The American Journal of Surgery (2009) 197, 271–274

The American Journal of Surgery®

The Midwest Surgical Association

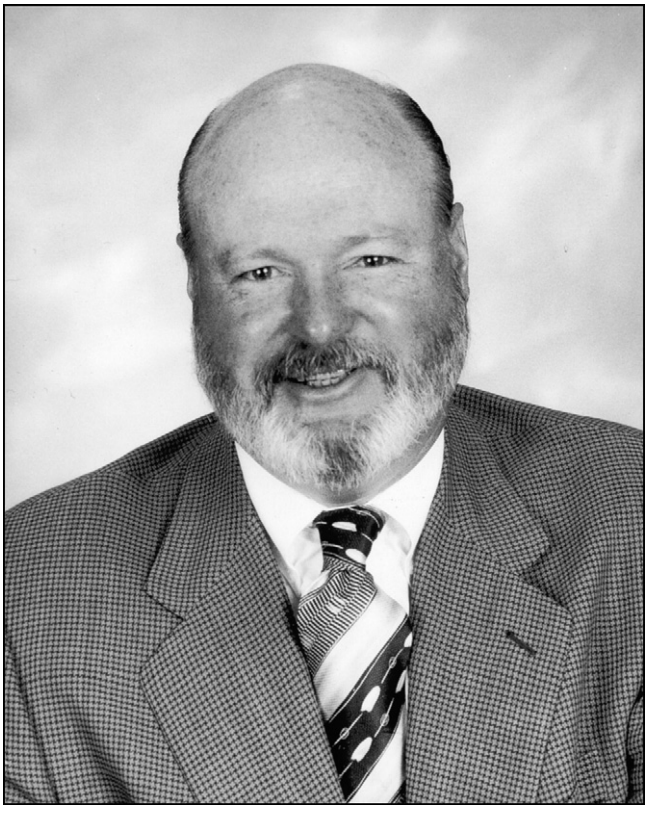
Presidential address: Res ipsa loquitur: "the thing speaks for itself"

James R. DeBord, M.D., F.A.C.S.*

Illinois Medical Center, 1001 Main Street, 3rd Floor, Peoria, IL 61606, USA

Having reviewed all of the previous presidential addresses of the Midwest Surgical Association and after reviewing the myriad of problems facing American medicine and especially American surgery, I quickly realized that I am not equipped to solve these concerns in this short address. I decided, however, that I do have opinions on lots of issues and an inner compass that I believe understands the direction that we must go. The core of my opinions, which are visceral, come from my 34 years as a surgical resident, practicing surgeon, and teacher of this wonderful combination of art and science called surgery. Thus, the title of my talk—res ipsa loquitur—speaks for itself.

As with everyone in this association, my foundation in surgery comes from my personal mentors, the first of which was my father, Dr. Robert A DeBord, the 12th president of this organization. He taught me the most about the style of being a surgeon, the strength of a calm demeanor, and the value of a lack of arrogance. His technical skills were hallmarked by the absence of any wasted moves, and, although he seemed to be moving slowly, the operations were always completed much faster than those of his peers. I learned the value of a sense of humor and, from his comfortableness with people of all walks of life, the value of being friendly with and respectful of the support staff of the hospital. As Willis Potts' fellow in pediatric surgery from 1950 to 1951, he brought to Peoria in l952, with his board certification in both surgery and thoracic surgery, the era of modern, scientific surgery to central Illinois. I remember him telling me that he decided to go into medicine to get out of picking corn by hand in January, and I believe his farm roots were the center of his value system. I also remember him telling me during the 5 years I was fortunate to practice alongside of him that he would quit surgery if he ever had to send a patient to a collection agency over his bill. This, I regret, is one of his standards I have not been able to maintain. I am extremely proud to represent the first father–



Dr. DeBord

* Corresponding author: Tel.: +1-309-495-0224; fax: +1-309-676-5568.

E-mail address: jdebord@peoriasurgical.com

Manuscript received December 11, 2008; revised manuscript December 12, 2008.

