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Presidential address: To my fellows

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Tomorrow you will leave this program, and a tremendous amount of hard work and training will come to an end. You have prepared yourself as a physician and as a surgeon and have supplemented that experience with an intense year of hand surgery. You are now ready to leave the protective cover of the educational umbrella and begin your own practice.

Having been there myself a long time ago, I know how you feel. You have a tremendous sense of pride in what you have accomplished these many long years and an eagerness to apply what you have learned, to have your own patients. You are filled with all the right moral and ethical values, the compassion and empathy for the patients you will be treating, and a genuine desire to render the best possible care.

Before you leave, I wonder if I might have a few minutes to offer some thoughts, even some advice, about the world that awaits as you begin your new career.

At the present time, there is a lot of dissatisfaction with our current system of health care delivery and many changes are on the horizon that will directly, and perhaps unfavorably, affect the way that you treat patients. National health care expenditures are now 12% of the gross national product and are predicted to reach 17% by the end of this century. Every man, woman, and child in America now has a health care bill of about $2600 per year—roughly two and one half times their 1980 share. An estimated 37 million Americans have no health insurance, and growing public concern over access to care for the uninsured and sharply rising costs have led Americans to be much less satisfied with our health care system.

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Needless to say, physician incomes have been under intense attack as one of the major culprits in the escalating costs of health care. The U.S. Census Bureau reports that physician incomes rose 20% faster than the average U.S. household income from 1981 through 1989, and it is widely held that our fee-for-service method of physician reimbursement encourages an overuse of surgical services. In his book, *America's Health Care Revolution* (New York: Simon & Schuster, 1986), former HEW Secretary Joseph A. Califano estimates that 25%—or more than $150 billion—is wasted yearly.

A survey recently published by the Metropolitan Life Insurance Company indicated that there was across-the-board agreement that the health care system in this country needs some revision and that compromises will have to be made by almost all parties. It was the consensus that the system of the futures should continue to involve both public and private sectors and that health insurance for everyone be fair and appropriate. Not unexpectedly, 4% of the physicians surveyed felt that the current health care system needs an overhaul and 64% indicated that fundamental changes are needed. Physicians were overwhelmingly against national health insurance.

To date there have been a number of legislative proposals designed to reduce health care costs and extend health services to the uninsured. Democrats and labor unions have traditionally favored a government-run national health insurance plan supported by tax dollars. In fact, a bill calling for a Canadian type of national health plan has already been introduced. Frustrated by four decades of failure with the nationalization approach, Senator Edward Kennedy and his colleagues appear willing to settle for a plan requiring businesses to provide health insurance for their workers, with the government insuring everyone else. Republicans continue to oppose either a government- or business-run health insurance system, preferring instead a market-oriented approach. President Bush has publicly rejected

the concept of federally mandated national medical care, and Senator John Chafee, chairman of the Senate Republicans' Task Force on Health Care, plans to introduce a wide range of changes that will significantly change the present medical care system. Oregon has already passed a law that authorizes the state to provide Medicaid services on a prioritized basis.

Following the Omnibus Budget Reconciliation Act of 1989, a new Medicare physician system was developed, using a schedule of payments derived from the resource-based relative value scale (RBRVS) for physician services. The transition to the new system is scheduled to begin on Jan. 1, 1992, and payment amounts in each locality will be determined by an RBRVS, a geographic adjustment factor, and a monetary conversion factor. Although Congress had hoped for payment reform to neither increase nor decrease overall payments to physicians, the Health Care Financing Administration (HCFA) proposed a 16% reduction in the conversion factor based in part on a demeaning volume-offset assumption that physicians would increase the volume of services to offset the decrease in payment for each service. Nice to know that our profession is so well regarded by governmental agencies!

In late August, following an avalanche of criticism that included more than 95,000 letters, the Department of Health and Human Services agreed to a revised version that would cut surgeons' payments by about 6% by 1996. In the latest development, James Todd, executive vice president of the American Medical Association, flatly rejected the compromise.

Of considerable concern is to what extent and how quickly private insurers will adopt RBRVS? Private insurers are said to be contemplating reimbursement controls primarily because they fear that doctors will try to recoup losses caused by the Medicare fee schedule. Surgeons are a particular worry because the RBRVS-based schedule is expected to cut fees for operations and increase payments for nonprocedural services and primary care. Private insurers are also closely monitoring the Physician Payment Review Commissions' (PPRC) proposals designed to deter creative billing, including strict definitions of all servicees that should be included in a global surgical fee. If they adopt similar restrictions, private payers could have a powerful tool to minimize income-enhancing billing strategies.

Getting depressed? Let's talk about medical liability. Be aware that you will be going into practice in a country that has 70% of the world's lawyers and generates 18 million new lawsuits annually. Punitive damage awards have jumped dramatically and our legal mechanism for compensating personal injury, known as the tort system, is responsible for the escalating problems of availability, affordability, and adequacy of malpractice insurance. Seventy-four percent of the annual $5 billion in medical liability insurance premium is spent on administrative costs and legal fees, with only 24% recovered by malpractice victims. It reminds me of the sarcastic joke:

Q. Why does New Jersey have so much industrial waste and Washington, D.C., so many lawyers?
A. New Jersey had first choice.

