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Presidential address: Physician accountability—Winning the public trust

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Standing behind this podium, where so many great leaders of hand surgery have stood in years past, gives me a proper sense of humility and a wonderful feeling of pride. I am especially proud to know that many of you in this audience are committed to preserving and further strengthening public trust and confidence in our cherished profession.

Three years ago, when I was elected to this position, I believe that my administrative efforts would be devoted to continuing education in hand surgery. After all, that had been my primary area of responsibility for the various American Society for Surgery of the Hand committees on which I had served. Well, as so often happens, expectations were soon confounded by realities. My responsibilities quickly changed; I soon found myself thrust into the new and bewildering world of the socioeconomics of health care—a world whose mind-boggling terminology hardly endears itself to newcomers. In this office, more than 90% of my time has been spent on health care issues related to government, physician reimbursement and privileges, credentialing, litigation, and ethics. Cognitive areas of education have been not much more than occasional, albeit welcome, distractions.

Just as the responsibilities for the officers of the Hand Society have rapidly changed in the past couple of years, so too have world politics. I certainly would never have envisioned that before the end of my tenure as president, the world would be almost entirely relieved of nearly a century of communism.

One man who has stood out as a towering hero during this era is Vaclev Havel, a playwright-turned-president of Czechoslovakia. As you know, Havel resigned as a matter of honor this past year from the Czechoslovakian presidency. Yet, whether in or out of office—or, indeed, whether in or out of prison—he opposed communism in his homeland for more than 40 years.[1] Unlike most modern-day politicians, he did not set out simply to please voters; he fought for what he thought was right. He took on the toughest public problems his country faced. And, in doing so, he championed values not often advanced in world politics—courtesy, good taste, intelligence, decency, and, above all, *responsibility*.

That word *responsibility* seems to dominate his vocabulary. He has repeated it again and again in his writings and speeches.[2] Showing political courage and penetrating insight, the likes of which we rarely see, Havel told women and men of his country that they could not blame the horrors of 40 years of Soviet occupation solely on the Soviet leaders but that they, themselves, had to accept a good share of the *responsibility*.

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If you question the wisdom of his message, remember that communism in Havel's homeland is now dead.

Havel's words have a meaning that goes deeper than polished rhetoric. He backs up his words and his beliefs with his life. His words are inspired by his deeds.

Although not faced with the problem of disentangling ourselves from the mess of communism, we physicians face a responsibility that seems almost as onerous. In this rapidly changing world, where the future arrives faster than it used to—especially in medicine—you and I have a responsibility to help shape the health care system. Physicians know the health care system better than anyone else. If our practices are to become ever more efficient and independent, if doctors are to retain a strong sense of their autonomy and individuality, it is going to be because we physicians have seen to it that those goals are met.

We must demonstrate to government and business leaders, as well as the public at large, that we have already put an enormous amount of effort into establishing this system and that we are committed to doing the hard work necessary to maximize the system's efficiency through a rigorous program of self-management. As John Tupper,[3] past president of the American Medical Association, said: "We don't want to put health care in the hands of those who put costs in front of human concerns."

Already we are being clobbered by countless government regulations concerning utilization, some of which are ill conceived, outrageously expensive, and of no detectable benefit to patient care whatsoever. Consider, for example, a recent report of the U.S. Health and Human Services Department. According to the HHS, the federal government paid review companies $13.3 million to examine 500,000 Medicare cataract operations. They found that only $1.4 million dollars was saved by preventing possibly unnecessary surgery. In other words, the U.S. government spent $13 million to save $1 million. Sound familiar? Is it any wonder that our health care system threatens to bankrupt our country?

As past Deputy Secretary of Health and Human Services Constance Horner has said: "If you nationalize health care, you can expect it to have all of the compassion of the IRS and all of the efficiency of the postal service." Let me be the first to say, "No thanks."

Closer to home, in the practice of plastic surgery, we have seen that politics can take control of science, as evidenced by the saga of the silicone breast implants. Politicians, administrators, and leaders of activist groups all gain public recognition simply by being negative, frequently without any scientific evidence at all. Newspapers trumpeting negative reports fly off the stands; the networks lead off their nightly newscasts with those same dubious reports. Often physicians, unprepared and arriving on the scene too late, are unable to strike a reasonable balance.

