Diseases of the Colon & Rectum

Presidential Address

"Latch on to the Affirmative: Don't Mess With Mr. In-Between"

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It has been a privilege and an honor to work this past year with a superb Executive Council and to be an advocate and caretaker of a most sacred trust, The American Society of Colon and Rectal Surgeons (ASCRS). As many of my predecessors have affirmed in their own cases, I have been able to do this only with the help and understanding of my colleagues at Mayo, my children, and most of all, my wife, Vikki. Please also permit me to acknowledge the influence and example of my father and mother, who started what are now three generations of Mayo-trained surgeons.

For two years, I have been considering what I would say to you at this moment, as the presidential address is the bane of all presidents. Although I am comfortable discussing with you, as colleagues, such things as diverticulitis or Crohn's disease, where I can hide behind data and clinical experience, this address requires something more for which I am somewhat ill-equipped—the sharing of pertinent philosophic beliefs, global perspective on our subspecialty, and recommendations for positive action. These inner revelations have been bound in conceptual constipation and have not come easily, and I am exhausted with the effort. Having reviewed the collective wisdom of more than a hundred years of presidential insight, I can tell you that much of this has been said before, and it should and will be said again. But because there is no escaping this obligation in my ultimate goal of achieving the exalted status of past president, here goes.

Bruce G. Wolff, M.D.

ACCENTUATE THE POSITIVE (Johnny Mercer) Performed by Dr. John. "You got to accentuate the positive, eliminate all the negative, latch on to the affirmative, don't mess with Mr. In-Between." © Harwin Music Corp. ASCAP

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"Never in the history of our organization have those within it, and those outside it, needed the organization more. The association maintains its effectiveness. Yet these are times of stress. Stress engenders fatigue, and fatigue, impatience. Out of impatience come altercation, enmity, and the search, in unlikely places, for solutions of problems."[1] These are the words of Dr. Buie, in 1947, but are equally cogent today. This is a bad news/good news discussion, and I make no claims to eloquence or gifted insight. I do, however, believe that we have our work cut out for us.

"MR. IN-BETWEEN"

First, let's talk about "Mr. In-Between." Mr. In-Between, for the purposes of this discussion, refers to those issues and problems, both internal and external, that our Society cannot deal with alone. For these we must look to join with other organizations and develop concerted efforts to effect change on a more global scale by providing resources and additional information to achieve desired ends.

The Southern language, a dialect becoming more and more rare in this country, is like Urdu, Esperanto, and Aramaic, and many other quaint languages, and is full of nuances and local color. The phrase "don't mess with" has two meanings to any bona fide Southerner, such as your current president. It can mean "leave alone" or "don't involve yourself," or "stay away from," something that can be injurious to one's health or livelihood. For example, "don't mess with that rattlesnake," is an admonition Bubba does not often heed. But, it also can mean "don't tinker with" an effort that is previously underway and going well, an effort that perhaps requires steadfast and ongoing support but is working quite well, thank you. This latter interpretation will be the one I will use in discussing these "in-between" issues.

HEALTH CARE COSTS

I have learned a lot from my dog this year. He is a small dog but has a big personality, a big heart, and clear cut objectives. He hates thunderstorms and believes that with bluster and bravado he can intimidate "Mother Nature" and chase these storms away. Who's to say that he never actually does this? There is an obvious parallel between our Society and this small dog.

Health care costs and related issues continue to be a huge problem, with U.S. health expenditures rising 7.7 percent in 2003 to nearly 1.7 trillion dollars, which for the first time exceeds 15 percent of the gross domestic product. Indeed, by 2013 health care

