I am thankful for the great honor and privilege you have bestowed on me in allowing me to serve as your President during the past year. It is particularly humbling to be standing before you, my professional peers, at this unique moment in time—June 7, 1999. There are 207 days, 12 hours, and 27 minutes left in this millennium, and the clock is ticking. As time runs out on this millennium, it seems appropriate to reflect on the issue of time and to review the past, take stock of the present, and think about the future and the future of vascular surgery. But first, I would like to reflect on what is most important in my own past, present, and future, and that is my family, my heritage, and my profession.

My family came to this country 54 years ago as refugees of World War II. I grew up in the parish house of the Latvian church in Brooklyn, NY, where my father to this day continues his commitment to his profession, the ministry, and devotes himself to the needs of the members of his congregation. As has been the case for millions of other refugees from around the world, the terrible misfortune of war and devastation also provided an incredible opportunity in America. I am grateful for my good fortune to have grown up in America and am mindful of my even greater fortune of the love and support of a wonderful family. Please permit me to pause for a moment here to thank my family: my parents, who brought me to this country and selflessly supported my growth and education; my wonderful, loving wife, Zinta, who has stood by my side, unfailingly supporting my professional career while nurturing our family in two cultures, Latvian and American; and my three wonderful children, Daina, Sascha, and Karina, all of whom speak fluent Latvian. There are no adequate words to thank you, at least not in English. Mīls, mīls paldies.

I would also like to thank my mentors: Dr William Fry, who set for me the standard of clinical excellence—surgical precision and patient care above all else; Dr David Skinner, who set for me the standard for academic excellence—combining research, teaching, and patient care into the everyday life of an academic surgeon; and Dr Seymour Glagov, who set for me the standard for basic investigation—the understanding of the fundamental biologic and pathologic processes of vascular disease. I am grateful for the support and inspiration of my superb colleagues on the faculties of the University of Chicago and Stanford University and for the creativity, energy, and commitment of the students, residents, and vascular surgery fellows with whom I have worked. They are the real future of vascular surgery.

Meanwhile, in Latvia, the Soviet occupation would last 50 years. Many of those in my family who were not killed by the Communists were deported to Siberia. Their opportunities were quite different from mine. This became a stark reality for me when I first visited Latvia in 1986, then still an occupied country under Soviet rule. For the first time, I met my relatives—my first cousins, who were my age, and their children, who were my children’s ages. We saw how different our lives were as a result of fate and government systems. We sometimes take for granted the incredible freedom and opportunities we enjoy in America. We must guard and protect our individual freedom against ever-increasing governmental regulation and control. I am filled with a great sense of gratitude for this great land of opportunity that is now my home, the United States, and a desire to give something back to my native country, Latvia, and to those less fortunate than I.
We have in our audience today five vascular surgeons from Latvia. Their situation in Latvia is a far cry from what we enjoy in the United States. Doctors in Latvia do not enjoy the wealth, status, and power that we do. They work in antiquated hospitals with inadequate resources and supplies. They receive meager salaries, and most of them must have second jobs to pay the bills. Despite this sad state of affairs, these are professional, dedicated, capable physicians. They work hard and provide good medical care. They did not go into medicine for the money. They are in it for the reasons we all went into medicine in the first place—to take care of the sick. Perhaps we can gain some perspective from our Latvian colleagues as we consider the issues that face us today.

Despite having the best healthcare system in the world with the knowledge, resources, technology, and capability to cure disease like never before, we are surrounded by a sense of doom and gloom. Doctors are frustrated and unhappy, patients are frustrated and unhappy, and the healthcare system is in turmoil, not because of factors within medicine but because of external economic forces that are threatening medicine. The managed care revolution, with its inherent focus on cost cutting and profit seeking, has dramatically altered the way medicine is practiced in America. The medical profession is under siege. It seems as though the healthcare of our nation, which society always had entrusted to medical professionals, has now been placed in the hands of financial people: chief executive officers, chief financial officers, administrators, and business managers.

The economic crisis in healthcare has raised many important questions. Will medicine play a major role in determining the health of society in the future? Will patients look to their doctors for advice, or will healthcare analysts and financial planners choose treatment? How can we resolve the conflicts between professionalism and managed care? Will the doctor of the 21st century be a true professional or merely the instrument of an insurance company trying to place barriers before patients and restrict access to care?