If we are to retake the lead in shaping our health care system—and we must—it is imperative that we first restore the public trust in our profession. How can we achieve this confidence? Only by being accountable. And that is not going to be easy if we have to rely on society around us to provide us with inspiring role models. We are living in an era marked by *un*accountability. Like it or not, it is all around us.

Witness the uproar and chaos that have resulted from fraud and a general lack of accountability in other spheres of our society:

1. In the financial industry:
   - — The BCCI scandal, which has impugned the reputation of even the highly regarded Clark Clifford.
   - — The savings and loan crisis: an unmitigated catastrophe.
   - — Junk bonds, which are sinking American corporations in a sea of debt.
   - — The federal government itself, from the escalation of the national debt, for which no one will take responsibility although many of us have our theories, all the way down to the checking accounts of U.S. congressmen.
2. In Supreme Court appointments:
   - — The Clarence Thomas confirmation hearings were hardly a model of public integrity.
3. In our presidential campaigns:
   - — The media were so busy trying to distinguish fact from fiction coming out of all three campaigns that they seemed to have time for little else.
4. In athletics:
   - — Steroid and drug use, as well as gambling, seem to have taken down minor and major players alike.
   - — Even at the level of Little League baseball, with the Philippines cheating with the composition of their World Series team, dishonesty seems to have become the rule rather than the exception.
5. In research and NIH funding in major universities:
   - — We are all too familiar with the problems here!

6. In medicine:
   — *Time* magazine reported that fraud may have accounted for as much as $75 billion in health care costs last year.[4]

We do live in a period when accountability and commitment have been eroded by the seductions of materialism. More than ever before, people want the simple truth. As I said a moment ago, if the good doctors are to regain the public trust, they must be accountable to their patients, themselves, and their profession. If we can't look to society at large for our inspiration, then how can we be accountable? There are, I think, many means, but I shall discuss only a few—the ones that I feel are especially critical. And, what's more, they're entirely achievable! These include (1) improving our image, (2) proper credentialing, (3) cost awareness, (4) continuing education, (5) outcome studies, (6) high ethical and moral standards, and (7) service to our patients.

Professional image

Our image, whether well or ill founded, cannot be disregarded as a superficial concern of no consequence. None other than Abraham Lincoln[5] observed: "With public sentiment, nothing can fail, without it nothing can succeed. Consequently, he who molds public sentiment goes deeper than he who enacts statutes or pronounces decisions." Those are words worth pondering if we hope to be credible shapers of health care.

Just as trust is the only bond of a lasting friendship, it remains the sole promise between physician and patient. It is crucial in other areas as well: Trust played a dominant role in the just completed presidential campaign.

In years past, those in the medical profession, quite unlike politicians, enjoyed a privileged position in society, based on the public's conviction that doctors would serve society's needs above all else. As of late, though, the public image of physicians has been tarnished. We see such statements in the press as "doctors disdain any attempt to hold themselves accountable for what they do," "any type of national health service might [horrors] reduce doctors' incomes from their present average of $150,000 per year," or, "doctors are at best well compensated for their work or at worst downright greedy."

Such press coverage should trouble all of us. As Arnold Relman,[6] recent editor of the *New England Journal of Medicine*, wrote: "If the physicians continue to allow themselves to be drawn along the path of private entrepreneurship, they will increasingly be seen as self-interested businessmen and will lose many of the privileges they now enjoy as fiduciaries and *trusted* professionals."

And it's not as if trust-seeking doctors face a scarce market: the demand for physician trust is in fact, greater than ever. A 1991 AMA public opinion poll revealed that 69% of the public said people are losing faith in doctors. In 1989 a similar poll reported the number to be 64%. In 1988 we were widely perceived as arrogant and overpaid.

Another example of the public's negative attitude toward physicians is reflected in medical malpractice statistics. When the case is tried by jury, the verdict favors the physician in only 29% of the decisions. When judged by arbitration, however, the verdict is evenly split, 50-50. This disparity in medical malpractice awards is greater than that for any other category of personal injury lawsuits.[7]

Don't despair, though; we *can* change our image. Remember, William the Conqueror was first known as William the Bastard, which means, if nothing else, that we have a fighting chance! And, in fact, there are promising signs of improvement. It is encouraging, for example, that the number of medical student applicants is rising sharply:

1990: 29,283

1992: 37,521, an increase of 28% in just 2 years!