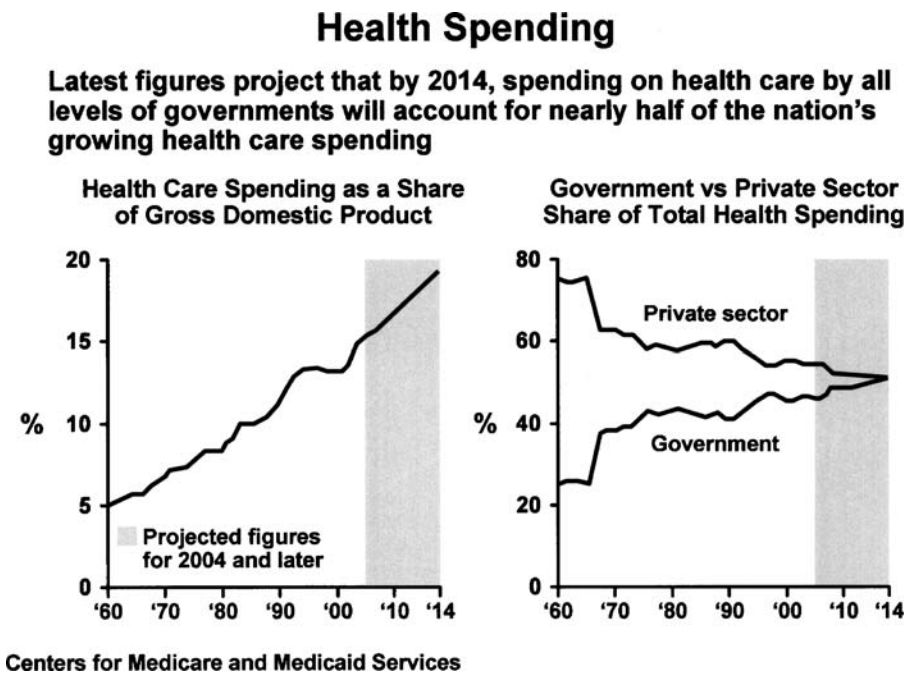

Figure 1.

Average Total CEO Compensation for 2002 (Not Including Stock Options)

Company	Salary ($)	Bonus ($)	Other* ($)	Total ($)
Aetna	1,000,000	2,500,000	89,490	3,589,490
Anthem	980,000	2,352,000	3,525,839	6,857,839
CIGNA	1,021,900	0	1,169,100	2,191,000
Health Net	754,808	700,000	72,011	1,526,819
Humana	700,000	612,500	336,472	1,648,972
PacifiCare	917,309	1,690,000	398,472	3,005,781
WellPoint	1,246,155	5,690,916	347,724	7,284,795
UnitedHealth Group	1,896,154	5,275,000	2,286,243	9,457,397

* "Other" may include long-term compensation payouts of either cash or restricted stock, 401(k) matching contributions, transportation such as cars and plane travel, expense allowances and insurance premiums

Kazel B, CEO compensation: Accomplishments translate into healthy paychecks www.amednews.com, May 26, 2003

Figure 2.

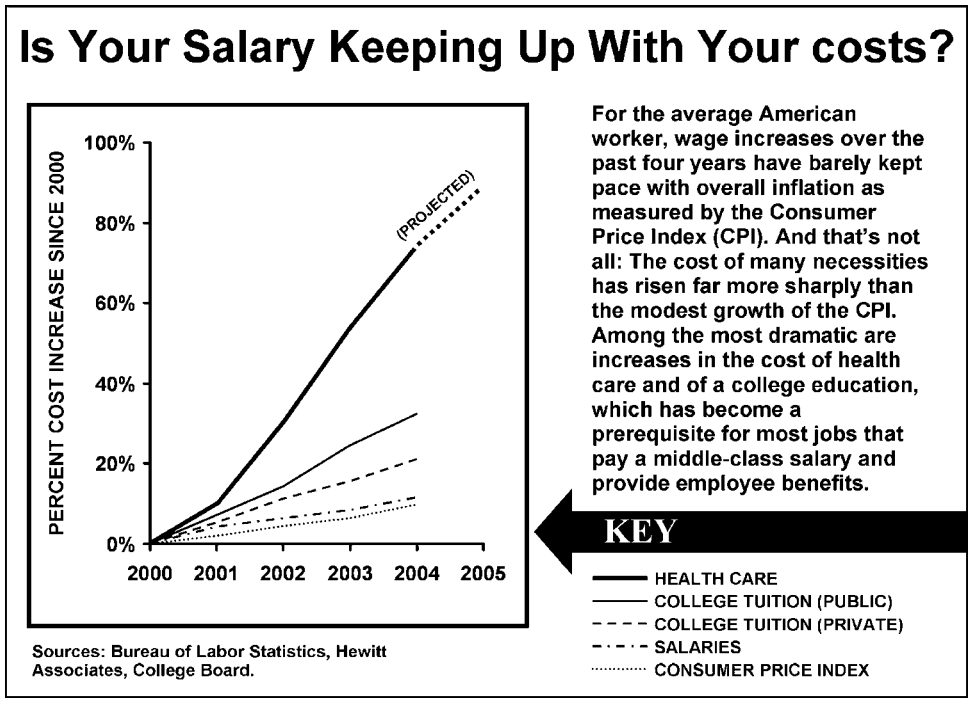

Figure 3. Reprinted from *PARADE* Magazine, March 13, 2005. © 2005 Lynn Brenner. All rights reserved.