Senator Orrin Hatch of Utah told Congress earlier this year that the United States faces a medical malpractice crisis. He stated: "There are 900 new malpractice lawsuits filed every day. Not only are we paying about $7 billion each year in direct medical liability costs, but we are also paying billions for unnecessary defensive medicine that is the result of the fear of litigation." As the late Senator Everett Dirkson, once said: "A billion here, a billion there, pretty soon it adds up to real money."

According to a recent survey conducted for the Medical Legal and Liability Committee of this Society, the average yearly professional liability premium for hand surgeons was about $30,000. Ten percent did not carry liability insurance, and only one third were rated primarily for hand surgery, a lower-risk category with more favorable rates. Forty-four percent of all lawsuits against hand surgeons occurred between 1986 and 1990; most took about 2 years to be resolved; 60% failed, and the average award for successful cases was just over $100,000. As expected, lawsuits had a profound impact on a hand surgeon's practice and emotional well-being.

Can you stand any more? Let's discuss the workers' compensation dilemma. Those of us who have been practicing hand surgery for a while are well aware of the tremendous increase in the number of work-related conditions, particularly cumulative trauma disorders, that we are seeing. They are clogging our offices, creating monumental paperwork problems, and severely compromising our ability to run efficient office hours and assess the true results of our procedures. The effect of both conservative and surgical management of these conditions is far worse than for similar, noncompensable disorders, and the cost to industry and third-party carriers is enormous. Many of the patients who have these problems lack or quickly lose the will to work and, without motivation, returning them to gainful employment is almost impossible.

A word about ethics. This country is experiencing more instances of ethical misconduct than I can ever remember. Every day we read about dishonest behavior by lawyers, bankers, stock brokers, politicians, educators, researchers, physicians, and even the clergy. We have already touched on the fact that a few surgeons resort to nefarious billing practices to generate larger

fees. There are also those who stretch the indications for some procedures and produce an inordinate amount of surgery from a relative few new patient encounters. Almost every patient is approached with the attitude that his or her condition merits some type of operative intervention with little consideration for what is truly best for that particular individual. Let's be reminded of the words of Stanley Hoerr: "We should always let our judgments and recommendations be guided by the fact that we operate on patients not diseases" (Strauss MB, ed. Familiar medical quotations. Boston: Little, Brown, 1968).

I'm sure you appreciate the fact that you are entering practice in the midst of a monumental technologic boom. New devices are being introduced almost daily, some with a minimum of documentation as to their efficacy and safety. Profit-motivated companies and even a few surgeons extol the virtues of new products that they have developed, many of which will have a very short life span before they are declared obsolete. John Goodfellow, the editor of the *Journal of Bone and Joint Surgery*, stated: "What is the practitioner to do . . . to protect his patients from the ill effects of commercialism and the overenthusiasm of inventors and yet stay up-to-date and not be too slow to adopt any real advance. Experience shows that to achieve this requires a highly suspicious approach to everything that he is told and everything that he reads." Goodfellow concluded that "he should accept new ideas in the same frame of mind that he would when buying a second hand car, and he should attribute to the innovator and inventor the same level of credibility that he usually reserves for politicians." We must be ever cognizant of the high price of technology and the fact that costs are ultimately passed on to our patients.

In a fascinating book entitled *Technology and Power* (New York: Springer-Verlag, 1989) David Kipnis paints a worrisome scenario. He suggests, as many others have, that physicians have changed over the years from the trusted, loyal family counselor with a compassionate bedside manner to an impersonal professional who moves from patient to patient, diagnosing and prescribing with a minimum of patient contact. He notes: "Technology already can duplicate many of the diagnostic and healing skills of physicians. These newer techniques provide the potential for fractionalizing the physician's work along traditional industrial lines, thus providing a significant dollar savings for organizations that employ physicians. Management may replace physicians with technicians whose job will be to manage diagnostic equipment and the computer's diagnosis and treatment plans for the patient. If these events happen, the next decade may find a two-tiered system of health care specialists. The first tier will be composed of technicians who will diagnose, oversee, and treat sickness of a routine kind. The second tier will be composed of the few medical specialists needed to perform the labor intensive work of medicine including operative procedures and unusual medical events. In this scenario, technology, once the physician's ally in gaining power, now threatens." Sound unlikely? Don't be too sure.

I suspect that public opinion of surgeons is better than when Dylan Thomas stated: "When I take up assassination, I shall start with the surgeons in this city and work my way up to the gutter." Nonetheless, it is apparent that patients' opinions of their physicians have deteriorated considerably in recent years. The 1991 public opinion poll of the American Medical Association found that the way doctors explain things to their patients has declined and 63% believe "doctors are too interested in making money." Only three of ten felt doctors spend enough time with their patients, and agreement with the statement "people are beginning to lose faith in doctors" reached its highest level—69%—in 1991.

