

# 1990 EAST Presidential Address: Searching For Values In Changing Times

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*Is there anything whereof it may be said:  
See, this is new?*

*Ecclesiastes 1:10*

I want to begin by thanking you for the honor bestowed upon me by election as your President. This is a compliment I have never taken lightly and one which certainly never will be forgotten. Throughout the year I have done my very best to define, expand, and faithfully fulfill the duties of this office, and I am forever grateful for the chance you gave me to do it.

Presidential addresses usually have three concerns—the state of the organization; what's wrong with medicine; and Ringing Declarations of Purpose. This one includes each of these subjects, but is exquisitely timed because I recognize that I am the only thing standing between you and lunch.

First let me mention a few of the lessons life has to teach. One is that "no one gets anywhere alone." My college chemistry professor was the first person with enough confidence in my meager abilities to make me think I might accomplish something some day, and I'll never forget him. He's gone a long time now, but my first son has his name. A few years later Doctor Gerald Shaftan introduced me to trauma patients and to the experimental laboratory, and Doctor Peter Kottmeier was such a giant that to become anything other than a pediatric surgeon after meeting him was unthinkable. He was my teacher, my advisor, my boss (very definitely my boss), then later my colleague, and now my friend. My youngest son, who's here today, carries his name. Then I met Doctor H. William Clatworthy and had a chance to train with him in a second pediatric surgery residency. Doctor Clatworthy is one of the originators of my specialty and a man whose accomplishments and force of will cast a giant shadow. I've yet to meet anyone who is his intellectual equal, and I don't expect to. It's too bad I was through having sons by the time I met Doctor Clatworthy.

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In my time with these great men, and many others, it is unlikely they had any notion that I was headed for the honor you grace me with today. My success is really their success. All of us should remember that we are only the current link in a long chain that goes back through the generations, a chain which we have a solemn obligation to perpetuate. Those who have torches must pass them on to others.

I also have the enormous good fortune to have as my partner my darling Kathleen, without whom I would never have earned the registration fee, much less the presidency. We've done everything together, through good times and tough times, and my success is hers, and the children's, too, and I would like to dedicate this occasion to my family and my teachers in gratitude for their contributions to everything I've ever done.

Another lesson is that "the harder you work, the luckier you get." The thing at which I worked hardest was to become a pediatric surgeon. I feel so sorry for those of you who will never know the thrill of the 70-year cure, or the joy of helping a child get better. My agenda within my own specialty has been to stimulate interest in improved trauma care, a task which turned out to be easier than you might think, because pediatric surgeons remember that it was trauma that gave birth to their specialty.

The first pediatric surgeon was Doctor William E. Ladd, a Boston general surgeon in the early 1900s. In December 1917, a French munitions ship collided with a freighter and caused an enormous explosion in the harbor in Halifax, Nova Scotia: 2,000 people died that day, and 9,000 were injured and 31,000 more became homeless. The Canadian doctors asked for help and the Boston team was led by Doctor Ladd. He was so moved by the differences in the medical needs of the injured children that even before returning home, he decided to devote the rest of his career exclusively to the surgical care of infants and children. Each year, Boston's Christmas tree is a gift from the people of Nova Scotia, but the children of the world have been the real beneficiaries of Doctor Ladd's discoveries.

It is possible that some of you may be having trouble convincing your own colleagues about the value of traumatology. It can be very discouraging to be one of the 10% of surgeons who are genuinely interested in this field of study. I urge you to press on, but you must realize

that recognition will not come with a new board or a special certificate; ironically, applications for new boards of trauma surgery and pediatric surgery were both denied by the Advisory Board for Medical Specialties at the same meeting in 1957. General surgery is now so hopelessly splintered that no one has any taste for more subspecialties. As the specialties of surgery seek redefinition and the scope of general surgery narrows, I predict that trauma will become increasingly important to surgeons. Stick with it—successful pioneering has its own rewards, despite the bumpiness of the road.

Because our Association has brought us together today, let me tender a report on the health of EAST. The life cycle of a medical organization is a deeply Sisyphean venture. For 12 months you push a rock up a hill, and then scramble out of the way before it crushes you on its way down. Each January someone else dusts everything off and the push starts again. Most presidents are so busy dodging the rocks that they don't have time to admire the dimples on the surface. Because Kimball Maull was such an effective first president and because of the quality and dedication of our officers and directors, their momentum alone made this year's trip up the hill pretty easy.

Your founding group has some very clear ideas about this organization. It is intended to be a learned society with the primary purpose of creating an atmosphere for the encouragement and stimulation of improved trauma care. Election to membership is an honor in itself. Membership includes admission to a scientific forum at which juried papers are presented and where acceptance of a paper is a higher honor, bringing authors the recognition of their peers. Few rewards have more meaning than the respect of the only people who really understand—the people who do the same thing you do.

