

**The Colorectal Surgeon in 2015: The Missing Pieces**  
**American Society of Colon Rectal Surgery Presidential Address 2015**

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Friends and Colleagues,

As I stand before you this morning to present the 114<sup>th</sup> Presidential Address to the American Society of Colon Rectal Surgery, I find myself both humbled and honored.

The privilege of serving as your president for the past year has been the pinnacle of my surgical career. I thank you for that trust and I promise to cherish this experience always.

As I sat in my office pondering the subject of today's Presidential Address, my eyes scanned the walls and bounced between the diplomas, plaques, and pictures that represent some of the important milestones in my career. Seeing them, I felt a false sense of security. The topic of my speech, I thought, will be the complete picture of the colon and rectal surgeon in 2015, sort of a complete blueprint for younger colleagues to follow. After all, I have been an academic surgeon for more than three decades and I have seen it all. How hard could this project be? I thought that the picture of a colon and rectal surgeon in 2015 is just like a giant jigsaw puzzle and since I have mastered all the pieces, all I will need to do is to put the puzzle together for my colleagues to see.

As I started to put pen to paper, however, I was jolted by a strong dose of reality. I had not mastered all of the pieces, and after I had put together the puzzle, there was a problem with the picture—a big problem. Three large pieces were missing. It is the problem with these three missing pieces that I want to discuss with you this morning. Now the golden rule for resolving

problems with any jigsaw puzzle is to start with the pieces we do understand, so let's begin with the first piece: How did I become a part of this puzzle in the first place?

Growing up in a middle class family in North Texas, I had no physician role models. There had never been a doctor in my family, and my family doctor's practice was less than attractive. I remember trips to his office and sitting in my underwear on a cold examining table that was covered with white butcher-like paper and being asked to breathe in and out until I was hypocarbic. Then there was the short walk to his office where I would sit and watch him write out a prescription with a large black fountain pen as fat as a cigar. I thought to myself, "If this is the practice of medicine, I have to vote a resounding NO!"

As an undergraduate at the University of Oklahoma, I lived in a fraternity house. One fall evening, several of my fraternity brothers returned from a night of drinking and catching a movie. They descended upon my room and told me about the great movie they had just seen. They swore to me that one of the actors portrayed a character with an uncanny resemblance both to my sense of humor and demeanor. They assured me that I needed to follow in this character's footsteps and that medicine was the perfect career path for me. They told me to forget my dreams of becoming a university history professor or coaching college basketball. That movie was *M.A.S.H.* and the character was Hawkeye Pierce.

In just 112 minutes, my life had changed. It was clear that medicine could be both meaningful and enjoyable. As they say in poker, I was all in. I chose surgery and never looked back.

After graduating from the University of Texas Medical School, I had a fire in my belly for surgery and sought the best training available. I was fortunate enough to gain a training position in the general surgical program at the University of Louisville under the direction of

Hiram Polk. He was internationally renowned. Dr. Polk was a product, as well as a disciple, of the Halstedian method of surgical education. As you remember, Halsted was the first chair of surgery at the Johns Hopkins Hospital and is considered the father of American surgical education. His basic principles were as follows:

1. The resident must have intense and repetitive opportunities to take care of surgical patients under the supervision of a skilled surgical teacher.
2. The resident must acquire an understanding of the scientific basis of surgical disease.
3. The resident must acquire skills in patient management and technical operations of increasing complexity with greater enhanced responsibility and independence.

When my internship class at the University of Louisville first set our feet on the floor of the old Louisville General Teaching Hospital, we were all brought up to speed on how things would run. Dr. Polk and his staff made it clear—crystal clear—what was expected of us and it worked. The following were Dr. Polk's axioms:

1. Above all else, make sure the patient gets the highest quality of care. Your patient is always your number1 priority.
2. Laziness is an unacceptable sin and historically has led to dismissal from this program.
3. Residents are responsible for at least 50% of their education. Read and study on your own; the faculty is not here to spoon-feed you.
4. Keep score; learn from your errors; commit to constant quality improvement.
5. Always appreciate the role of basic science and research in the art of surgery.