These are the fundamental questions that we must address in this age of turmoil and rapid change to understand where we are going in the future. And in doing so, it seems to me, we can boil it down to three key issues: time, money, and professionalism. Do we have time to be physicians and surgeons? Will there be enough money for medical care? Will the profession of medicine survive?

First, let us consider time. A millennium seems like an eternity. As a child, I remember how time seemed to stand still. Summer vacation lasted forever, and then the school year would never end. But now, each passing year is a smaller and smaller percent of my lifetime. A year passes in a moment. And now time will run out in this millennium.

In a review of the past millennium, it is remarkable not only how things have changed but also how rapidly the rate of change has increased, particularly in the last half of the last century of this millennium. In our everyday lives today, we are using technology that we did not even dream was possible just a decade ago. Much of the technology is focused on labor-saving devices that would give us more time: machines, tractors, vacuum cleaners, and dishwashers.

Just thirty years ago, the experts were assuring us that, with advances in technology, our biggest challenge would be what to do with all the leisure time we were going to have in the future. But the future is now, and life for most of us has become so complicated, rapid paced, and stressful that the idea of leisure time has become antiquated. We have run out of time. We want more time, but we cannot get it. Time quickly disappears and is gone forever.

We need more time. We need time for our patients. We need time for our families. We need time for ourselves and for our everyday lives. We need time for the profession of medicine and for the profession of vascular surgery. The care of patients with vascular disease requires time. As we lose time and get busier and busier, we seem to be enjoying it less and less.

In this all-too-fast-paced environment, we must take the time to stop and reflect, to reorganize our priorities. What is really important to us as individuals, family members, physicians, and vascular surgeons? Why did we go into medicine in the first place?

It is no accident that the fastest-growing segment of the healthcare market is alternative medicine. Patients seek out chiropractors, herbal and Chinese medicine practitioners, and faith healers of all types because they spend time with patients, provide them with information and hope, and give them a role in their own healthcare decisions. We must be there for our patients. We must provide the time they need if we are to survive as the specialty that provides care for patients with vascular disease.

The second critical issue is money. Just as we have run out of time, we also seem to have run out of money. In this era of managed care, health maintenance organizations do not manage care but manage costs. Both nonprofit and for-profit health maintenance organizations compete for patients largely on the basis of price. They focus on the short term by reducing monthly premiums to sign up as many “covered lives” as possible and balance the equation...
by rationing care. This is particularly pernicious when physicians are taken out of the decision loop or, worse yet, when physicians are placed in positions of conflict of interest by the use of economic incentives to withhold care. Physician reimbursement patterns provide a disincentive for physicians to spend time with their patients. Whereas we have grown up thinking that “time is money,” we now find that “time is no money.”

In most professions, including the legal profession, services are billed on the basis of time spent. This is not the case in medicine. We are being asked to do more and are being paid less. This is particularly true in vascular surgery. Vascular surgery services are time intensive and were undervalued when the relative value unit (RVU) system was introduced in 1992. This is because vascular surgeons were not represented in the Hsiao studies, which set the relative work values. Vascular society efforts to rectify this problem, led by Hugh Trout, were blocked by the Health Care Financing Administration (HCFA) in 1993. The further decline in Medicare reimbursements that was mandated by the Balanced Budget Act of 1997 is now resulting in a crisis for vascular surgery.

In September of last year, the Joint Vascular Societies again appealed to HCFA for revision of Medicare payment policies. Drs Zwolak and Oblath presented extensive and convincing data to the Administrator of HCFA, Nancy M in-D eParle, that the medicare fee schedule reductions imposed on vascular surgery were a severe threat to the future of high-quality vascular surgery. They pointed out that the abrupt elimination of the separate surgical conversion factor in 1998 cut 9% from our Medicare payments in a single year. We now face another 12% reduction with resource-based practice expense. Carotid endarterectomy, our most commonly performed operation, is a good example. In 1992, the global RVU was 35.26 with a typical payment of $1200. In 2002, the total RVU will be 31.08. With an adjustment for a 3% annual inflation rate and with the unlikely assumption that the conversion factor will not decrease further, the typical Medicare payment in 2002 will be only $800 in 1992 dollars, according to a letter from R.W. Oblath et al, September 1998. This represents an absolute payment reduction to the surgeon of 33% in a decade when all other medical expenses have increased much faster than 3% inflation and when, during the same period, inflation-adjusted payments for evaluation and management services increased substantially.

