A Bold Message for the Next Millennium

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I am honored to have been your president for the past year. I now go back to being what I like best, a colon and rectal surgeon. As colon and rectal surgeons, we enjoy being able to diagnose and treat the many diseases and disorders that our patients experience. Even better, we are proud that we can successfully treat most patients. However, we owe a debt of gratitude to our predecessors, the colon and rectal surgeons who have guided this society during the past century.

As you know, we meet in a very special year, the 100th anniversary of The American Society of Colon and Rectal Surgeons. During this century more improvements in health care have been made than in all recorded time. It has been marvelous to be a physician in the 20th century. My message today is to point out where The American Society of Colon and Rectal Surgeons has been in the 20th century, point out where we are regarding colorectal cancer screening at the end of the century, and make a strong recommendation about how we must tread boldly into the new millennium.

THE PAST CENTURY

Less than two centuries ago, one of my heroes, Thomas Jefferson, occupied the White House, just down the street. His foresight lead to the Louisiana Purchase, the New Frontier. Thereafter, he commissioned Meriwether Lewis and William Clark to explore the western reaches of our nation. The trail that they established eventually became a road and later in the century became highways and great railways. These same railways became the major means of cross-country travel for our predecessors. In 1899 our original thirteen members traveled mainly by train to Columbus, Ohio, and there established our society under the leadership of our first society president, Joseph M. Mathews of Louisville, Kentucky.

The next century led to the expansion of the institutions of our society that we now take for granted. The direction was clear, but the obstacles were many. In 1916 T. Chittenden Hill of Boston said in his presidential address to this society, "It is well for us to remember we may think at times our specialty slighted, but nearly every specialty of medicine has had to overcome certain prejudices." Each step for our society had to be bold. In reading the history of our society, the dogged devotion, courage, and confidence of our past members has gained us a Board of Colon and Rectal Surgery, has gained us a journal, has gained us residencies, has gained us a Program Directors Association, and has gained us a research foundation, and in this decade these institutions have been united under our strategic plan.

THE END OF A CENTURY

As we exit a century, I must mention a concerted effort by many of us to publicize the fact that screening for colon and rectal cancer is the means to prevent and cure colorectal cancer. This is so obvious to us who are close to this subject that we find it difficult to imagine that others do not embrace this concept quickly. However, it took the better part of two decades to convince Congress to support colorectal cancer screening.

My personal experience will relate what efforts have been made to tell other medical disciplines, the

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government, and the public that early detection of premalignant neoplasms and colorectal cancer equals lives saved. Furthermore, it is cost effective. Because of an early interest in colonoscopy and flexible sigmoidoscopy by members of The American Society of Colon and Rectal Surgeons, endoscopy has been recognized and retained as a technique that is a standard of practice for surgeons. Late in the 1970s, several of us taught a series of courses designed to teach the newest technology, flexible sigmoidoscopy, to our members, general surgeons, and primary care doctors. During this same period we began to lobby the Congress regarding the benefits of colorectal cancer screening. This was to no avail, because the different disciplines of medicine were not delivering a consistent message.

As the decade of the 1990s was entered, there was a movement to show that screening does count. Several of us in our society were involved in activities to write evidence-based guidelines which then could be used to show Congress and the public that screening for colorectal cancer has merit, more so than some of the more talked-about cancers.[1–4] Then the resolute lobbying efforts paid off, and Congress wrote the guidelines into the Balanced Budget Act of 1997 to include Medicare spending to reimburse for colorectal cancer screening. In the past two years there has been much effort to bring screening to the attention of both doctors and the public. Subsequently, we have been on newscasts, talk shows, and satellite courses expounding on the virtues of performing or submitting to colorectal cancer screening. As your president, I have attended several meetings to "kick off" campaigns to educate the country. Gastrointestinal societies, the American Cancer Society, the Health Care Finance Administration, through the Centers for Disease Control and Prevention, and a new Colorectal Cancer Roundtable, which is a group of interested societies, have had media events to launch campaigns. One of these events was a live television announcement by Hillary Clinton at the White House, at which she made a plea for Americans to undergo colon and rectal cancer screening. Three of our members represented other interested groups, and I represented our Society.