spending may well approach 20 percent of the Gross Domestic Product (Fig. 1). Health care insurance is rising for all of us (Fig. 2). Last year's rise of 11.2 percent in premiums paid by U.S. employers was an increase five times higher than wages and was the fourth in a row to exceed 10 percent, after a 13.9 percent jump in 2003 (Fig. 3).[2]

There are still 45 million uninsured in this country, and they are receiving very expensive medical care as poor, or nonexistent, preventative strategies lead to crisis medical management, and this care is delivered most often in emergency rooms. As Albert Einstein said, "The significant problems we face cannot be solved with the same level of thinking that created them." I certainly wouldn't presume to voice a solution for these mammoth issues, but this is an example of an issue where we have to ally ourselves with others and continue to apply pressure to Congress and our legislators to address this national disgrace.

REIMBURSEMENT

Reimbursement is another issue on which it is difficult to have an impact, but we are fortunate to have many members of our Society actively involved, including Frank Opelka, Lester Rosen, David Margolin, Steve Wexner, and Tony Senagore, among others. Dr. Senagore is 1 of only 15 physicians on the Centers for Medicare & Medicaid Services (CMS) Physician Payment Advisory Panel, which gives us considerable influence.

From 1991 to 2005 medical practice costs have increased by 41 percent, but payments to doctors have risen only 18 percent. Under the current flawed physician payment formula, doctors are slated for a reduction of 5.2 percent in reimbursement in 2006 and similarly sized reductions in the years ahead. If these cuts come to pass, the reductions would total 31 percent during the next eight years. At the same time, the cost of running physician practice and caring for patients is expected to increase another 19 percent[3] (Fig. 4). The American Medical Association (AMA) has been very active in this, and through its efforts there is a 2.7 percent payment increase next year from the Medicare Payment Advisory Commission (MEDPAC) to partially offset this inequity. Again, we must join with other physicians and physician organizations to keep a steady focus on medical finance.

Payment Update vs Medical Inflation

Year	Payment update (%)	Medical inflation (%)
2006	-5.2	1.9
2007	-5.0	2.2
2008	-5.3	1.8
2009	-4.8	2.4
2010	-4.8	2.4
2011	-4.8	2.4
2012	-4.8	2.4
2013	-2.1	2.3

2004 Medicare Trustees Report

Figure 4. Reprinted from *American Medical News*, Volume 48, No. 1, January 3/10, 2005. © 2005 American Medical Association. All rights reserved.

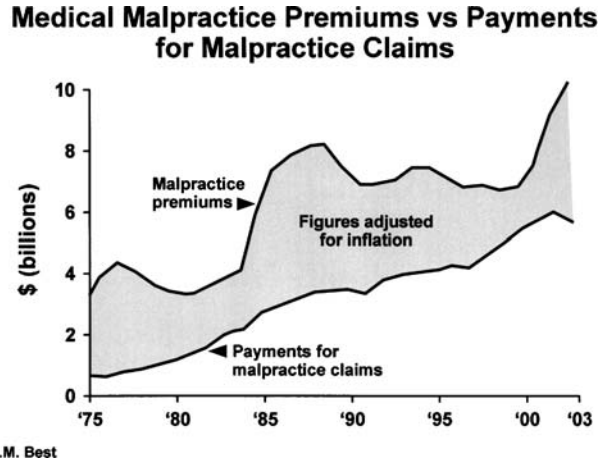

Figure 5.