Our Governmental Relations Committee, headed by Bob Zwolak and his team of Bob Oblath, Hugh Trout, Tony Sidaway, Gary Seabrook, Craig Kent, Denny Baker, and Carlo Dall’Olm o, has made our voice heard in Washington and has made important progress on our behalf. But the obstacles and problems abound, with no real relief in sight.

Remember that 70% of our patients are Medicare beneficiaries, so we depend on the medicare fee schedule more than any other specialty. And in Medicare, we now find ourselves in a zero sum game in terms of healthcare economics. There is only a finite sum of money available for Medicare patients. The federal government has mandated no increase in Medicare expenditures. In fact, they will decrease dramatically as a result of the Balanced Budget Act of 1997. Of the $127 billion that is to be saved over 5 years, $116 billion will come from reductions in Medicare. The bottom line is that, to maintain budgetary neutrality as the number of Medicare beneficiaries inevitably increases, the conversion factor must decrease. It is no secret that we will work harder and be paid less.

This change will be implemented by a progressive reduction in the RVU reimbursement rate. We will simply be paid less for the same amount of work. At some point, if this trend continues, we will reach a time when it no longer pays to deliver the service. Of course, we cannot NOT take care of the patient. We always have, and we always will. But at some point, one goes out of business and stops practicing altogether. It is not overstating the problem to contend that the reductions in Medicare fees from 1992 to 2002 threaten to eliminate high-quality vascular surgery. We are already at risk of losing our most valuable resources: wise and experienced vascular surgeons with the largest practices. In the last few years, we have seen many of our most skilled colleagues retire early because of frustration over rapidly declining reimbursement. Perhaps even more worrisome is the fact that we may not be able to nurture our “young,” our students, residents, and fellows, to become future vascular surgeons because of their fears, which, I might add, are well justified, that after 7 or 8 years of postgraduate training, they may not be able to pay off their medical school debts and earn a reasonable living.

Given this bleak picture, one might ask, “Why would anyone choose to go into vascular surgery?” In fact, I believe there is a real danger that in the future we may find that the brightest and most qualified students and residents will choose fields other than vascular surgery. The long hours required for vascular surgery and inadequate compensation may result in a decreasing number of vascular surgeons and too few specialists capable of direct vascular
repair. The future shortage of vascular surgeons may be significantly worse than those numbers projected by Dr Jim Stanley’s workforce study. These problems will be compounded by the economic crisis that faces hospitals, particularly the academic health centers. Most major teaching hospitals are now losing money, despite record numbers of patients, operating rooms at capacity, and a demand for services that is greater than ever. Some of the nation’s most prestigious academic medical centers report losses as high as $1 million a week. The deficits are prompting massive layoffs of staff and reducing hospital bond ratings. Strategies that involve mergers and acquisitions seem to be failing, and we are beginning to see bankruptcies of major teaching facilities. Many teaching hospitals are threatened. These are the very hospitals that are the major providers of healthcare to the poor and indigent. How will we meet this crying need?

Furthermore, will there be funding for graduate medical education? The National Bipartisan Commission on the Future of Medicare disbanded in March of this year. The commission fell one vote short of the 11 needed to achieve the super majority necessary to endorse a proposed set of reforms to Congress and the President. The plan by Commission Chairman Senator John Beaux proposed, among other reforms, to end the entitlement status of the $2.2 billion direct and indirect Medicare financing for graduate medical education. Such a process would shift graduate medical education financing to the annual appropriations process and would threaten the financial stability necessary to support residency programs that last from 3 to 7 years. Senator John D. Rockefeller IV, one of the seven who voted against the plan, warned advocates for teaching hospitals that the Medicare reforms stand a good chance of being passed by the Senate. It seems no one wants to pay for medical education, and the buck is being passed.