Now that we have screening, who is going to do it? Primary care doctors have no excuse for not adding colorectal cancer screening to their armamentarium of preventive medicine. Or do they? In general, the primary care doctors know of this issue, but do not respond to it because of the lack of skill needed to perform specialized endoscopy. Our society can teach screening skills to primary care doctors better than any other group. To this end, I have appointed a new committee, called the Professional Outreach Committee, to have as one of its goals the education of primary care doctors in colorectal cancer screening and flexible sigmoidoscopy. Many of you will be called on to carry out this program in your own region.

THE NEXT CENTURY

Let us suppose that this effort does succeed and screening becomes a commonplace activity in the house of medicine in the next century. Then we should see an influx of new colorectal cancers, which require surgical treatment. Who should treat these patients? In 1908 A. B. Cooke of Nashville, Tennessee, said in his presidential address, "At the present time the average patient requires something more of the man who is to be entrusted with his case than the title, M.D." In 1917 Alfred Zobel of San Francisco, California, said, "I believe this era of specialization gives evidence of the advancement and betterment of the whole profession; that it means far more efficient service rendered to the public than it has received in the past." In those early years our predecessors were faced with charlatans and quacks. Today we are faced with half-trained surgeons. We are faced with surgeons who have a practice that prohibits adequate or frequent use of skills in the treatment of colorectal disease that might make them effective. In other words we are faced with the "occasional surgeon" who does not know that he is not competent and not effective. The old adage that "a little knowledge is a dangerous thing" is true in this setting. The surgical adage, "A chance to cut is a chance to cure" has a corollary: "Cut across cancer and you kill the patient."

Therefore, how do colon and rectal surgeons fit into the big picture of colorectal disease? I'll tell you how: practice the principals of colon and rectal surgery better, prove it, and publicize it. Of course, the ultimate test is how our patients fare. To this end we must provide superior training for our young surgeons, expanding their knowledge, honing their technical skills, maturing their judgement, and imparting a sense of responsibility, compassion, and kindness.

Just down the street are the seats of government. I remind you that 35 years ago they brought us Medicare, even though the American Medical Association opposed it. At this time in history, Medicare is break-

ing the bank and may not be viable for many more years. To its credit Congress has financed research in medicine, but advances often lead to a side effect, an increase in cost. Reducing the cost of medicine has become an obsession to Congress in the past few years. This has been because of pressure from American industry and from a generally healthy public. Eventually, they will learn that getting the patient with a specific disease to the appropriate specialist is the most cost-effective medicine.[5–16]

The baby boomers, those born shortly after World War II, are the major voting block in this country, and they are the same group who wants limitless medical care for free. They are still at an age where most of them are healthy. Increasing the average age of death is a major achievement of medicine in the 20th century. However, the baby boomers are aging, and with age comes infirmity and disease. At that point we change their names from health care consumers to patients. They, in turn, must change our name from provider back to physician.

I don't know many 100-year-olds. However, we can treat conditions that shorten lives and keep many people from reaching the 100-year mark. What kills has not changed for decades: it is heart disease and cancer. We are making the public aware that colorectal cancer is the number two cancer killer in this country when males and females are counted together. Our aging population will demand to be empowered to choose their physician. Congress will follow the demand of the voters. Also, the public will demand quality in medicine; likewise, they will demand quality in colon and rectal surgery. Not the quality that the government desires, which means cheap. Not the quality that the government promotes in its centers of excellence, which simply means cheap. Not the quality that the insurance company sells, which also means cheap. The patient is being left out of the quality equation.

Ultimately, patients will demand meaningful medical intervention that improves their health and quality of life. Yet how will quality be measured? Methods of measuring clinical performance are being sought and tried in various specialties and by the American Medical Association. To be sure, the government or the insurance carriers will measure your performance if we do not do it within the house of medicine. Even now your hospital and your insurance companies are profiling you. These profiles can tell a lot about you and your practices. They are supposed to be confidential. However, keeping them confidential will be a major issue in the next decade.