TORT REFORM

The current liability crisis also is news to no one, with the median medical liability awards jumping 110 percent from 1994 to 2002, topping $1 million. The average award reached $3.9 million in 2001 (Fig. 5). A February 2003 poll showed that 84 percent of Americans fear that skyrocketing medical liability costs will limit their access to care. Forty-five percent of hospitals have reported that the professional liability situation resulted in a loss of physicians and/or reduced coverage in emergency departments.[4] As if this is not enough, in the past year, professional liability insurance premiums have increased 37 percent (Fig. 6). We need to enlist patients as our allies in this, and we must commit ourselves fully to the crusade to improve patient safety and reduce medical errors.

The American College of Surgeons Political Action Committee (ACSPAC) is an excellent resource for our financial attention, and although we may not like the fact that money buys access in Washington, this is simply a matter of fact. I urge you all to contribute to the ACSPAC.

LOSS OF PROFESSIONAL STATURE

We have endured a loss of professional status in recent years with terms such as "clients" replacing "patients," with business terminology and "business ethics" creeping into our daily medical practice with administrators, insurance companies, and even CMS referring to us as "providers" or "units," with a presumed interchangeable malleability but without any real concept of what it takes to care for a sick patient in our subspecialty.

Administrators and functionaries have inserted themselves into the patient-physician relationship as

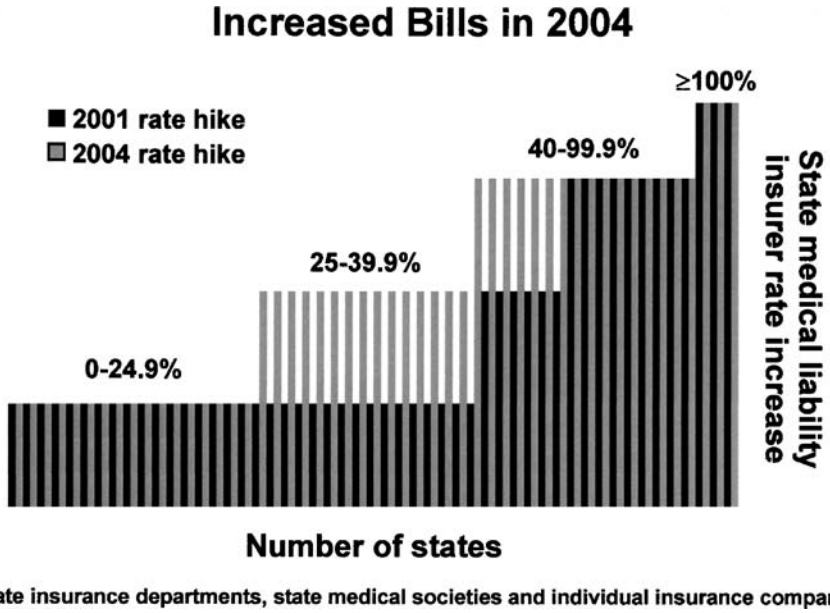

Figure 6.

never before, making for some very impatient doctors. These days, and I am sure the same goes for many of you, I find only two times when I am content in my professional life: when I am talking to a patient about their operation, or when I am actually in the operating room, where I still seem to have some semblance or modicum of control over things.

By adhering to the seven principles of professionalism, by examining our outcomes, and improving our results, by renewing our oath of Hippocrates, being genuine, and spending time with our patients, we will ultimately regain our lost professional stature.[5]

MAINTENANCE OF CERTIFICATION

Maintenance of certification (MOC) is an example of something that a few individuals thought was a good idea and that took on a life of its own. This was done under the old admonition, and if I may paraphrase Dr. John, "If we don't do it, you know somebody else will." Maintenance of certification has two laudable goals: one is to convince the public, the government, and anyone else who is interested, that we are adhering to the six Accreditation Council for Graduate Medical Education (ACGME) Core Competencies (Fig. 7).

The second goal is to improve patient care. The components of maintenance of certification are four facets (Fig. 8). The last, evaluation of performance and practice, is the most difficult and problematic component, but your Standards Committee under Tom Read is working hard along with the American College of Surgeons (ACS) to diminish the onerous impact of data collection for us. This requirement may ultimately be simply to be involved in some sort of practice assessment program, and this is soon to be finalized. I urge you all to attend the session given

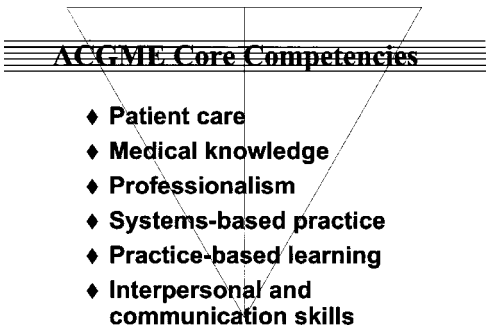

Figure 7.