We therefore need to consider not only will anyone want to go into vascular surgery, but also what will be the teaching environment for future vascular surgeons? This is a critical question for the future of our profession. What else does the future hold? The great philosopher Yogi Berra once stated that “the future ain’t what it used to be.” However, in many ways, the future is dictated by what already has happened. Consider, for example, the influence of birth rates. We can know what will happen in the future simply by knowing how many babies are born each year. Add to this the immigration rate, and you will know what the population of the country will be years into the future.

Generation cycles, which have been tracked as far back as the 1400s, occur every 40 years. In the United States, immigration, rather than birth rate, was the driving factor behind growth and generation cycles before the early 1900s. A surge in the birth rate from 1945 to 1965 along with a great increase in immigration created the “baby boom generation” that we hear so much about. This generation will be four times the size of the previous generation. The members of this generation are now at the peak of their productivity and consumption. This is, to a large extent, what is driving our current and prolonged economic boom. But soon they will reach retirement age, and these baby boomers will become Medicare patients. They will spend less, and the economy will decline. Advances in medicine, public health, and nutrition have increased longevity, and this generation will be the first generation that has not physically toiled for 40 years before retirement. They will be in better shape to have vascular disease. An individual born in 1997 can expect to live to 76.5 years, about 29 years longer than a person born in 1900.

Thus, there is no question that the number of elderly people and the number of patients with vascular disease will increase markedly in the next millennium. One hundred years ago, only three million Americans were more than the age of 65 years. Today, 33 million Americans live beyond that age. By the year 2040, the number of individuals in the United States who are more than the age of 50 years is expected to double, jumping from 70 million to 140 million. Today, there are roughly 38 million Medicare beneficiaries, but by 2030, when the last of the baby boomers will be 65 years old, there will be 76 million Medicare beneficiaries. The demand for vascular care will be unprecedented. We must begin thinking about how we will meet this demand. Again, will we have enough vascular surgeons, and how will we pay for patient care?

If we do not address and solve these problems, the losers will be the patients with vascular disease. And from a societal standpoint, that is a major concern—the prospect of not having qualified practitioners to perform sophisticated, high-intensity vascular surgery in the future. A decline in the quality of vascular care will cause significant increases in costs to the healthcare system. Will there be a significant decrease in the quality of care? Will we see more strokes, amputations, and ruptured aneurysms? Will we see the day when major treatment decisions are made on the basis of reimbursement patterns?
Today, for example, a radiologist would be paid more for venography and placement of an inferior vena cava (IVC) filter than we would be paid for a femoral-distal bypass grafting procedure that would take 4 to 6 hours. Percutaneous catheter-directed thrombolysis, angioplasty, and stenting pay about the same as a ruptured aneurysm repair. Moreover, we care for that patient for 90 days with in-hospital care, intensive care unit care, and postoperative care, and perhaps weekly follow-up visits in the clinic if wound care is required, all for the same global fee. However, the percutaneous interventional procedure can be repeated the next day and the day after and full payment will be received for each procedure. It would be a tragedy if the ultimate solution were to apply therapies because of how they are reimbursed and to abandon those therapies that either are not reimbursed or are reimbursed inadequately. The reimbursement schedules should be fair and should reflect the time and effort expended lest unintended consequences occur that are not to the benefit of the patient.

What can we do to address these issues? First, we must bring public awareness to the problem. Individual patients and doctors are already aware that there is a problem. But this must become an issue for Congress and for the President. In the future, the most potent political force in our country will be senior citizens, not only because they are so large in number, but also because they are the one demographic group that consistently goes to the polls and votes. Thus, the concerns of the senior citizens will be heard and addressed. We must support our social and legislative issues committee and educate our citizens on the importance of vascular disease therapy. We must work together with our interventional colleagues to ensure that a coding and reimbursement system is in place that will properly pay for services rendered and effort expended regardless of specialty. We all must become involved and begin to address the issues of supply and demand before the supply of vascular surgeons runs out and the demands of our senior citizens cannot be met. We must protect our research and teaching environments and stimulate our students, our residents, and our fellows by being role models in the profession of vascular surgery.

But all is not doom and gloom. I, for one, believe that the problems will be addressed and solved—they always are. Worsening problems will force change. The aging population in future elections will demand it, and science and technology will come to the rescue with new and more effective treatment strategies. Science and technology have always led the way.