6. When making clinical decisions, remember you are risking the patient's life, not yours. Always use perspective as your moral compass.

My internship year was a year when testosterone toxicity was ramped. We interns felt we were the marines of medicine. When we were beeped about an incoming gunshot wound to the emergency room, our eyes lit up like headlights of a car, while the chief resident would hang his head and groan, "Here we go again." The dichotomy of these reactions illustrates the maturation process that is necessary to progress from an intern to a chief resident. Unfortunately, outside forces are presently interfering with this much-needed 5-year maturation process.

After completing my training at the University of Louisville, I took a fellowship in colon and rectal surgery at the Ochsner Clinic in New Orleans. I had the opportunity to work with some of the legends in colon and rectal surgery: Dr. Patrick Hanley, Dr. Merrill Hines, Dr. John Ray, and Dr. Byron Gathright. After completing my fellowship, I accepted a position on the staff of the Department of Colon and Rectal Surgery at Ochsner and for the next three decades I carried on the tradition of the Halstedian method for training residents just as I had been trained under Dr. Polk. But then, out of nowhere, came a loud knocking on the door of surgical education and when that door was opened, surgical educators found a wolf in sheep's clothing declaring, "We are the government and we are going to fix the problems of surgical education."

This was the first piece of the jigsaw puzzle that I could not master. Under Halsted's method, the resident received a lot of supervision during the internship year and then as the resident progressed to the fifth year, he would find more independence and less surgical supervision in the classical maturing process. Unfortunately, this process could no longer be followed. The four basic reasons this approach could no longer be utilized as a game plan were (1) restrictive requirements on supervision of surgical residents, (2) duty hour restrictions, (3)

reduced volume of surgery, and (4) increased reliance on post-residency training. In 1969, the US Government began requiring documentation of oversight of surgical residents. Then in 1995, the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services, ruled that teaching surgeons must be present for “key portions of the procedure.” In 1995, the government established PATH (Physicians at Teaching Hospitals) audits that reviewed teaching physicians’ compliance with Medicare billing rules. The government reviewed many educational facilities and then brought a sledgehammer down on the University of Pennsylvania; in 1995, the university entered into a voluntary settlement with the Department of Justice and agreed to pay about \$30 million in disputed Medicare billings and damages. It was evident at this point that the government was going to completely control surgical education.

The next issue to be addressed was duty hour restrictions, although early ACGME requirements did not expressly mention duty hours. In 1971, the first formal study of resident performance after long duty hours was completed. Post-call residents were studied versus rested colleagues in reading a standard EKG, and the rested colleagues made fewer errors. Then in 1987, the ACGME task force of resident hours and supervision set up guidelines stating that residents should (1) get 1 day in 7 away from the hospital, (2) take call no more frequently than every third night, and (3) have adequate backup. In addition, institutions were required to enact policies to ensure adequate supervision and communication. In 1998, the AAMC issued a physician statement that those hours should not exceed 80 hours per week, averaged over 4 weeks, including moonlighting. By July 1, 2003, the ACGME had instituted standards for all accredited residency programs.

The next issue affecting residency training is the reduction in case volume. Several major factors led to the reduction in case volume. The first factor was non-operative treatment. The

trauma literature began to show that a partially torn spleen or a lacerated liver could be observed by CAT scan with the patient in an intensive care setting and oftentimes surgical intervention could be avoided. Another factor was the great advances in medical management. Improvement in the treatment of inflammatory bowel disease by medications such as TNF-alpha inhibitors led to prolonged periods of patient stability without the need for surgical intervention. Another classic example is the improvement of treatment for peptic ulcer disease that has resulted in residents having minimal exposure to operations for this disease process. Other factors contributing to a reduction in case volume are improvements in interventional procedures such as the treatment of portal hypertension with TIPS and improvements in vascular techniques for vascular cardiac and neurological diseases. Advances in diagnostic imaging also led to a reduction in case volume.