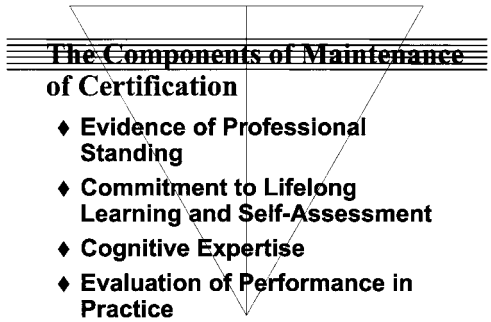

Figure 8.

by Dr. Fleshman on this vital issue on Wednesday. Again, MOC is now a fact of life, there is no recourse, and we should not waste energy railing against what undoubtedly will be additional effort and expense to maintain our board certification.

My last comment on this topic is that we should encourage, if not demand, that the American Board of Medical Specialties, and the Boards themselves, develop a critical process to demonstrate that this new MOC pathway has improved care of surgical patients, or not. We pride ourselves on evidence-based practice, why should we just assume that this MOC process will lead to all of us becoming better doctors?

There is another issue to be addressed. Our Society and Board have always supported certification by the American Board of Surgery (ABS) before a candidate can become eligible to take the qualifying and certifying exams of the American Board of Colon and Rectal Surgery. With the drastic changes in residency training these days, the 80-hour work week, the 3-year general track leading to subspecialty training, as proposed by the American Surgical Association (ASA), ACS Blue Ribbon Committee on Surgical Residency Training, and most importantly, the changes in general surgery itself, one wonders, with this narrowing of the educational window, how important it is for future colon and rectal surgeons to know how to treat parathyroid or breast disease. I suggest to you that we must carefully reevaluate the active training regimen leading to board certification in colon and rectal surgery, and work with our colleagues in general surgery to develop a more specific and efficient curriculum for our residents.

THE 80-HOUR WORK WEEK

We are now into the second year of the 80-hour work week mandated by the ACGME to start July 1, 2003. Again, this maneuver is typical of those elaborated by well-intentioned individuals to correct a very real, short-term problem but with no real understanding as to, or much apparent thought about, the long-term ramifications. There has been much angst and self-flagellation over this mandate, but there has been little study of the downstream effects.

There have been good effects, such as those in a study from Awad *et al.*,[6] showing that surgical residents, who had previously shown similar mental health scores to patients with chronic depression, have improved Medical Certification Standards (MCS) scores after the institution of the 80-hour work week. Similarly, mean American Board of Surgery in-training examination scores have improved significantly for junior residents after the reduction of work hours.[7]

On the other hand, some studies have shown an association between potentially preventable adverse effects and coverage by physicians from another service. Camins *et al.*[7] have found that in-hospital complications and diagnostic test delays were more frequent since New York state enacted work hour limitations. In another study from a Boston teaching hospital, a tired junior resident was able to provide more appropriate care to a patient with whom he was well acquainted than another, well-rested, resident could who was less familiar with the case.[8] Moreover, a recent study from Vanderbilt comparing large databases from New York state nonteaching hospitals, California teaching hospitals, and New York state teaching hospitals has found a worsening in certain patient safety indicators, such as accidental punctures and deep venous thrombosis and pulmonary emboli.[9]

So although the shortening of resident work hours may move us, as Dr. Russell of the ACS has stated, to a team approach in surgical care, with the increased involvement of physician assistants, physician extenders, pharmacists, and others, and a concomitant decreased resident involvement, this may well represent a worthy change, chiefly in focusing resident hours on educational endeavors and eliminating fruitless noneducational effort. However, the long-term consequences are yet to be seen, and this would include assessment of the quality of the surgical training, the commitment of these young Generation Y surgeons to their patients and professions, and ultimately the interactions with us older surgeons, with the difference of perspective between every-other-night-trained individuals with those who have perhaps developed a shift worker mentality, and how they deal with the exigencies of patient care outside of the protective cocoon of a residency program, when there is no one else to take over the care of a sick patient at shift expiration. Make no mistake, there are well-documented, attitudinal differences in Generation Ys—the importance of being a team player, rather than leader and innovator, the need for a "balanced" life over pursuit of income and achievement, and a sense of shared responsibility—"our patient" rather than "my" patient. We must prepare for this change and accommodate it. Hopefully,

many of our young surgical trainees will rise to the occasion, and they, too, will prove to be adaptable.

