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Do It Right, Do the Right Thing

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Ladies and gentlemen, members of EAST, and guests! In preparation for this address, I reviewed my predecessors presentations. Dr. Maull urged us to dispel fatalism in 1989. **[1]** Dr. Harris searched for values in our changing times. **[2]** Dr. Jacobs identified forces that shape trauma care. **[3]** Dr. Champion reflected on directions of trauma care. **[4]** Dr. Schwab identified the largest sociomedical problem of the turn of the century. **[5]** Dr. Rhodes gave practical guidelines for trauma care. **[6]** Dr. Boyd reported on the principles of action. **[7]** Each was a prescient view of the challenges to trauma care. I urge each member to review their comments.

I will focus on a continuation of their theme and offer an action plan. I have decided to do so because we stand on the threshold of a new century. Each of us has come to this place in time with unique experiences of mentorship, academic preparation, and clinical experience. Our common thread is our dedication to the trauma patient.

Each will be asked to address issues and challenges daily. How we do so and what we do will effect generations of future trauma patients. At the turn of the century we are facing questions like: Can we define life, liberty and the pursuit of happiness specifically? Can we reliably ensure access to health care for all?

Our sense of mission and vision of the future are important components as we deal with the challenges and questions. My presidential address is a call to active advocacy. I implore you to "Do it right, do the right thing".

Modern health care advocates autonomy not cohesiveness. It values patient choice but reduces patient options. It promotes the bottom line and not people. It sees outcome through economic glasses. It replaces a commitment to excellence with a mandate for equity. It does not ensure equal health care to the economically challenged. It is a bean counters plan concocted by people who don't know beans about health care.

This is the result of society's failure to address basic issues of health care and economy. Largely, it is a failure of professional and political leadership. Professionally, many of our colleagues take more than they give. Politically, many of our leaders use health care and social systems for their own gain. Somehow, we have lost the vision of our mission and responsibility. **Figure 1**

Figure 1.

Entrepreneurs found health care in the seventies. The medical market place was an open and largely unregulated area. It soon became dominated by technology that superseded the normally accepted "doctor skills". Hospitals became technological marvels. Public policy for Medicare and Medicaid created a funding source that could supply this market with sufficient funds to make entrepreneurial investment reasonable.

Some define this entrepreneurship as an organized license to steal. Others see it as the natural order of life. In the initial phases, it provided resources and fulfilled the dream of universal health care, where every malady could be addressed directly. In the later phases, it created circumstances where health care devices have astronomical prices and minor problems have million dollar responses. Decisions are directed by the corporate bottom line and controlled by the fear of litigation.

The process has made us all commodities to be managed and used. Health care is provided according to the number of covered lives per annum. Health care providers are seen in terms of the number of contact hours per day. We are part of a system of health care delivery that sets a priority on certain types of care. Delays in delivering care are economically driven. The bottom line is important. The question is whose bottom line is being valued in the decision process.

Students are taught more about the cost per dose than the pharmacology of the drug given. They are indoctrinated to careers and training programs are modified according to the mantra of managed care. Residents are concerned with a "niche market," attractiveness of their skills to their eventual employer, and their benefits package. Attending staff are evaluated according to the length of stay of their patients or the number of resource days utilized.

The natural result is a struggle for the control of health care. In many ways, health care providers and patients are in a "free fire zone" in a modern economic war. Neither controls the environment. Both are victims and victimize the system simultaneously.

Today, the other side is winning.

However, all is not lost. Groups of health care professionals are addressing issues aggressively. The Phoenix analogy that a better health care system may emerge from the ashes of the past health care system has become a popular concept in groups who accept the challenge of change. The major goals of these groups are intelligent organization, focus, and outcome-based service.

None of the issues are new. Most of the issues, challenges, and responses have been with us for a long time. The history of the response to change in medicine is nicely chronicled in Paul Starr's book The Social Transformation of American Medicine. **[8]** I recommend it to each of you.

The latest hot topic is managed care. At its best, managed care is a system of care that tries to address all of the needs of patients. It proposes to manage access, maintain outcome, and decrease cost. The question is who manages it and to what goal is it managed.