0002-9610/$ - see front matter © 2009 Published by Elsevier Inc.
doi:10.1016/j.amjsurg.2008.12.005

son presidents of the Midwest Surgical Association (MSA) and to dedicate this brief address to him.

The Peoria Surgical Group, Ltd, was started in l952 by my father, Dr. Ward Eastman, and Dr. Harrison Putman, who are all now deceased. It has grown to become the fulltime faculty of the Department of Surgery of the University of Illinois College of Medicine at Peoria, with 17 surgeons as of this date. A long history between the MSA and The Peoria Surgical Group exists, and I am also proud to be the 4th President of the MSA from our Department of Surgery—my father in l969, Dr. William H Marshall in l973, and Dr. Norman Estes in l999.

My formal surgical training was at the University of Illinois Hospitals in Chicago where my Chief, Dr Lloyd Nyhus, an internationally renowned surgeon and educator, influenced me greatly with the breadth and depth of his program. He trained "general surgeons" who could work comfortably in all body cavities. He created a residency program built not only on strong faculty but also on a culture of graded independent resident responsibility that produced surgeons of good skill and good teaching philosophies. The strong resident-to-resident bonds have lasted a lifetime. In addition to Dr. Nyhus, I must credit my other key mentors including Dr. Robert Baker, who taught me the Socratic method of surgical teaching; Dr. Olga Jonasson for her discipline, integrity, and inner strength; and Dr. Tapas Das Gupta for teaching me that everything is resectable and for teaching me to operate with a #24 blade now known locally as "The DeBord Sword." These surgeons had a profound influence on my training and in the development of my surgical judgment.

My residency from 1974 to 1979 was probably the greatest time in my life from an excitement and learning point of view. We did not have the 80-hour workweek then and were totally immersed in technical surgery, patient care, and teaching junior residents and medical students. Strong bonds and friendships were made especially among similar level residents, and I see or speak to my fellow "chiefs" frequently. They are all successful in their own right in academic and/or private practice surgery. I believe they all achieved their goals by the work ethic initially instilled in them by their parents and by the times (the mid-70s), by the pressures of a pyramid residency system that allowed only the best to proceed past the first year, and by the demands of the 100- to 120-hour workweek that the job and the patient load demanded. My concern with today's students and residents, and society in general, is the erosion of that work ethic because of changing societal norms, government rules and regulations (the 80-hour work rules), and the desire for lifestyle issues to take precedence over work issues. At the risk of being labeled senile or out of touch, I do not believe you can replace the learning that is lost from the patients you do not see, the complications you do not diagnose and treat, and the longitudinal care of the patient that you do not totally experience in today's 80-hour-workweek surgical residencies with shift sign outs, night float teams, and physician extenders interfering with the resident-patient relationship. Because these new work paradigms are not going away, it is incumbent on surgical educators to devise plans to minimize these missed clinical opportunities. We must remember the value of the careful abdominal examination and remember that you cannot develop a sense for the acute abdomen just by reading Sir Zachary Cope's book *The Acute Abdomen*. You must examine hundreds of abdomens, both positive and negative, and this takes years. We must not let these experiences be lost to our trainees and be replaced by midlevel providers and emergency room physicians and computed tomography scanners! The 2 most valuable tools we can teach our residents are to rely on the abdominal examination and the pertinent history of the present illness. With these 2 skills, an experienced surgeon can diagnose most everything within his/her clinical domain. To do this, there is no substitute for seeing patient after patient after patient. I believe the 80-hour work restriction on surgical residents is misconceived and a mistake, but it is being dealt with. At the same time, there is pressure to reduce the years of resident training overall. I cannot fathom that we can produce adequately trained surgeons in less than 5 years, and I am skeptical of the value of reducing basic surgical training for vascular surgeons, plastic surgeons, and thoracic surgeons. Various 4 to 2 or 3 to 3 programs leading to subspecialty certification only without American Board of Surgery primary certification, I believe, are not a good idea and will weaken the overall surgical manpower of this country long into the future. I am, of course, familiar with all the arguments behind these proposals, and many are superficially appealing, but I do not believe these new shortened hybrid training programs are in the best interests of American surgery, the American public, or the surgeons themselves. One of the great appeals of returning to Peoria from my training in Chicago was the opportunity to practice real general surgery. Even in l979, there were restrictions in large metropolitan areas on what constituted certain specialty turf, but this was not an issue in returning to Peoria; although with my boards in general surgery and the only surgeon in Peoria at that time with vascular boards, I was not expecting any restrictions. I rapidly learned or relearned thoracic and pediatric surgery from my father and Bill Marshall and found myself immersed in a true general surgery practice doing vascular; general; endocrine; pediatric; gynecologic; bariatric; thoracic; and, with my master's degree in immunology, even renal transplant surgery. I was in heaven. I remember one day the diversity of my practice stunned me when after operating on a 600-g baby for necrotizing enterocolitis, I performed a gastric bypass on a 600-lb woman! This is when it became apparent to me that I had been totally mistaken when I told my wife that life would definitely be easier, and I would have more free time after residency when I was in a practice.