THE AFFIRMATIVE

Having thoroughly depressed everyone, it is time to move on to the second section of this homily, which is the affirmative. Is there anything to latch on to and feel good about? The answer is yes, and we have been through dark days before. As a student of history, I believe we should briefly look to our colon and rectal surgical ancestry for inspiration.

A most remarkable figure in our history was Felix (and for much of this information, I must thank Dan Rosenthal). In January 1686, Louis XIV of France, "the Sun King," had a problem where the sun don't shine. He had a perianal abscess that drained and progressed to a chronic fistula-in-ano. Until approximately that time, barber surgeons were considered largely to be mere technicians (sound familiar?), who did little more than to trim hair and drain abscesses. After the physicians had applied all of the poultices and salves to no avail, Louis looked to his royal surgeon, Charles Francois Felix de Tassy, for relief. Felix, understandably nervous, very carefully studied Galen's technique of fistulotomy, and prepared his instruments. Several courtiers, hearing of the impending serious operation on the king, volunteered to act as subjects on whom Felix could hone his technique. Well, you might ask, where are such people today when we are trying to put patients into studies?

One morning in November 1686, the fistulotomy was performed without anesthesia; Louis showed incredible strength and fortitude, and tolerated the procedure well. Louis, in fact, underwent several subsequent procedures before an eventual cure was affected. For this, in gratitude, Louis granted Felix an estate and a large sum of money, and the royal surgeon was elevated to a status commensurate with that of the physician. Therefore, we can safely assume that had it not been for this intrepid colon and rectal surgeon, Felix, both we and our colleagues in neurosurgery and cardiac surgery would still be giving haircuts.

Let us now move forward to 1899, to the founding of this Society, and I will mention particularly Joseph Mathews for whom the Mathews lectures is named. Dr. Louis A. Buie, from my own institution, also was a founder, and was the first editor of *Diseases of the Colon & Rectum*, and again this Journal led to increased recognition of our subspecialty. In 1940 the American Board of Proctology was approved as a subsidiary Board of the American Board of Surgery. This key event was followed in 1949 by the recognition of the American Board of Proctology as an independent Board. In 1959, discussion began about an American Board of Colon and Rectal Surgery replacing the American Board of Proctology, and this change came approximately in 1960. In 1973 a certificate of incorporation was filed in the state of Delaware, and we officially became The American Society of Colon and Rectal Surgeons, with the current residency requirements established to which we still subscribe. There have been struggles in recent times, and many of the people in this room, including Whitney Boggs, who, in the early 1980s, did not have enough money in the ASCRS account to pay for the annual meeting, have carefully preserved this heritage and added luster to it.

So, having inherited an established, independent board, a highly regarded Journal, and increasing recognition as a vital subspecialty, what else is there that we can feel good about? Again, there is quite a bit. Our standing in the surgical community has increased. Of 1,276 board-certified colon and rectal surgeons, 600 now list academic affiliations. Most university teaching programs have, or are actively seeking, a board-certified colon and rectal surgeon to add as an essential member of the faculty.

We have an increasing presence in major surgical societies, such as the American Surgical Association (ASA), of whom 24 of our number are members, the Southern Surgical Association, of whom 5 are members; the Western Surgical Association, of whom 18 are members, and The Society of Surgery of the Alimentary Tract (SSAT), of whom 147 are members. Needless to say, 15 to 20 years ago there were few of us who participated in these distinguished organizations, and we were viewed a bit askance.

Today, at the American College of Surgeons Clinical Congress, colon and rectal surgery general sessions are among the most popular and heavily attended, and have been for years. We have been an integral part of that program and have gained much through that association, with ultimately one of our number, Tom Russell, becoming a highly regarded and able executive director of the preeminent surgical organization in this country, and perhaps the world.