The number of applicants to Duke Medical School was up 10% this past year. Our dean tells us that the two main reasons for the increase are (1) increased efforts to encourage students to enter the medical profession and (2) fewer students are attracted to financial fields.

If those figures fail to dispel your disenchantment, you might like to know about a recent *Money* magazine ranking of the 100 "best jobs in America."[8] The careers were ranked on criteria that included pay, job satisfaction, prestige, and security. Physicians were ranked third, with only biologists and geologists (for reasons that escape me) scoring better. Physicians earned the highest salary of any career listed.

Yet, according to another survey, we are the most reluctant to share our wealth. *Bartender* magazine, in a survey of 1000 bars and restaurants nationwide, reported that physicians were the worst tippers in 1991, followed by schoolteachers, accountants, and, of course, lawyers.[9]

Although many physicians have long since unburdened themselves of the notion that doctors have control of health care, the public still holds physicians accountable for the state of our health care system. There is small comfort in knowing that physicians' fees ac-

count for only 19% of the dollars spent on health care and that this percentage has remained stable for a quarter of a century. I do not believe the public will begrudge the physician a good income if he or she charges reasonable fees, is cost-conscious, refers solely on the basis of patients' actual needs, and demonstrates up-to-date knowledge and competency.

We hand surgeons are a fortunate lot. Our work is enjoyable and, by the way, we get paid well for it. I doubt that any of you, when you were young, ever dreamed that you would be paid so well for doing what you like to do. I know most of you are caring and charitable individuals—as testified by, among other things, your generosity to the Hand Foundation. Seize this opportunity and commit yourselves to elevating our profession to a position of high public trust and confidence.

Credentialing and certification

There is a tendency in our country to set minimum standards, in medicine as well as in industry. An example in medicine is the establishment of clinical guidelines. With this approach we can be good, but we will not become better, which should, of course, be our ultimate goal. An industrialist recently remarked: "Quality control engineers know that such floors rapidly become ceilings, and that a company that seeks merely to meet standards cannot achieve excellence."[10]

There is general agreement in our profession that it is far better for physicians to maintain responsibility for their own certification and recertification rather than leave such concerns to the management of the government. We are all justifiably uneasy under the yoke of the National Practitioner's Data Bank and, more recently, under the Health Care Quality Initiative—an assessment to be administered by Medicare PRO to search for patterns indicating substandard care. In American medicine, therefore, the greatest influence on setting high standards of professional and ethical care are the speciality boards.

In its setting of standards, the American Board of Medical Specialities (ABMS)—the umbrella organization of the 23 official Boards, including the American Boards of General, Plastic and Orthopaedic Surgery—has stressed the difference between licensure and certification. *Licensure* implies minimal standards of practice in all fields of medicine. (As George Omer says, "Your dog has a license.") *Certification* implies excellence in a special field of practice.

The objectives of recertification—which is the policy in 17 of the 23 Boards—are to verify the physicians' continuing qualifications for practice and to assure the public that an individual is providing a high standard of care in his specialty. This is one of our profession's primary and most effective means of responding to our society's demand for accountability.

Believe me, patients are becoming keenly interested in ABMS boarding—if for no other reason than because of the birth of so many self-designated Boards. At last count, there were 121 quasi or bogus Boards—all beginning with the prefix "American Board"—and more are being formed each month. They are created under the guise of providing better care for patients. In reality, however, they are simply deceptive marketing credentials designed to enhance the physician's status, and perhaps to allow him to charge correspondingly higher fees.

Even more disturbing, industry has joined the parade; for example, there is an industry that certifies surgeons in the use of specialized instruments. What is even more pathetic is that accreditation panels of many hospitals recognize these ersatz certificates, which are handed out for one purpose—to sell more products.