Medical journals are now publishing articles based on outcomes. For example, it is no surprise that the chance for survival after a myocardial infarction is better when the treating physician is a cardiologist as opposed to others, as reported by Jollis and colleagues in *The New England Journal of Medicine*.[17] Cardiac and transplant surgeons have looked at volume and frequency of performing a specific surgery, and it is not surprising that those operations have a better outcome when done frequently by a good surgeon. In cancer surgery this is also true. For breast, esophagus, pancreas, and stomach cancers, the more experienced surgeons have the best results, as reported in the surgical literature.[18–26] It is no wonder that there is a difference in colorectal cancer results also.[27–40] Evidence continues to accumulate, as seen in papers presented at this meeting.

Some articles report that good results are an institutional phenomenon.[41] Do not think for a second that it is an institution. There may be clusters of good surgeons, which lend the appearance that an institution is responsible. Always it is the individual surgeon that makes the difference in outcome. A body of supporting evidence is accumulating in the surgical literature, which I will append to the printed version of this article. Obtain this bibliography and I challenge you to add to it in future years.

When I was a young surgeon, I spent some time at St. Mark's Hospital in London. Basil Morson was the pathologist at that time. He had succeeded Cuthbert Dukes, whose name is associated with the classification of rectal cancer on which all classifications are based today. Basil had extended the studies of factors related to carcinoma of the rectum, which helped in the prognostication and staging of the disease. I asked him what he thought was the most important factor in the cure of colorectal cancer. His answer was "selection of the surgeon." He clearly had recognized the differences in surgeons skilled in colon and rectal surgery and had the advantage of seeing the results in both the gross and microscopic specimens. The surgeon is a prognostic variable. Optimal containment of cancer involves wide lymph node excision and clear margins of resection. Patients often present with a contained malignancy. However, as a result of flawed technique, the cancer is disseminated. There is a difference. There is a difference in morbidity. There is a difference in mortality. There is a difference in the

hospitalization time. There is a difference in surgical judgement and surgical detail, which leads to a difference in the cure rates. The standards of care must be redefined.

However, we must be prepared to change with the advent of superior methods and techniques. I was trying to remember what I do technically that is the same as when I came out of residency. There is nothing, from fissures to cancers, that I do the same. I trust that we are doing things better. A successful surgery is a great high. However, there are emotional ups and there are emotional downs throughout the career of a surgeon. We do not always win. For example, from the time I began speaking today, three of our fellow citizens died of colorectal cancer. With this in mind, let me set the stage for a story that every colon and rectal surgeon has experienced. A couple are holding hands, looking scared, and they have tears of fear in their eyes. One of them has rectal cancer. The question that one of them finally has courage to ask is "will I need to wear a bag, a colostomy bag?" More often than not, the surgeon experienced in colon and rectal surgery can answer "no," because he recognizes the extent of the disease and factors permitting sparing of the sphincter mechanism. When the same question is addressed to a less knowledgeable or skilled surgeon, the answer is "yes, you will need a colostomy." To have the specimen removed *en bloc*, perform a low anastomosis, and have the pathologist report clean margins around the cancer is a natural high for a colon and rectal surgeon. Five years later another feeling of accomplishment is reached when the patient is still alive and well. You have gained both cure and preservation of function. We must spread this word to the public.

The public needs to know that when colorectal disease attacks, they should seek the best help available. The patient will want evidence-based selection of their physician and surgeon. Publicizing this message will require boldness. I repeat: there is a difference. Those surgeons who have taken the time to learn about and treat colorectal disease have better results. Our revised strategic plans should include strategies to deliver this message. Remember, we build on the foundations of 100 years of The American Society of Colon and Rectal Surgeons. We bring into the next century—even more, into the next millennium—a gift to our fellow man: our knowledge, our judgment, and our skill. Everyone deserves to know about us.

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