Our second purpose is to disseminate scientific information through the printed word. We are fortunate to have arrived at a collegial and mutually agreeable arrangement with the *Journal of Trauma*, which is now the official publication of our Association. The linchpin of this agreement was the promise of expedited publication of papers from our annual meeting, and you have seen this promise fulfilled in two 1989 issues. Our Publications Committee and the editorial staff of the *Journal of Trauma* have earned our gratitude and get a tip of the hat for their hard work. Their efforts have given EAST the credibility that comes with timely delivery on a tough promise.

Our third purpose is to meet once a year to trade professional experiences, to gain succor from our colleagues, and find out that everyone has the same problems we do. Bartlett Giamatti said that "part of the purpose of going . . . is to enjoy the gathering, to see and hear the crowd become a community, to cheer, to intervene, to swap stories and pleasantries and opinions with those around you. It is a gathering of the tribe at one of its fundamental rituals, and it is meant to provide

pleasure as well as a release from daily cares. It [should] be strenuous and relaxing, a break from work, a time to pass on lore to the next generation, and a way of looking at life, and [a time] to each." I hope our meeting will be all of this, and more.

Our fourth purpose is to make our views known, a task getting easier as membership expands at a pace more rapid than we ever expected. By the end of this meeting we will have more than 300 members. The ranks of EAST include general surgeons, orthopaedic surgeons, neurosurgeons, pediatric surgeons, and plastic surgeons, but EAST is also an umbrella society. Everyone with an interest in trauma should feel at home here, and our associate members include internists, intensivists, educators, nurses, epidemiologists, and biostatisticians.

We started this year pleased with the quick and wide acceptance of this new society. By midyear our progress had become more like Patton crossing the Rhine, moving so fast that the supplies couldn't keep up with us. As an organization grows its affairs become increasingly complex, and a good deal of attention was paid this year to responsiveness and to efficiency, and to a functioning committee structure. In fiscal matters the Association is in robust financial health and will be handed over to your new officers in proper condition.

I know the new officers and directors will continue the tradition of an open organization which exists to serve all its members. There is no "in-group." The Bylaws were written to preclude the possibility of officers-for-life; each Board self destructs every two years, no officer or director can succeed himself, and the disappearance of officers (especially presidents) is programmed.

There is one problem yet to be solved—the role of our senior members, a thought increasingly on my mind. The original plan was to generate the senior membership over time from within the organization. Now we also admit senior members by application, and we have a group of vibrant, vocal seniors whose role in the organization remains undefined. A committee of senior members has been appointed to study this issue and make suggestions to the kids on the Board. Our future leaders will have to find a place for these dinosaurs to play.

We are all aware of the unusual breadth of trauma care. I would like to single out research for a moment, because I am increasingly concerned that experimental surgery is not getting the emphasis it deserves. Where will future progress come from?

There are two vexatious problems about research. One is that financial backing is harder and harder to obtain from other than proprietary sources, and the other is that surgical research involving cell genetics and molecular biology is becoming categorized as "critical care" and presented where few can hear it. Past progress in trauma care has depended far more on basic research than on technology, and if we continue this artificial separation we'll look back on it someday and realize the mistake we made, after it's too late.

I urge you to oppose any effort to separate critical care from trauma or from general surgery. The further fragmentation of surgery is wrong and it must be resisted, even by those who might gain either short-term benefits or professional fulfillment from it. Splitting trauma research from critical care would be foolish since they are two sides of the same coin. The trauma patient is both the universal critical care model and the clinical laboratory.

I believe our current discoveries about the immune process are giant steps. Once upon a time, I had a professor of bacteriology who spent the whole Fall term trying to convince us that what we knew as tuberculosis had nothing to do with the tubercle bacillus, but was actually due to *our reaction* to the tubercle bacillus. He was ahead of his time. Now we are beginning to see how the effects of blood loss, soft-tissue injury, fractures, infections, and other injuries are due not to the wounding agent so much as to the angry macrophage, which when activated produces compounds capable of setting off bioactive cascades. As we come to understand these mediators, the ability to block or fine-tune the response comes within our grasp. In my life, I have seen only three such fundamental advances—antibiotics, understanding DNA, and parenteral nutrition. Each of these changed the world. Modulation of the inflammatory process is next. Some day, everyone will carry around a little syrette containing the right monoclonal antibodies to stop the biochemical reactions initiated by trauma, and the first person to reach an accident victim will inject it, and the golden hour will stand still.

This magic bullet hasn't been found yet, however, and research funds are in short supply. Young surgeons are not being trained in research techniques and are not given much incentive to include laboratory research in their career plans. Because of economic pressures, surgery finds itself unprepared to participate in the explosive growth of knowledge in the basic sciences. I urge you to pay careful attention to new findings as they become available, and to be certain that the findings of the experimental laboratory always have a place at this meeting.