When I started in a practice in 1979, I had no formal training in or understanding of business issues because my college, graduate school, medical school, and residency

classes, a total of 14 years of education after high school, were all science courses without any basic education requirements in accounting or finance. However, unlike today, surgeons actually were well paid in the late 70s and 80s, and we did not need negotiating skills for contracts with providers. We had the luxury not to worry about caring for public aid patients or self-pay patients, which then, as now, was a euphemism for no-pay patients. In our community, we had generous payers like Caterpillar Tractor Co, and life was good. Today, everybody, including Caterpillar, wants a discount or to be tied to some meager percentage multiple of Medicare so we all find ourselves working harder to do more volume for less pay while our costs of doing business rise with inflation. Medical inflation from June 2007 to June 2008 was 4.6%. Why is it that the solution to all corporate and government expense issues falls to health care cuts? When a poor person takes food stamps to a grocery store, the grocer gets $1.00 for every $1.00 worth of food the customer buys. Why do we get 20 cents or 50 cents for a $1.00 worth of health care? This is without a doubt the biggest threat to all our futures, especially the young surgeons who have maybe never known a rational payment system for their services. The "I'm mad as hell and I am not going to take it any longer" quote from the movie Network reflects all our sentiments but implies that we can do something about it. I do not know the answer, but it seems to me that major health care reform must consider the following basic realities:

1. Our current health care delivery system does not work well and has poor access with the number of underinsured or noninsured rising rapidly.
2. A single payer system should be most efficient. The current system suffers greatly from excessive middlemen and enormous administrative costs that divert money away from care and providers.
3. All Americans should be provided a standard benefit package regardless of income, employment status, health status, or age.
4. Employer-sponsored health care is basically paid for by workers through lower wages and not out of corporate profits. It is not a "free" benefit.
5. Chronic illnesses such as diabetes, heart failure, and emphysema are responsible for 70% of health care costs.
6. A nationally integrated electronic medical record system will bring major efficiencies and safety to an increasingly itinerate population.
7. A national quality and outcome assessment program needs to be implemented, possibly based on the National Surgical Quality Improvement Project (NSQIP) model now perfected by the American College of Surgeons. This will lead to a consensus on the best medical/surgical therapies that will standardize health care delivery throughout the country and lead to sustained improvements in quality.
8. Reasonable allowances must be made for research and development in the pharmaceutical and medical technology arenas, but the costs of drugs and devices must be more rational and better controlled.
9. Payment to providers may be based in part on performance measures but must be fair and reasonable and reflect the education, training, and professionalism of physicians. The current procedural terminology (CPT) and resource based relative value scale (RBRVS) systems do not necessarily need to be abandoned.
10. The single payer system must not be restrained by artificial and political factoring that results in constant uncertainty and economic damage to providers.
11. The American people have to accept health care as a universal right for all and accept that it is going to continue to increase as a percentage of GNP as our population enlarges and ages.