The remarkable advances in genomics and molecular biology and pharmacology will transform the practice of medicine. The changes that we have witnessed during the past few years in the rapidly changing technology of the treatment of aortic aneurysms, carotid artery disease, and peripheral occlusive disease have made it clear that vascular surgery will never be the same. Will we grow and adapt, accommodating and embracing the technology and changes, or will we let the world pass us by? We are on the cusp of a paradigm shift in vascular care, which will be spurred by enormous increases in demand. The decline in reimbursement for time-intensive open surgery threatens this mode of therapy, but it will not disappear, and it will continue to play a role in vascular surgery.

New technology, new imaging capabilities, and web-based communication will revolutionize the way people seek and find their doctors, the way we practice and administer treatment to vascular patients, and the way we are compensated. New technology has already revolutionized the way we visualize blood vessels and envision the treatment of vascular disease. Diagnostic methods will be noninvasive, with complete three-dimensional imaging of the vasculature that will soon replace diagnostic angiography. We will be able to plan and execute treatments in virtual reality and test their effectiveness before instituting treatment. Catheter-based treatments will largely replace open surgical procedures, and vascular surgical care will dramatically change. Perhaps a large part of what we do will be outpatient based. Outmoded methods of treatment will be abandoned, not necessarily because they are ineffective or risky, but because the patient will demand the newer noninvasive methods. Witness the growth of carotid stenting when a proven, effective surgical therapy is available.

However, although new techniques and technology are critical to the future of vascular surgery, we must remember that technology is merely a tool. The more complex and sophisticated treatment options become and the more information and choices become available to patients on the Internet, the more people will need the wise counsel of a knowledgeable doctor. They will have information overload and will not know where to turn. There will also be an enormous segment of society that will be left behind in the information age. The knowledge gap will widen enormously.

Patients will more and more need the advice and comfort of a caring physician. And yet, patients more and more are increasingly believing that they have no doctor. Many perceive that the principal focus of medicine is moving away from its focus on
caring. Patients feel shortchanged by the hurried pace and brevity of their encounters with doctors. They want their doctor back.\textsuperscript{14}

This brings me to the third and most important subject: professionalism. You may recall that when the Clinton administration began its effort to reform healthcare in this country, it convened a secretive panel led by Ira Magaziner. Notable was the fact that this panel, which would set the course and direction of the nation’s healthcare for the future, excluded doctors and physician organizations. We heard such things as “if we could control Medicare fraud and abuse there was enough money to pay for the care of the nation’s uninsured.” Although the Clinton health plan failed, the legacy of excluding and distrusting doctors persists. The government has launched a crackdown on Medicare fraud and abuse, contending that simply the submission of an inaccurate bill may constitute fraud. We are guilty until proven innocent, and the government is enlisting our elderly patients as “whistle blowers” with bounty payment rewards to detect allegedly fraudulent bills.\textsuperscript{15} Does this represent mistrust only by our government, or do our patients no longer trust us? Does the public no longer trust doctors? Is the medical profession no longer entrusted with responsibility for the nation’s health?

Professionalism is a commitment to subordinate one’s self interest to the interest of one’s patients. This constitutes the very foundation of trust on which our social contract rests. Maintaining the mutual trust in the doctor-patient relationship is the only way to assure the public that medicine is fulfilling its sacred obligation. No patient’s bill of rights, no laws, no review panels or regulations, no whistle blowers or watchdog federal agencies can substitute for the fundamental TRUST and CARING that are central to the profession of medicine.

There are several features that characterize professionalism: (1) altruism and a commitment to a greater good; (2) a high degree of knowledge, special education, and training; (3) the ability and willingness to apply that knowledge and skill to a greater societal good; (4) autonomy and the right to self regulate and society’s implicit trust in that self regulation; and (5) conformance to and development of a code of ethics, such as the Hippocratic oath.\textsuperscript{16}

However, the principles of professionalism are in direct conflict with the commercialization of medicine. Ethical challenges exist in reconciling Hippocratic medicine, which is based on the doctor-patient relationship, with population-based healthcare, in which considerations of cost effectiveness and distribution of healthcare resources are focused on achieving the greatest good for the greatest number of people. This puts us in conflict as professionals. Do we care for our individual patient above all else, or do we devote ourselves to healthcare systems that distribute services to people on the basis of population or group outcome measures designed to control costs and improve efficiency? We, as surgeons, have always dealt closely and directly with our individual patient. Will we still have the right to put our patient first, above all else, in the future? Along with the compensation issues I discussed earlier, the managed care revolution is threatening professionalism in several important ways.