These industries have sprung up because of market demand; the public is deeply concerned about physician competency and is eager for means by which to measure it. The competition notwithstanding, the public is becoming increasingly aware of American Board of Medical Specialty boarding. The ABMS received more than 300,000 calls last year at its toll-free number for patients querying physician status. That is nearly 1000 calls per day!

Managed care is also looking closely at ABMS credentials. For example, Aetna Insurance Company says it has required its 126,000 physician applicants to be certified by an ABMS specialty board.

Finally, governments are becoming involved. In states such as California, for example, physicians are restricted to listing *only* ABMS Boards in their advertisements.

In 1989 the first Certificate of Added Qualifications (CAQs) in Hand Surgery was offered by the Boards of Surgery and Orthopaedic Surgery.[11] The American Board of Plastic Surgery subsequently joined this subspecialty's certifying process. After additional examinations in 1990 and 1992, 978 surgeons now possess a CAQ in surgery of the hand. By the way, the architects of the CAQ envisioned that there were about 1000 surgeons in the United States who could legitimately be called hand surgeons and be certified.

The CAQ is intended for those surgeons who, by virtue of their additional training, hand surgery–oriented practices, and contributions to the field, have demonstrated qualifications in hand surgery that are

above and beyond those expected of other surgeons.[12] The issuance of the CAQ for our specialty—which, by the way, is the same type of certificate that distinguishes other specialties such as cardiology, gastroenterology, and rheumatology—has definitely been a major step in delineating our specialty. Controversial in the past and present? Yes. I am convinced, however, that it properly legitimizes its holders in hand surgery, for we are now recognized by an official body—none other than the ABMS.

I realize that there are those who are opposed to the CAQ, but if they want to attack fragmentation or subspecialty labeling, I suggest that they direct their efforts against the quasi boards or the advertisements on letterheads listing hand surgery for those who are not fully trained or thoroughly knowledgeable in the field. As a patient, would you prefer to see a physician who is "certified" by a letterhead, yellow pages ad, "Jake Leg" bogus board, commercial outfit, or the ABMS? Before you answer, let me tell you that psychometric analysis of the CAQ examination has revealed that those surgeons who have had adequate training in hand surgery and whose practices are primarily composed of hand surgery are likely to pass the examination.[11] Other surgeons without this background have a high probability of failure. As I understand it, that is exactly as it should be.

The ASSH can be proud of its initiative and leadership in the historic development of the CAQ.[13] The certificate underscores the credibility and legitimacy of those who have earned it. Election to membership of this Society further recognizes the hand surgeon's commitment to the specialty. Although selection is intended for those proven worthy by the highest standards, our membership must not suggest arrogant elitism, which is just as threatening to our profession as openly accepting egalitarianism. Neither attitude is good for hand surgery.

Cost awareness

We physicians must accept responsibility for helping our patients obtain high-quality care with a minimum outlay of dollars. Being the advocate of the patient has always been the cornerstone on which medicine stands. Just as we must be responsible for knowing the benefits and risks of procedures we perform, we are also obligated to know the prices of new technology. As clinical investigators, we tend to take great efforts to describe the benefits of our treatments, but say nothing about the costs.

Every day during the presidential campaign we were reminded of the high cost of medical care in the United States—about $800 billion a year, or 12% of the GNP, and still rising. It is predicted to reach $2 trillion within the decade. I do not think we need any analogy about how many trips to the sun we could take if each of those dollars were a mile; suffice it to say that $2 trillion is a lot of money.

We are reviewed by the public, not ony for our fees but for other related costs as well. Although less than 20% of the health care expenditures are for physician reimbursement, physicians control perhaps as much as 85% of health care costs by how we practice medicine.

Shamefully, there are members of our profession who not only charge for every piece of advice, needle stick, and prescription but also perform creative billing or unbundling of fees. Having sat on various review boards and credentialing committees from the state level to the ABOS, I have been embarrassed for our profession by the flagrant misuse of the billing or CPT codes. We have a responsibility to speak out against those physicians who are guilty of egregious billing.

Nearly all physicians have good intentions when ordering a series of diagnostic tests for their patients. However, expensive examinations by CAT scans, magnetic resonance imaging, and more recently computer-generated assessments of hand function, to name a few, are frequently overused and have no bearing on the treatment or outcome. We must all be more selective.