My last subject concerns me most deeply of all. Not long ago, while traveling, my wife had a minor problem with a contact lens. From the telephone book I picked what looked like the best hospital in town, and called and got the name and phone number of the chief of ophthalmology. After persuading his secretary that my wife would be a worthy patient, she was allowed the privilege of seeing the doctor that day. He figured out the diagnosis and prescribed a simple solution. As I was standing in the corridor saying my goodbyes, Miss Pinchface came up and said, "That'll be \$50, please." The look on my face must have spoken volumes, because even the doctor got scared. He sheepishly explained that people like me who get a salary (which I don't) could never understand the economic pressures (which I do) that

control medical practice today. I had never been asked to pay a doctor bill in my whole life, but as I think back over the experience, my anger of the moment has turned to sorrow for what we have become, or think we have.

Each decade of this century has defined itself. The '50s—my generation; the "Yes sir/no sir" generation—had a long run, starting when President Eisenhower was elected and ending with the death of President Kennedy. The age of Aquarius—which is a song title to me, but a way of life to many of you—ended with Watergate and the surrender of Saigon; and the '80s—the "bottom line" generation—is just ending now. For medicine, and for trauma in particular, this decade started with considerable promise but wound up on the rocks and shoals of economic disaster.

Our hospitals are closing the trauma centers we worked so hard to open because the balance sheet has replaced the public good as the index of success. Hospital administrators have been re-cast as business executives expected to engage in competitive marketing practices, making sure their institution offers the latest in hospital *chic*. Some would be willing to change the standard of care to make the budget work. Despite a consensus that medical care uses up too much of the gross national product, every day I have to contend with people trying to make a business out of the care of the sick. These well-intentioned intruders distract me from my real job of helping shepherd my patients and their families through an illness, for which they trust me and put their lives in my hands. It's frustrating to waste my time on all this other stuff, and the incessant demands of the marketplace and hospital economics are becoming tiresome.

The corporate mentality is usually insensitive to the needs of the sick and injured, particularly the sick and injured poor. In the near future society will have to face up to the problem of how to pay for trauma care, because trauma isn't going away and the alternatives are to let the injured die in the streets or in unprepared hospitals. Maybe every tub *doesn't* have to sit on its own bottom; maybe the coronary artery bypass graft is Nature's way to allow the trauma center to lose money, and maybe it's our job to stand up and say so.

Medicine, that great servant of society, has almost been blown away by a cyclone of social change. If you think the problems are financial, you're right! No one seems to mind the good things we do, and perhaps doctors are guilty of some of the things of which we're accused, but the accusations and jealousies miss the point. Medicine is now challenged by one single major threat to future progress. It isn't the overproduction of doctors. There *are* too many doctors in many parts of the United States, and in the future there may be *many* too many doctors. But that is not the real problem. It is not the increasing intrusion of government into our daily lives, heavy-handed and misguided as some of that intrusion may be. It is worse than that. It isn't even the avarice of

a small number of greedy lawyers and sob-sister juries who created the malpractice problem that has driven so many of our colleagues into premature retirement. It's a disease—a disease that's been around for a long time, but one that recently has increased in virulence and in contagion until it threatens to destroy a whole generation of good doctors.

The name of this disease is *Business*. It masquerades by synonyms—"cost containment," "managed care," and a lot of others. The symptoms are when doctors stop being patient advocates, and start using business school language and portraying themselves as economic geniuses, or even worse, "managers." And it's catching—you catch it from your friends, your neighbors, your colleagues, your hospital administrators. Just go to your next hospital meeting and see how long it takes for the conversation to get around to what's good for the patient. You may have a long wait. We spend too much time trying to figure out what's good for us and for the hospital, and precious little worrying about our patients.

Medicine only fails when measured by the yardstick of business. The comparison isn't fair, and the psychic toll is immense. For whom do we work? The patient? The insurance company? The hospital? The government? Society? And when the interests of society seem to conflict with the needs of individual patients, are there ethical guidelines for making the choice? I think so! Our job is to practice medicine, our common objective to help patients, and we are at our best when ministering to those who put their life in our hands.

A doctor's fulfillment should come from the intimacy of patient care, but in this decade, honor and principle have been held prisoner to the dollar and the bottom line. The hospitals have become entrepreneurial and we are unwisely following their lead. It has cost us the doctor-patient relationship; suddenly, almost overnight, the so-called third parties have become the second parties and we're on the outside looking in. The patient has become someone who contracts for care with "the system" instead of with a doctor, and the hospital has become the arbiter of patient needs. How quickly the astonishing becomes commonplace. I could even live with this if patients were better off, but I don't think they are. How can there be compassion in a system like this?