The first threat is an attack on professional judgment. One of the central characteristics of professionals is that they are empowered and obligated to make judgments that are in the best interests of their patients. Although scientific data and evidence have been critical to the advancement of medicine, the application of evidence-based medicine to treatment algorithms eliminates the professional from the decision-making process. We see this in the current popular notion that new treatments can only be advocated if validated by prospective randomized clinical trials—a process, which by its very nature, eliminates professional judgment. For example, to participate in a prospective randomized clinical trial on carotid stenting, the vascular surgeon must be able to say to his or her patient that “in my best professional judgment, I do not know which form of treatment is best for you, endarterectomy or carotid stenting, and I, therefore, give you the opportunity to participate in a trial where the treatment will be chosen at random.” In other words, “I have no advice or recommendation for you, my patient.” That is not to say that we do not need to do the study or that we do not need to know the outcome of such a randomized trial, but it does pose an ethical dilemma for the doctor’s professional judgment and commitment to the best interests of the patient.

Evidence-based medicine is statistically oriented and eliminates physician judgment for an individual patient. It is population-based medicine, not individual-based medicine, which is at the core of the doctor-patient relationship. Brought to the extreme, this strategy could eliminate physicians from making therapeutic recommendations and decisions and have technicians apply treatments based strictly on statistically based “evidence.” I believe this would be as detrimental for patients as it obviously would be for the profession.

The second attack is on collegial self-regulation. A core value of professionals is that a profession is a self-regulating body of people. The profession sets and
regulates training curricula and standards and oversees peer review of practice standards. Surgery has a long tradition of upholding standards through the American College of Surgeons and the American Board of Surgery. As the field of vascular surgery has grown and evolved as its own distinct specialty with its own body of basic fundamental knowledge and unique clinical expertise, the need for it to regulate itself as its own professional discipline has become apparent.

Thus evolved the Program Evaluation and Endorsement Committee, the vascular fellowships under Residency Review Committee review, the Association of Program Directors in Vascular Surgery, and the American Board of Vascular Surgery. The importance to the vascular surgery profession of board regulation of training standards by vascular surgeons has been emphasized by Dr. Stanley in his Presidential address to this Society.17 The creation of a sub-board for vascular surgery under the umbrella of the American Board of Surgery is evidence of the evolution of vascular surgery as its own profession, which requires peer self-regulation. The early work of the sub-board has been promising, and we must work to develop it as the mechanism by which we, as vascular surgeons, exercise our obligation to self-regulate our profession. This is the standard by which the success of the sub-board should be judged. It is encouraging that professional groups, rather than splitting apart, now are beginning to join together to challenge the attack on the overall profession by the managed-care economy and regulatory changes occurring in our society. We must maintain our right to self regulate to maintain our profession.

Although professionals receive remuneration for what they do, this is not our primary motivation. What really motivates physicians is membership in one’s professional society of peers. Peers set the standards. Peer review and acceptance and a focus on peer professional activities are central to our lives. Witness the importance we attach to membership in the Society for Vascular Surgery and the International Society for Cardiovascular Surgery. If our peers do not accept us, we are outcasts. Each hospital has its own peer review mechanism, both formal and informal. We evaluate ourselves and our peers on an individual basis. We monitor our own results, and, as Norman Hertzer correctly concluded in his Presidential address, “results are everything” in vascular surgery.18 We must demonstrate our outcomes and results to our patients, our referring doctors, to the payers, and to the public.

However, the current enthusiasm for outcome analysis with large-sample, computer-generated analysis of large data banks again risks missing the boat of individual result assessment. Managed-care advocates are purely financially driven in studying outcome analysis. Excessive zeal in evaluating outcomes without reliable risk stratification (and I have not yet seen a reliable way to do this, given the complexity of patients) runs the risk of focusing healthcare on patients with good risk and denying care to the patients at high risk and to those who are most infirm.