In 1990 orthopaedic implants generated $2.2 billion in the United States, and it is estimated that this figure will grow to $4 billion by 1995.[14] Implant prices increased 15% annually from 1986 to 1991, while physicians' fees rose 5% annually. The pharmaceutical companies, which own most of the surgical equipment and implant firms, report a 70% profit, which far exeeds any other form of business. The average profit margin is reported to be four times the average for all other industries in the Standard & Poor 500.

At present 40% to 50% of the Diagnosis-Related Group payment now goes to implant cost. It is predicted that within 10 years the entire DRG payment will be used to purchase the implant.

Two New York orthopaedic hospitals—the Hospital for Special Surgery and the Hospital for Bone and Joint Diseases—have shown that we can do something about these escalating costs.[15, 16] Cost-awareness programs in each of these hospitals have decreased expenditures on implants by $250,000 per year. These programs involve negotiating with the distributors, limiting the variations of implants, consignment, and waste reduction. It has been estimated that $1.2 billion could be saved over the next 5 years if one half of all hospitals followed similar programs. Those who have created such pro-

grams emphasize that, for these efforts to succeed, the surgeons (not the administrators) must assume primary *responsibility* for their implementation, especially in the areas of negotiating and decision making.

Unfortunately, in several areas the hospital administrators have contributed to the unnecessary escalation of health care costs. Since there is a limited amount of funding in the pie, the hosptials and clinics are competing for a piece of it in a manner similar to corporations that sell toothpaste or automobiles.

One of the more pathetic activities by some hospitals has been economic credentialing of physicians. This is credentialing not only on the basis of competency but also in consideration of the financial impact the physician has on the institution. I was introduced to this practice last year when I was part of an external review team for an orthopaedic program at one of our major universities. The hospital director boastfully presented a file containing economic dossiers on each attending physician. He had carefully prepared computerized information on the dollar value of the diagnostic tests ordered by each physician in order to tabulate which physician generated income for the hospital.

Believe it or not, in a 1991 survey by the American Hospital Association magazine, 42% of the chief executives of hospitals stated that they may use some type of economic credentialing in the next 1 to 5 years.

Get this! A Florida judge ruled that a hospital may deny a qualified surgeon certain hospital privileges solely for economic reasons. Given such practices, how on earth can we be so concerned about the possibility of exclusivity by the CAQ in hand surgery? Credentialing founded on economics is not compatible with the calling of our profession; ours is to be a profession that stubbornly values quality of performance above financial remuneration in serving those who need us.

On a related topic, do you realize that the cost of prescription drugs averages 32% higher in the United States than in Canada? There is an even greater price discrepancy for particular medications. For example, Isordil is nine times higher in the United States than in Canada. Someone needs to do some negotiating! The rest of us need to help educate other physicians and the public about such flagrant profit making.

Incidentally, not all reports about health care costs in Canada are favorable. Put another way, the surgeons there are not always looked upon by government with the same affection enjoyed by Dave Winfield, David Cone, Pat Borders, and the other World Series heroes. Federal Minister of Health Benoit Bouchard recently reported that 30% of medical and surgical procedures are unnecessary. Ontario Health Minister Frances Lankin warned that 50% of all elective surgery in Canada is *in*appropriate.[17]

Physicians and health care practices in both countries have indeed been subject to sharp criticism. This public sentiment—whether well or ill founded—must be improved.

Continuing education

As I reviewed previous presidential addresses, I noticed that perhaps the most popular topic was education in hand surgery. My background has mainly involved medical education; that certainly has been one of my greatest joys. However, as I mentioned at the outset of this address, the responsibilities of this office have changed with the societal pressures on the practice of hand surgery. Consequently, since the proportion of my time required for academia has been small compared to socioeconomic issues, I shall devote only a few comments to it today.

Education for ourselves and for the public is surely central to our profession. We, as specialists, are unquestionably becoming better educated despite the various imposed burdens and frustrations of practice.

There is objective evidence of increased accumulation of knowledge in the specialty of orthopaedic surgery. In 1992, 94% of first-time American and Canadian takers of the Part I written examination for the ABOS passed. This compares with 88% in 1989. The pass rate has increased each year, even while the examination's degree of difficulty has increased by all psychometric measures! Today's surgeons are smarter.