I believe the future standing of our profession rests on our determination and ability to convince our fellow citizens that if medical care is too expensive, which it may be, the proper place for the next cut is trimming the size of the giant medical-industrial-regulatory complex, not in reducing patient care and services. There comes a point at which human needs and corporate finances become divergent. Conflicts between altruism and financial imperatives are too often resolved in favor of the numbers, often under pressure from managers who do not see the big picture and whose jobs and advancement may be at stake.

We do have successes, and because of our successes we

have a wonderful opportunity, and indeed an urgent obligation, to go further than we have ever gone before to push back frontiers in trauma care. Judged by the sole criterion of our ability to help people, the practice of medicine and surgery is much more fun as time passes because we can do so much more for our patients than we could just a few short years ago.

I urge you and your friends to get back to medicine and avoid becoming ensnared in business. This entreaty does not come from a pie-in-the-sky idealist; I'm as pragmatic as the next fellow and understand the value of a healthy bottom line—in fact, I'm responsible for a few. But I would never accept that responsibility as an end in itself, only as a way to keep the hospitals open so we can do a better job for our patients. I think that the failure to make that distinction is the basis of our confusion.

Although the business of America may be business, the business of medicine is *medicine*. The Hippocratic oath binds physicians to serve only their patients, a social compact which has served doctors and society well. Fiscal considerations should be removed from medical decision making. Commercial values have no more to do with taking care of people than business ethics have to do with medical ethics. We need to go back to the time when the doctors decided what was good for patients and the Board of Trustees figured out how to pay for it.

Above my desk is a copy of the Norman Rockwell painting "Doctor With Doll," showing a country doctor listening with his stethoscope to a doll's chest, trustingly held by a little girl. Lately I look at it a lot more than I used to, because it reminds me of the simple concern and friendship that used to characterize our profession. It still can, of course, but it seems that it takes a lot more effort than it used to . . .

The chill of business is upon us. Doctors are caught between the Scylla of desire to take care of their patients, and the Charybdis of a public policy which seeks to limit health care cost. The sense of vocation, of "a calling," has collapsed. Our purpose and our ethic of service is in mortal jeopardy. If we do not recapture our values, our commitment to learning and our scholarly endeavors, we will become mere tradesmen and give up any claim to moral authority, and any hope of making a difference in the few short years given to each of us. Tradesmen buy and sell in the marketplace; doctors deal in trust, and hope, and courage.

Calvin Coolidge, my favorite president, said "we draw our presidents from the people. When they leave office, it is becoming for them to engage in some dignified employment where they can be of service to others. It is a wholesome thing to return to the people."

Your old president is just about ready to come back, looking forward to the joys of senior membership, however uncharted those joys may be. If you want to help me on my way, just do three things.

The first is to be a loyal and contributing member of

EAST. Just the fact that you would elect a pediatric surgeon says a lot about the warm and tolerant nature of this group. Show your support for the Association by becoming intimately involved in the issues, and articulating the directions you think we should take. EAST has limitless horizons, and can have a substantial impact upon the future of trauma care because the future belongs to its members.

I hope that whenever you can you will do something to support research. Pay attention to basic research, even if you don't do any yourself, because Doctor Francis Moore was right when he likened the surgical investigator to "a bridgetender, channeling knowledge from the biologic sciences to areas of clinical relevance." He meant it's up to you. The research system serves all of us, but it only works if clinicians stay involved.

Most of all, I'll be happy if you go home with a renewed sense of purpose to make trauma care better, and to devote your time and energy to becoming a missionary for the needs of your individual patients, and for all patients, so that their voice will more effectively be heard. It is up to you to decide if in this adverse climate, doctors will be able to preserve their historic influence and autonomy as advocates for their patients. In trauma care I believe that as a society and as a profession, we have yet to invest the time, talent, emphasis, or resources to combat our biggest public health problem, and that we

still entrust too much of the care to trauma patients to luck.

Remember how you felt on the day you finished training: "I'm a surgeon; I save people's lives with my bare hands; I'm the luckiest person in the whole world." You were right to feel that way, and I hope you always will. If you're still proud of what we do, and happy and grateful to do it, you can help a lot of people by going home and getting on with it. Judge your own life by the only standard that matters—your ability to help patients.

Presidents are notorious navel-gazers, often better at posing questions than at prescribing solutions. As I try to see past the turbulence into the future, I believe that in changing times our values are our best guide. We may not always know the road to take, but if we know where we want to go and what we need to accomplish, we'll get there. On a nice day you can take a plane up to 30,000 feet and see all the way up the East coast. But you can also get on a highway and make the same trip driving at night, and never see any further than what you see in your car headlights—but you can make the whole trip that way and get to exactly the same place. In the darkness of uncertain and changing times, the more we fall back on fundamental values and re-dedicate ourselves to doing the right thing, the more we become a driver with better and brighter headlights.

With a clear vision of where we want to go, no matter how dark the night, sooner or later we'll get there.