The third element under attack is professional development and education. Adequate training and the instillation of the essential ingredients and characteristics of a profession require a professional community that is alive and well. Medicine is not carrying out a technical exercise but living a professional existence. There is a process of initiation into the profession through our educational and training programs, including internship, residency, and fellowship. These long and arduous years of training must now increasingly clear that we must work together to instill core values and judgment through mentorship and professional role models. We must preserve and protect our teaching environments.

Cooperation among different specialties is also important in the current economic climate. Although turf battles may have been popular in years past, it is now increasingly clear that we must work together to preserve the right to deliver the highest quality care to our patients. Gone is the idea that “we will not teach you this or that technique in the hope that we can keep it for ourselves.” Such logic never had merit, for technology and techniques are simply techniques. Technology cannot be owned by a specialty. Techniques do not comprise a discipline or specialty—they are simply tools. Different specialties may use new tools and technologies in different ways, which are appropriate for their patients and practices. We must begin by integrating educational activities to improve communication. Each of our multiple vascular specialties brings a different and complementary perspective on the same fundamental problem: vascular disease. We can, and we do, learn from each other, for vascular disease is one that requires a long-term commitment of care for each patient from professionals.

There can be no doubt that professionalism in medicine provides an intrinsic value. Professionalism is good for society, good for individuals in society, the patients, and good for the professionals themselves. Society entrusts the health of its members to highly skilled and well-trained individuals who have a moral obligation to promote the health and well being of the members of society.19

The individual members of society benefit from
this professionalism through improved health, a sense of well being, and moral confidence in knowing that the physician is there for them, ostensibly with only one motivation—to provide the best possible medical care.

And the professionals themselves benefit. Society provides many rewards to the professional physicians, among them power, status, and wealth. But these are not enough. Internal rewards, such as self esteem, gratitude from patients, professional satisfaction, and companionship and praise from colleagues, are also necessary. These rewards are based on relationships, and they require time to cultivate. The doctor-patient relationship is paramount to professional satisfaction. And frankly, this is what is most threatened by the managed-care revolution.

Although management guidelines and evidence-based medicine may be effective for certain populations of well-defined and specified conditions, they are unlikely to be effective for the patients who are the sickest and need a doctor the most. In cases of mortality, complexity, chronicity, and debility, the physician must exercise individualized care and judgment. The doctor-patient relationship is most critical to patients at these times of crisis and uncertainty in their lives. They want and need someone who cares for them and about them. As the population ages, more patients will demand the right to have a long-term relationship with a physician they can trust because there is value in the relationship itself.

For the doctor, the doctor-patient relationship is also critical, not only for our personal satisfaction as physicians but also for the future of our specialty. Vascular surgeons were the first to develop effective methods of vascular therapy and reconstruction and noninvasive vascular diagnosis. With these tools, vascular surgery evolved as a specialty focused on the short-term and long-term management of patients with vascular disease. We have an understanding of the natural history of vascular disease and of nonoperative, conservative strategies and the outcomes of direct and indirect treatments. The direct long-term interaction and focus on the patient as a whole is critical in being the vascular doctor. But as technology advances, what remains is the doctor-patient relationship, and the maintenance of this relationship is the future of vascular surgery.

The critical question is, who will fill this role? Will vascular surgeons be professionals who provide care to patients with vascular disease? Or will vascular surgeons become technicians who apply therapy while allowing physicians in other specialties to assume responsibility for vascular care? It is my belief that the key to preserving our place as the primary caretaker of patients with vascular disease is preserving the doctor-patient relationship.

Now I have some thoughts on the future for the next generation of vascular surgeons.

Despite the problems that surround us, now is a good time for vascular surgery. This is a time of great advancement in the field, of breakthrough, fundamental changes in the way we think about and treat vascular disease. The explosion of new knowledge will continue, and you have an opportunity to be at the forefront of this expanding knowledge base. To this extent, you are fortunate to have the active support of the Lifeline Foundation, the National Institutes of Health, and the industry to support your investigations.