Further evidence of our dedication to continuing education can be found in the results of a recent *re*certifying examination for a selected group of older orthopaedic surgeons. All 147 examinees achieved a passing grade of 68% or more on a genuinely comprehensive examination. This is truly gratifying for those of us who are interested in demonstrating continued high standards of competency.

Over the past 3 years I have talked with many colleagues who have said: "You know, I didn't really care to take an exam, but I learned some from my review, and some of the material has helped me in my practice." That is the name of the game!

There is, though, at least one distressing trend in the area of education that merits mention. I am profoundly concerned about the apparent decreasing commitment to compensate or support partners in a group, or even in an academic center, who are spending time out of the office for academic pursuits, education courses, research, societal committee work, and the like. I have too often been witness to changes in attitudes and prac-

tice contracts that discontinue support for their members who are participating in CME or committee work. It unfortunately is more prevalent among the more financially oriented younger physicians. I ask you: Is this a profession or a business? Are we doctors or vendors? Let your conscience make your decision.

Outcome studies

As John Goodfellow,[17] editor of the British *Journal of Bone and Joint Surgery,* recently pointed out: "We are facing a problem of *'percentage medicine'* which is a situation where all people can no longer receive all the care that could be given." The Oregon Medicaid priority plan is an example. Patients are aware of this predicament and are genuinely concerned. As Dr. Goodfellow stated, this uneasiness is a sign that "the public no longer trusts its physician." One way to regain the public's confidence is with the aid of outcome studies.

Patients want to know the advantages and drawbacks of the possible procedures. They want to know what works and what does not and how their lives will be affected by the surgery. The physicians also need to know how the patients value the results of the procedures. That is more, of course, than just an assessment of x-ray films, range of motion, and functional studies.

The need for these outcomes studies is particularly indicated by the bombardment in our specialities of endoscopic procedures ("Nintendo surgery," as some call it). The unprecedented distasteful advertising by industry and surgeons alike has confused our patients. I heard a friend remark that "endoscopic carpal tunnel release sounded so good" he might elect to have the procedure, even though he had no symptoms. The useful information, including risks and complications, gained from well-designed outcome studies can only help to renew patient-doctor trust.

Ethics

Ethics define what we ought to do. It is obviously an area of immediate concern in medicine since everyone seems to be talking about it. Ethics is a common topic in all varieties of meetings, workships, symposia—even presidential addresses. The oath of Hippocrates has been our universal code of ethics, and the AMA code has served most societies. Now the specialty societies, including the ASSH, are developing their own codes of ethics, as well as position papers on important ethical issues.

The ethical area that has received the greatest national attention and most stirred the sentiment of the public has been the issue of self-referral by physicians who invest in health care facilities. A report released by the Florida Health Care Cost Containment Board in 1991 revealed that 80% of physicians in Florida have investments in medical ventures to which they could refer patients. More than 40% hold stakes in diagnostic image centers. The study concluded that physician referral arrangements had a negative impact on both access and cost.

I could rationalize to myself that physician investment in health and the related areas of diagnosis and treatment is not unethical as long as it genuinely meshes with the commitment to serve the patient's needs. Yet these ventures must never be motivated by profit. Personally, I believe it more appropriate for them to be owned by nonphysicians, or at least by physicians who do not refer.

The AMA and the American Academy of Orthopaedic Surgeons during the past year have developed rigid policies on physician self-referral. The legal noose was tightened in July 1991 when the U.S. Department of Health and Human Services issued the "safe harbor" regulation, which permits self-referral only under very narrow constraints.

Realistically, the solution to the ethical behavior problem does not rely on the imposing of regulations and laws. Ethics is above and beyond the law. Experience has taught us that attempted legislation of mortality usually fails. Historically, self-regulation and dedication to service have been emblematic of our profession. Let's keep our profession noble by maintaining or renewing our commitment to service as our primary, overriding objective.