I submit that the ideal trauma system is a complex managed care organization that addresses all the needs of the trauma patient. In many ways, the development of local trauma systems is 20 years ahead of the rest of health care delivery. I have been able to closely observe three trauma systems over the last 5 years. Illinois, Pennsylvania, and New York have faced issues and achieved answers. The answers are different in each place. Still, they work.

They have done so with system principles largely developed by members of this association. Dr. Jacob's contributions to trauma as a public health issue, Dr. Champions's contributions to measurement of outcome, Dr. Schwab's view of violence prevention, and Dr. Rhodes' contributions to quality and practice guidelines have made significant contributions to this effort.

Yet, these systems are in jeopardy. Some health care planners advocate an open market where all providers compete for patients, where the cost for care and the length of stay are markers of efficiency. In this type of market, all patients are not equally represented. The majority of trauma victims have no voice in these decisions. Many are socially or economically disenfranchised. They are seen as the users or abusers of health care in a system where they contribute little. Some believe that the trauma victim contributes to his or her predicament and deserves the outcome.

Our commitment to patient care demands that we participate on a daily basis. We must assume the role of active advocates. Our success in dealing with the challenges will be based in our personal vision, education, commitment, and organization. Clearly, if we do not take action, the Phoenix will be reborn without our contribution. Care of the trauma patient could remain in the ashes. We must do the right thing and do it right.

I believe there are five themes that we must embrace to be successful in doing the right thing: (1) We must realize that the whole is greater than the sum of its parts. (2) We must accept that a trauma system is not a bureaucratic place, but a people place. (3) We must insist that trauma will remain strong only to the degree that it will commit to excellence and equity for all. (4) Trauma surgeons must relate their research to the urgent social problems in trauma care. (5) The trauma system must reaffirm the essentialness of service.

Let's inspect these five themes more closely. The whole is greater than the sum of its parts. Every trauma system has components. Each seems minor in scale. Prehospital care providers, ambulance systems, emergency physicians, trauma surgeons, critical care nurses, physiatrists, and rehabilitation therapists are individual components of a trauma system. Separately, they have little impact. Yet, working together they have significant impact.

A trauma system is not a bureaucratic place, but a people place. People get injured. In the development of system response, concentrating on the bureaucracy is easy and attractive. Writing protocols or guidelines, demanding response times, confusing quality with documentation is easy. We must emphasize that the system is people serving people. Each person has the potential to become a victim. When injured, the patient is not a commodity, but a member of a community. Failure to deal adequately with the least member of the society is a system failure that diminishes each of us.

Trauma will remain strong only to the degree that it will commit to excellence and equity for all. Some believe that the trauma patient contributes to his or her own outcome and deserves the outcome. Many are victims of social and societal abuse beyond their control. Many have lost the support of the society by their own actions. Still, excellence in care and equity for all patients regardless of background must be the sustaining principle.

Trauma surgeons must relate their research to the urgent social problems in trauma care. Accidents don't just happen. Complex social events contribute to them. Recidivism in personal violence trauma is based on drug abuse and social injustice. Motor vehicle crashes are based on alcohol abuse and poor judgement. The traumatic event is the outcome of deeper issues. Real prevention has a real impact.

The trauma system must reaffirm the essentialness of service. For thousands of years, physicians have served the infirm and injured. This has given us a privileged position in society. Any system of service has to achieve this goal. Each of us can become a victim. If this happens, the system must serve our needs directly.

I return to my original position. Change in health care is inevitable. We have accepted the responsibility for the injured patient. The membership and leaders of EAST have addressed the challenges aggressively. Each has offered wisdom that can be applied to the challenges. We have the ability to deal with the challenges. We have the responsibility to be the advocate for future patients who have no voice in the present discussions.

Do it right, do the right thing. Make the whole greater than the sum of its parts. Make the trauma system work for people, both patients and professionals. Make a commitment to excellence and equity. Use your considerable skill to show how modern trauma care deals with urgent social problems. Make service to injured patients the primary goal of each trauma system. If you do it, it will be the right thing.

In closing, I would like to reaffirm my appreciation for the high honor afforded me by the Eastern Association for the Surgery of Trauma and thank the membership for the privilege of the floor and the honor of serving as your President.

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