Today there are 76 residency positions, in 40 active colon and rectal surgery training programs. We have more than 2,600 members of our Society, and this

continues to grow, and more emphasis in the future will be placed on including the allied health members with whom we work, and we must develop specialized programs for them.

But, how many colon and rectal surgeons do we need? The answer is that we will need more. Part of the reason for this is the colorectal cancer procedure forecast as Baby Boomers age. There is a 35 to 46 percent increase predicted for these procedures (Table 1).[10]

Another indication for an increase is the following: recently, with the help of Mayo statisticians and the Olmsted County Epidemiology Group, I reviewed the risk of having colon and rectal surgery in a stable population representative of most of this country's white ethnic group. You will note two things in this study: operations for various common surgical procedures, with the exception of colon and rectal surgery, were flat in the years from 1995 to 2000, and that the likelihood of undergoing these types of procedures, except for cardiovascular, was much less than the likelihood of a patient undergoing a colon and rectal surgical procedure. And, this likelihood increased steadily.

You also will note that colon and rectal screening procedures, such as colonoscopy and flexible sigmoidoscopy, also have increased dramatically with a rate of approximately 15 per thousand. This means that we will be busy in the future, particularly as this huge segment of our population ages, and as public awareness increases. We also must remember, in this country of high patient expectations and demand, that we will be sought out for these procedures, whether performed laparoscopically or open. There is a plethora of studies in the literature in many areas showing that volume and subspecialty training are associated with better outcomes, and this is certainly true for colon and rectal surgery.

Let me illustrate this last point. Many years ago when I was a new consultant, I went into Bob Beart's office, who was my mentor and chief at that time. I told him about a young Jehovah's Witness who needed an ileoanal procedure and would, of course, not take blood products in any shape or form, even by autotransfusion, and had been turned down at several other places. I was concerned about this, because this was the first time I had encountered this situation, and asked his advice. He said, "Who can do this operation better than you can?" I immediately thought, but did not say, "Well, how about you?" But, of course, this was not his point, and since then I have done, very carefully, several major procedures in similar patients, as many of us here have, who have come to us as a last resort.

Another positive aspect is our educational effort. I submit to you that we are one of the most evidence-based specialties, and one has only to look at this years' program to see that again there are a number of prospective, randomized studies being presented, and many of us in the recent past have participated in some of the largest prospective, randomized surgical trials ever conducted.

Our practice parameters, thanks to the Standards Committee, are thoroughly researched and vetted, and this is some of the finest work the Society has ever produced. We hope shortly to have, through your membership in this organization, free access to the Cochrane Collaboration Reviews, which is another enormous learning resource. We have strong affiliations with the SSAT and the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), and we look for future beneficial collaborations with such organizations as the soon-to-be merged European Society of Coloproctology, in addition to our current strong Tripartite ties, and we look forward to a superb meeting in Dublin in July. Colon and rectal certification training programs are coming to pass in many areas of the world, and others look to this Society and to our Board for aid and advice, and we are very pleased to provide assistance to our international colleagues in their efforts to establish this subspecialty abroad.

And yet, through all of these problems and successes, among the people represented here today, and with others not able to be here, there is a special cohesive and collegial mix of surgeons with many

Table 1.

CR Cancer Forecast 2004-2014

DRG & Type	Volume	Descriptions	10 yr % change in Discharge Volumes
146.1 Surg	16,783	Rectal Resection W CC	+46%
148.1 Surg	134,557	Major and Small Bowel Procedures W CC	+35%
149.1 Surg	36,914	Major and Small Bowel Procedures W/O CC	+37%

SG_2 Report

common bonds, with the ability to speak openly and freely to each other, to learn together new techniques, to revisit old truths, and simply to visit. I look out in this room and what do I see? I see loyalty, friendship, and excellence in patient care. There is a special feeling in this group—it is a family, as Dr. Fry has put it. I believe that there are certain characteristics of colon and rectal surgeons that make this gathering unique, and among these is a sense of humor, and perhaps a sly sense of self-deprecation. After all, we deal with a very basic and fundamental, if you will, organ system. This Society, and other elements of our subspecialty, including the Board, Residency Review Committee (RRC), and the Program Directors Association, will shortly become even more essential in maintaining our practice and in our credentialing as colon and rectal surgeons, and particularly in providing the educational basis for this. This presents a major challenge, and we must focus, prioritize, and concentrate our energies and resources. We have a rare unanimity of Society, RRC, Board, and Program Directors Association handed down to us by many who have gone before, and also by many in this room today. But, what will we do for those who come after us?