The devil, of course, is in the details, which will be hotly and extensively challenged, especially when someone's ox is about to be gored. I believe health care should be a nonpartisan political issue that will require support and understanding from both sides of the aisle and will almost certainly, in this country, evolve as a private-public hybrid system but evolve it must. I hope the American public can grasp that this is a critical issue to the future of our country because it will require that the public send a clear message to Congress that they also are "mad as hell and are not going to take it any longer."

The most enjoyable part of my life in surgery has always been and continues to be the teaching and development of residents in surgery. The 5 years of training goes by quickly, but the relationships and mentoring goes on much longer and to watch a new doctor fresh out of medical school on July 1 leave on June 30 5 years later a competent safe and maturing surgeon is truly my most rewarding moment. Since 1979, I have been involved with the training of 64 residents who now work in both private and academic arenas throughout the United States, with 25 of them in Illinois and 13 active members of the Midwest Surgical Association. Although moments ago I was ranting my concerns about residency training and reduced work hours and resultant reduced patient interactions and operative experience, I am not convinced that the "golden age" of surgical training has passed. The culture of surgery that attracted my generation and earlier ones into the trenches, often at huge public hospitals, at the time seemed a fair tradeoff for the lifestyle sacrifices it demanded. However, in 1 generation, the perspective about work has gone from career centered to family centered and reflects not just an attitude in medicine but the whole spectrum of the American workforce. The work-life balance issue is here to stay, and it is up to our profession and residency training programs to manage these life balance issues so that in addition to happy and well-balanced residents, we continue to produce safe, competent, and maturing young surgeons for the future. God knows we will need them, and many of us may need them sooner rather than later. We clearly are on the verge of a manpower shortage in surgery, and the new work ethic, the increasing number of women in surgery (all 3 of our incoming first-

year residents this year are women), and the trend away from general surgery and toward surgical subspecialists will aggravate the workforce shortage. I want to be clear that women make excellent surgeons, but it is well documented that their active surgical careers, often interrupted for childrearing and family responsibilities, are often shorter or more limited than male surgeons. Hopefully, medical schools and residency positions will expand to meet this clear demand from our enlarging and aging population.

As the problems build for medicine and especially surgery in meeting our workload demands and battling the economic pressures of the current payment system and the worsening medical liability crisis, I am concerned that we do not lose our most valued asset, our professionalism. I see an erosion in collegial relationships as competition worsens, turf issues blur traditional practice boundaries, and economic pressures push more and more specialists to the edge of their competencies or into business relationships that might be borderline with respect to conflicts of interest with their patients. I see an increasing aversion to the care of the needy and uninsured, a group that is growing larger and larger each year. Physicians and surgeons alike are less and less interested in uncompensated hospital committee work, emergency room call, trauma call, and after-hours patient care issues. This, in my opinion, is unprofessional. And while we are on this subject, we sometimes can be our own worst enemy. I am appalled to see surgeons seeing patients in their office routinely in scrub suits or other very casual dress and even making rounds in the hospital in blue jeans and tee shirts. This, in my opinion, is not professional.

These are complex issues, many based again on our schizophrenic health care system and the current medical liability environment, but we must maintain our professionalism above all or we risk becoming tradesmen in the eyes of the public. That public is our current greatest asset.

I would like to close with a few comments on professional organizations. When I was a medical student and resident, my father took me to the Chicago Surgical Society, which met once a month for dinner and a lecture. I would go with him once a year to the Central Surgical Association meeting where I was initially stunned at the sometimes pointed critique and criticism given to the scientific papers being presented. I learned a lot about professionalism at these meetings, and I believe that active participation in surgical societies is critical to ongoing professional development by surgeons. I cannot count the number of friends I have made and the value I have received from associations with colleagues from around the country that I have met and socialized with at these regional and national surgical society meetings. I encourage all of our young surgeons to take the precious time to earn membership and to attend 1 or 2 meetings a year. Get acquainted with your professional peers and leaders, comment on scientific papers, and present your own clinical or scientific work. I will say without reservation that the Midwest Surgical Association cannot be beat for its combination of science, family interaction, relaxation, and most of all professionalism. I thank you from the bottom of my heart for the privilege and honor of being your president.