It was evident that there were new huddles for surgical educators. An ever-expanding range of diseases is treated surgically. Residents were expected to learn more in a limited period of time, coupled with work hour restrictions and an increasing demand for documentation. Operating room time was too valuable to permit the acquisition of basic technical skills, and educators were required to produce adequate income for their institutions, chasing the Holy Grail of the RVU. There were also public demands for greater accountability in patient safety and heightened requirements for oversight and training. During this transition, multiple peer reviewed articles reflected surgical educators' concerns that general surgery residency graduates were inadequately prepared for fellowships. According to Frank R. Lewis, MD, Executive Director of the American Board of Surgery, duty hour restrictions have shortened the general surgical training experience up to 12 months. It also became apparent that the Millennials are a generation with their own outlook on life, including how they should be educated. We could no

longer teach surgery as we had done in the past when repetition was the key to gaining surgical skills, almost like going through a difficult football practice. As educators, we realized that we had to transition into the new world where residents are taught with computers, simulators, and robots.

The second piece of the puzzle that is missing is the issue of medical malpractice. Media headlines in the United States have pointed out that we face a medical malpractice crisis. The nation's largest malpractice company, St. Paul, which covered more than 42,000 doctors nationwide, declared bankruptcy, citing nearly \$1 billion in losses. Headlines in the paper pointed out that many OB/GYN MDs stopped delivering babies as malpractice premiums rose to \$200,000 to \$250,000 per year. Even the Las Vegas Trauma Center threatened closure due to skyrocketing malpractice premiums. The staggering statistics for colon and rectal surgeons' malpractice expenses are the real thing. In Dallas, Houston, and Galveston, costs ranged from \$34,306 to \$150,957. The American Medical Association produced a medical liability crisis map that classified states as acute crisis, caution, or stable. The effect that fear of malpractice liability has on clinical decision-making is significant. Even though only 6% of malpractice cases actually go to court, the fear associated with this process has led American doctors to practice what is known as defensive medicine. Defensive medicine leads to unnecessary testing, referrals, increased cost, and decreased access. So the question is, "Where are we today with medical liability?" Medical liability drains the healthcare system of approximately \$55.6 billion per year (2.4% of healthcare spending). Of all the people who have a valid malpractice claim, only 3 percent seek compensation for their injuries. Recent studies indicate that 25% of awards made to malpractice claimants are not factually supported by the merits of the cases, only 6% of filed cases ever go to court, and in the court setting physicians win 80% of the time. For every \$1

spent on compensation, \$.54 is spent on lawyers and experts in court. The most important point is that the medical liability system is not linked to quality and safety improvements. The process is purely ex post facto financial resolution and it leads to the question, “Is the court system helpful in improving medical quality?” The answer is clearly no; after 30 years of legal assault on the medical profession, what do we have to show for it? Would you tolerate a policeman who made false arrests 80% of the time or a prosecutor who went after the innocent 80% of the time? I know many of my colleagues don’t think about medical liability on a daily basis, but it is important to point out to them that just like a shark that lingers under the surface of the ocean, invisible to swimmers, medical liability is always there with potentially catastrophic consequences. The White House and Congress have only paid lip service to this problem over the last three decades, and it remains truly one of the great challenges for medicine.

As healthcare reforms continue to change the landscape of our country’s healthcare system, physicians will be forced to navigate through some tough obstacles. These include the increased cost of operating your practice, time-consuming regulatory burdens, and hassles with getting paid by insurance providers.

Physicians find themselves under constant pressure to get paid for the work they do. The American College of Surgeons Division of Advocacy and Health Policy has pointed out that healthcare is transforming from a fee-for-service basis to a system in which physicians and providers are paid based on the value of the service they deliver. Under this new model, value is based on a judgment of quality against cost, but obviously that is not easily defined. People will value different aspects of their treatment: Was their pain relieved? Did their symptoms resolve after treatment? Was the service they received what they expected? At present, defining the value of service is a moving target. Private insurers are also increasingly adopting this value-

based payment model. A recent study by the Analysis Group projected that 75% of payers will utilize this model by 2017.

