weather, with conditions on the mountain, with interpersonal relations, and with strikes of their Balti porters. Rowell later wrote this:*

"Immediately after we returned, we considered the

*Galen Rowell: *In the Throne Room of the Mountain Gods*. Sierra Club Books, San Francisco: 1977. p. 312.

trip to have been simply a miserable failure. The majority of us were sure that we would never want to return to Pakistan for climbing of any kind. Slowly, though, our memories of the experience began to change imperceptibly. These were the kinds of changes that make one always remember a trail as shorter, a beach as whiter, or a home as larger than it really was. The golden sieve of memory gradually softened the harshness of our experiences. We remembered the view of K-2 on a clear morning and all but forgot the constant grayness of a five-day storm. In our mind's eye, the light from a single Balti smile blinded us to the hundreds of frowns with which we were confronted during the long days of the strikes.

"We were experiencing a most remarkable facet of human existence: the ability to locate a kernel of joy in a field of sorrow. Those who always find the kernel are able to live happy lives no matter what they experience. Those who cannot are doomed to misery, no matter what other benefits they reap from the material world."

Surgeons can be counted on to accept the challenge to make our health care not only the best but the most economical in the world.

Discounted hospital charges and professional fees, marketing, and open competition for an increased market share would have been anathema 29 years ago when I was a newly initiated Fellow. Then, one risked censure if he sought, or even accepted, exposure in the public news media. Beaming pictures of open-heart surgery into the living rooms of America was inconceivable.

Of course, discounted services alone will not achieve the savings that payers seek. Achieving a more cost-effective manner of patient care by physicians and hospitals, stimulated by competition, may do so. Our American system is based upon competition and free enterprise. If competition and free enterprise have produced our standard of living and, among other things, a choice of a dozen types of heart valves, pacemakers, or pump oxygenators, it

may not be reasonable to resist its application to health care, which consumes ten percent of the gross national product.

I have no words of wisdom or guidelines about how to meet this challenge. The borders of ethical and professional conduct will be skirted as surgeons and hospitals enter the marketplace. I am taken aback by the prospect and hope that we will be involved only briefly and minimally in the application of business tactics to something I never considered a business. The bottom line is to do our best for the patient.

You have joined a fellowship of surgeons in one of the greatest surgical organizations in the world. The road thus far has been long and has required full use of your ability, energy and resources—and often the resources of family, friends, and lending agencies. I trust that there are none among you who regret this course with all its joys, sorrows, and hard work, or who would not follow it again under similar circumstances. You have earned the respect and trust of your colleagues and of society.

I hope you will use the American College of Surgeons as the mountaineer uses his rope, to tie you to the body of surgery and to your colleagues who are rising to similar challenges, as a guide when you follow and as a tie to your fellows when you lead.

I don't know the current state of the climbers on Mt. Everest with whom we were traveling. Three weeks ago they were only 4,000 feet from their goal but storms have since driven them off the face at least once. They are more than six days of difficult travel from communication to the outside world, and one cannot expect word until they reach the summit or abandon the quest. They, like you, are sure to have further trials but also like you can be counted on to give their best effort.

I close with a short poem by C. Day Lewis:

Those Himalayas of the mind
Are not so easily possessed.
There's more than precipice and storm
Between you and your Everest.