Seize the opportunity to learn and expand your horizons over and above standard open vascular reconstruction. But do not abandon the basic fundamentals of vascular surgical practice: learn them and practice them well because no one else will have the capability of direct, open reconstruction when needed, the most definitive and powerful treatment. The next 5 to 10 years will be tumultuous, uncertain, and anxiety filled as the healthcare system restructures itself. Do not lose faith. The practice as we know it will change, but the patients' needs will not change. They will be there, and you must be there for them. Keep at the forefront. In addition to vascular reconstruction, there will be gene therapy, catheter-based therapy, new technology, new strategies, strange proposals—some will work, many will not. But always maintain the best interests of the patient foremost.

After 10 years, there will be an unprecedented demand for your services. If you have been under compensated up to this point, you will now be paid a premium. The massive increase in patient demand will be accompanied by an inadequate supply of skilled vascular surgeons, particularly those with skills in open surgical repair and reconstruction. General surgeons will no longer have the skills for major aortic surgery. You will be overwhelmed by demand. This demand for your services will continue throughout your career. As demand increases, training programs will be expanded, but given the length of time needed to properly train vascular surgeons, the buildup will be slow. The proper number of surgeons will likely be reached just about the time the number of patients begins to decrease in 2040, and then there will be a surplus of vascular surgeons. Thus, this is the golden era for the next generation of vascular surgery. Enjoy it and make the most of it.
My advice:
1. Be receptive to new ideas and new strategies.
2. Learn endovascular skills, evaluate new technology, and incorporate them into your practice as appropriate while maintaining your surgical skills.
3. Generate new knowledge, for knowledge will lead the way.
4. Work together with your colleagues in other disciplines to improve the care of patients with vascular disease.
5. Preserve and promote professionalism and the sacredness of the doctor/patient relationship.

Let me conclude by once again addressing the special elements of time and caring. As we have seen, the current economic climate is to reduce costs and to reduce reimbursements for time and energy expended. There is no compensation for more time spent with a patient. In the case of global billing, extra time means no extra money.

Yet time is the indispensable element that cannot be replaced in the doctor-patient relationship. And it is this element of time with the patient that is incompatible with medical care for profit.

Time is required for caring. Time is required for professional judgment, and that time varies with the complexity of each case. But the most important element is the interaction and contact with the patient. There must be communication, which is free from the constraint of time, at least for a moment. This is the so-called timeless moment of meaning and communication. The most essential quality of the doctor-patient relationship is the doctor’s presence with the patient. The gift of healing is the act of being there. There must be that indispensable element of human compassion and science, knowledge, and technology.

This human interaction takes time, but not necessarily much time. There are 10 simple rules:
1. Take the time to listen. Listen for 1 minute to your patient. The average doctor listens for about 18 seconds before interrupting the patient.
2. Make contact. Touch the patient’s hand.
3. Sit down when you talk.
5. Focus on the patient’s needs and listen and feel what those needs are.
6. Determine whether the patient is really sick. Does the patient really need treatment or just some kindness and understanding?
7. Learn to listen, look, and feel.
8. Do not put your hand on the doorknob as you give advice.
9. Always conclude with, “Is there something else you want to tell me?”
10. Take the time to show the patient you care.

As we lose time and have less time to give, we risk retreating from our covenant with the patient, we risk retreating from our covenant with students and residents, and we risk retreating from our covenant with society. If we continue to retreat, we will lose our patients and we will lose the viability of our specialty and the vitality of our profession. We will simply become providers of healthcare, controlled and externally regulated. We will not be professionals, and we will not like it.

In the ever increasing pace of the Internet, instant communication, and the ubiquitous cell phones and pagers, we are always reachable, always in touch. But perhaps we are not listening and communicating.

Human interaction requires spending time, feeling, seeing, touching, smelling, and listening. We must listen to our patients and regain from society a trust in our profession. The patients will speak for us, the public will speak for us, IF WE CARE FOR THEM! We need our patients’ trust now, and we will need it even more in the next millennium.

We must find that timeless moment each day, for ourselves, for our families and loved ones, and for our patients. The timeless moment is a moment of instant communication and understanding, the communication and understanding that takes place between a couple in love, a mother and child, true friends, and a doctor and patient. It occurs when we say a prayer, establish a trust, and make a commitment. It is that commitment of a doctor to the patient.

We must cherish and cultivate these timeless moments for the future. That is our challenge and our responsibility.

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