The Physicians Foundation believes that physician autonomy—particularly related to a doctor’s ability to exercise independent medical judgment without nonclinical personnel interfering with these decisions—is markedly deteriorating. Factors contributing to the loss of this autonomy include problematic and decreasing reimbursements and liability and defensive medicine pressures.

Increasing administrative and governmental regulations are often cited as chief factors contributing to our present pervasive physician discontent. A recent study by the Physicians Foundation found that excessive red tape regulations are forcing many physicians to decrease the time spent with patients in order to deal with nonclinical paperwork and other administrative burdens under the guise of quality. An example is the frustration of dealing with preauthorizations and precertifications that are hurdles to providing treatment to patients in a timely fashion. The American Medical Association survey pointed out that physicians spend an average of 20 hours per week on these preauthorization activities.

This October, the ICD-10 transition deadline finally arrives. No matter where practices are in their preparation for ICD-10, the new coding system will cost a considerable amount of money. The American Medical Association estimates that small practices could spend \$56,693 to \$226,000 to implement the coding system. Coding experts point out that even the most well-executed transition efforts will probably still experience challenges resulting in claim denials or delayed payments.

The controversy surrounding the maintenance of certification program is extensive, and there is significant backlash over the cost and time requirements. The application fees alone are

disheartening. Long-term concerns are that this test performance can be associated with state licensure, hospital credentialing, and even insurance credentialing. Although this process is necessary as it serves both the public and the medical community, it is cumbersome and time consuming, and the expense adds to surgeons' frustration about practice.

If you feel you are glued to your computer for much of the day, it is not your imagination. Again, many physicians are saying the mounting paperwork is keeping them from spending quality time with their patients, and now that 80% of physicians are employees of large hospital systems, they are no longer empowered to make individual choices regarding their practice. This trend is eroding physician on-job happiness. To put the situation in perspective, a surgeon stated that arriving at work in the morning and swiping his parking card was the last independent act he would perform for the day; administration would control the rest of his day.

So in summary, the missing pieces of the jigsaw puzzle are education hurdles, medical malpractice, and frustrations about practice.

At the outset of my talk I said would try to provide for you a complete picture of the colon and rectal surgeon in 2015—a complete blueprint for my younger colleagues to follow. However, that jigsaw puzzle is not complete because I have not mastered all of the missing pieces and unfortunately I will not have time in my career to complete this puzzle. Therefore, I challenge each and every one you today to commit to resolving these issues so we can continue to provide the highest quality of care to our patients and evolve as teachers, researchers, and surgeons. I know this process for you will be frustrating and depressing at times, but I am confident that you will rise to these challenges. Most important, you need to keep this process in perspective. So as I close, let me share with you a quote that will hopefully remind you not to lose sight of the picture.

You might think I would choose a quote from Dr. Halstead, Dr. Polk, or Dr. Sabiston; however, I have selected a quote from Ian Kennedy. You may ask, “Why Ian Kennedy?” In January 1991, my eldest son, who was in the 5<sup>th</sup> grade, brought home a note from his teacher requesting fathers to come to class to explain their jobs. I took masks, hats, and gloves to the class and described what a surgeon does. A few weeks later, I received letters from the students thanking me for coming. One of the letters particularly caught my eye because out of the mouths of children often come life’s truisms. This note has been in my desk drawer since 1991 and I want to share it with you today. Ian Kennedy wrote, “Dear Dr. Hicks, I enjoyed your presentation about surgery. Thank you for giving up your time to see us. Your job is probably the best the job in the world.”

So despite all the frustrations we face practicing surgery in 2015, never forget that Ian had it right: You have the best job in the world.

Thank you and Godspeed.