Hopefully, I have set the stage for the next endeavor that we face. There is a very serious threat to our Society, but there is something that we can do about it. Many of you may now realize that it costs more than a million dollars to put this meeting on every year. If we had to pay for this ourselves, there would be at least a $1,000 registration fee. Two-thirds of this meeting is now subsidized by our friends and associates in the pharmaceutical and surgical implement industry. But increasing strictures in phRMA regulations, and in ACCME accreditation guidelines, make it more difficult for us to get financial support from them as we have in the past. There may well come a day, particularly after another financial downturn, such as occurred after 9/11, when the Society may not have the wherewithal to produce meetings such as this, even on a reduced scale.

To address this issue, your Executive Council, last year, formed the ASCRS Educational Endowment Fund (EEF), and this initiative came from many besides me: Ira Kodner, Frank Opelka, Jim Fleshman, and others, and more than $500,000 has been placed in this fund, but this is not nearly enough. The desire is that this money will serve as a "rainy day" fund, a reserve for the future, and as insurance for the Society to perform its' educational mission. For us to be able to do this, we need much more than this modest start. Only in nurturing this initial effort, and building a sound reserve, can we ensure that the superb educational programs and professional association we have inherited and enjoy today, thanks to those many visionaries and guardians who started all this in 1899, secured our Board in 1949, successfully led the transition to colon and rectal surgery from proctology, gave us a sound financial operational picture, and founded our Journal, will be available as a legacy to colon and rectal surgeons 10, 20, or 50 years down the road. To subsidize the EEF, we are beginning a campaign that hopefully will secure our future as a Society. You are here today, and because you are here, there is every likelihood that you have, in the past, received more from this society than was compensated by dues and registration fees. The hope is that many of you will consider the many options, such as outright donations, or planned giving through a bequest, or charitable trusts. We want to make this easy for you. We also must ensure that the Research Foundation (RF) is maintained in good financial health. Yes, we are asking a lot, but there is no conflict here; all three (EEF, RF, and Board) need and deserve our support and are critical to our profession's future and our patients' well-being; as a member of ASCRS you are fortunate to have the choice to support all three, two of the three, or one of the three as you desire and are able. I urge each of you to think of what the Society gives to you today and has meant to you in the past, the friendships you have made, the pleasant associations you have had, and act on this completely tax-deductible effort to meet our Society's future obligations.

Well, it is unseemly to finish with my hand out, asking for a handout. So, I would like to leave you with a most important philosophical point. Recently we have become so caught up in the technology and business of medicine that we have lost, dismissed, or ignored the art of medicine. Let me provide an example. A few years ago, I came home from a long operating day thinking about relative value units, my operating room (OR) utilization, turnover time, changes in my OR crew, and all of the day-to-day basic business of surgical practice, which is much of our environment these days. A woman who has cared for our children, middle-aged, religious, and stalwart, was in the kitchen when I came home. She said, "Doctor, who did you help today?" Who had I helped today? What a novel thought! That was the furthest thing from my mind. The problem is, with all

the pressures and stresses in our everyday practice, we don't stop and consider that we are engaged in the noblest profession of mankind, that we have the unique ability, unknown to any other species, of opening each other up, going inside, and fixing things, and, on balance, there aren't that many of us who have the avocation, the training, and the commitment to do that. And if you think about it, all else pales in comparison to this primal goal—the money, the bureaucratic nonsense, the administrative hassles. It is easy to loose sight of this basic foundation of our lives as surgeons, and the trust that our patients place in us hoping that we can help them. To be sure, as Richard Selzer[11] has said, we are the servants and our patients are the masters. The trust we are given is sacred, inviolable, and the essential element in the practice of medicine, and a recovered patient is our greatest reward. We are not speaking of overblown egos but of the humility that should come with great privilege and of the surgeon's oft-battered self-esteem. So I ask you to think about who you have helped on a daily basis and remember that you are unique and that you have the skills and the dedication to work wonders if you just "latch on to the affirmative."

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