Service

Service is the rent we pay for being physicians. It is not something we do when other goals are achieved; it is the heart of our profession—the spirit, the glue that binds us together. It is, in fact, the human dimension, the part of our profession that is motivated by caring and compassion, that separates us from the computer. Our profession is unique in that our basic calling is service for our patients, above any concern for financial reimbursement. Patients share a confidence with us that few others are fortunate to experience.

In the face of the current societal and economic pressures, we must not give up these pure, deep-rooted values. We are here to serve our patients, not ourselves. Politicians tend to forget this, but we must not. We are a profession, not a business; we are doctors with patients, not providers with customers.

The good doctor does more than just skillfully operate or appropriately prescribe therapy. He gives com-

Table I. American Society for Surgery of the Hand committees responsible for promoting accountability

Professional image	*Credentialing*	*Cost awareness*	*CME*	*Outcome studies*	*Ethics*	*Service*
Membership Ethics Bunnell Fellow	Joint Committee on Hand Surgery Impact CAQ	Clinical guidelines Coding Priorities Government affairs Manpower Priorities	Tumor registry Computer uses Newsletter Course planning Hand surgery update Annual meeting Review courses Residents and fellows conference Hand surgery fellowships Journal Self-assessment Audiovisual	Clinical assessment Outcome	Policy and information Ethics Material and technology	Industrial Injuries and prevention Research Hand surgery manual Public affairs

passion and humor, and he loses a part of himself to each patient when the outcome is less than anticipated. The various publications that pretend to list the best doctors in America fall far short, for these deeper values are never considered in the rankings. Patients are our source of strength. We must build on this energy by restoring their trust. Do not complain to them but, rather, talk to them in a positive manner, always with documentation and with the presence of accountability.

ASSH and responsibility

Let me say in conclusion that there will be changes in the rules that govern our practice, of that we can be certain. Just as advances in science and technology have improved our care, there will be changes in the social order that will influence our practice. I do not believe we need to fear if we simply follow the examples set by many of our members.

The members of the ASSH have provided leadership in each of the areas I have discussed; they have helped us to be responsible and accountable, and thereby to preserve the essential values of our profession. The related activities of the pertinent committees are listed in Table I. We can be proud of the high standards we have set—standards that, by the way, other specialities have now begun to mimic.

I introduced my remarks on responsibility and accountability today by highlighting the international heroics of Vaclev Havel. Yet we do not have to search quite so far for a hero of similar proportions in hand surgery. We have lived, learned, and worked with a hero—William E. Burkhalter. His face says it all: A man's man, A surgeon's surgeon. Bill Burkhalter stood for all the cherished values of our profession: integrity, trust, service, compassion, ethics, responsibility, accountability—you name it. He was a role model for any of us in this assembly.

There are more heroes out there. And there are more heroes to come—physicians who will accept responsibility for maintaining the high standards of our noble profession by holding accountable themselves first, then others also.

Some frustrated physicians look upon this era as "bad times." I think these are great times, great times to make a difference. I want to join you in accepting responsibility for helping to restore trust in our profession by being accountable.

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Open hand fractures: An analysis of the recovery of active motion and of complications

Seventy-five of 104 patients who underwent operative fixation of open hand fractures were reviewed between 6 months and 7 years after injury (average, 17 months). There were 140 fractures involving 125 fingers. Results, evaluated on the basis of total active range of digital motion achieved at final follow-up, correlated highly with severity of soft tissue injury. When open fractures of comparable severity were contrasted between groups that did and did not require additional extension by incision to achieve acceptable reduction and stabilization, there was some additional loss of active range of motion in the surgically treated group. Metacarpal fractures had significantly better outcomes than phalangeal fractures. Fractures involving the proximal phalanx or the proximal interphalangeal joint had the poorest prognosis, especially when they were associated with tendon injury. There were significant complications in 13 fingers. Infection and late amputation were related to wound severity. (J HAND SURG 1993;18A:387-94.)

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Several factors that influence the recovery of active range of motion and the severity of complications in hand fractures can be identified. These include patient, fracture, and management factors. Age (over 50 years), systemic illness (impaired healing response, compromised resistance and response to infection), fracture configuration (comminuted, segmental, multiple, or with bone loss), location (intra-articular and proximal phalangeal), type of fixation (plate), and excessive digital immobilization (more than 4 weeks)