Another concern is the prevailing attitude among many of todays' physicians and surgeons that they must be both practitoners and businessmen. It is increasingly difficult to keep up with the complex problems associated with running a practice office and still maintain the appropriate concern for patients. Some surgeons become involved in outside, medical related activities that involve associations with nonprofessional concerns, further deterring their ability to deliver high-level care. There also is a disturbing tendency for many surgeons to advertise. Whereas it was once an ethical doctrine that physicians would not promote their services, it has now become commonplace for individuals or groups to publicize their existence—and even their capabilities—in medical society journals, telephone book Yellow Pages, local newspapers and magazines, and even radio and television. Some of our colleagues actively solicit media coverage of dramatic operative procedures or new technology, often misrepresenting the true state of the art or the fact that the same or similar procedures can be performed by other surgeons in the community. Perhaps we should look back as far back as 1882, at the code of ethics of the American Medical Association, which stated: "It is derogatory to the dignity of the profession to resort to public advertisements or private cards or handbills . . . to publish cases and operations in the daily print . . ." etc. The FTC and the courts with their doubtful wisdom seem to have effectively struck down that code of conduct. Wouldn't it be sad if physicians were to come to advertise as vigorously and with as few principles as our friends in the legal profession?

Well, are you still as enthusiatic about heading out

into practice? Please relax a bit. Remember Thomas Fuller's words; "It is always darkest just before the day dawneth."

Actually, I found a contradictory axiom—"Rhonda's Rumination—which says, "It's always darkest before it's pitch black."

Anyway, I assure you that things aren't as bad as they sound. Let me give you my thoughts as to how the issues I have just mentioned will ultimately affect your career. I confess that most of my opinions are just personal beliefs, for I certainly don't have all the answers. I do, however, have an overwhelming feeling of optimism about the future of medicine in this country and the specialty of hand surgery.

When it comes to the impending governmental interdiction into the current American system for health care delivery, don't be shocked if there are no radical changes for quite some time. My skepticism is fired by my memories of the early 70s when more than a dozen initiatives for universal health coverage were introduced in Congress. Leaders of key groups and the public were unable to reach agreement on any single approach to reform. In fact, advocates of federal takeover have seen their idea go nowhere since it was first proposed more than four decades ago.

Few of us would argue with the recent statement of Daniel Callahan, PhD, of the Hastings Center for Bioethics in the *New England Journal of Medicine* (1990;322:1809-13) that an economically sound health care system must combine three elements: access for all to a base level of health care; a means of limiting the use of procedures that are ineffective, marginally effective, or too expensive; and some consensus on health care priorities, both social and individual. Working against those goals are several deeply ingrained values that the American public has come to expect. We covet freedom of choice for patients and physicians, we resent government control, we savor the concept of continued medical progress, and we have come to expect quality in health care, including a high level of technology. As Callahan puts it, "Choice is better than constraint, individual freedom better than government regulation, progress better than stagnation, capitalism better than socialism, and quality better than mediocrity." Before we adopt radical new health care plans, it would seem more logical and likely that new efforts at cost containment should be attempted. The possibilities of saving are enormous if we eliminate unnecessary or wasteful diagnostic devices and medical treatments, do away with costly malpractice claims, and pare away expensive bureaucracy.

Recent polls indicate that Americans still prefer a private-based health insurance system. In a survey conducted for the American Medical Association, the majority of those questioned indicated that they would actually pay more to retain private insurers, immediate access, the latest technology, and the ability to choose their own doctors and hospitals. In the long run, our patients will have a powerful mitigating influence on any drastic changes that the government may propose, and they clearly are not that unhappy with the present system. Probably changes will occur slowly, and the impact on the quality of our lives will not be profound.

Just to illustrate how long we have worried about the nationalization of health care delivery in this country, let me share with you some excerpts from a letter that my partner Hill Hastings' great uncle, former president of the American Medical Association, wrote Hill's father at Harvard University on Nov. 28, 1936, at the time of his decision to go to medical school:

> The big objection to a medical career nowadays is that there seems to be no doubt that medicine is going to be socialized. . . . The Prospects of medicine becoming a service of the government or of other organizations for medical service, with doctors as employees, is, I believe, certain to become a problem that you will have to face. If I had a son, I would strongly advise him against going into medicine now. I would go further, if I were a young doctor now myself, I would try to get out of it. This in spite of the fact that medicine has been an altogether satisfactory career for me.
>
> Yours affectionately,
> *Uncle Will*

As two subsequent generations of Hastings' surgeons will attest, Socialistic/Nationalistic medicine hasn't happened yet.

Okay, you must be feeling a little bit better. We have already seen that HCFA has abandoned its excessive Medicare physician fee schedule reduction and that the initiation of the plan scheduled for January 1992 may be delayed. In another major victory for doctors, lawmakers raised the charge ceilings that was to be imposed on all nonparticipating Medicare physicians, and Congress rejected several proposals that would have added more cost and inconvenience to the process of treating Medicare patients. In fact, a package of reforms has been approved to reduce doctors' Medicare hassles. Perhaps we're not going to get hurt too badly by Medicare over the next few years either.

Now that I've got you on the upswing, let's address an area where you will have to get involved. The government, businesses, and private payers are becoming increasingly aware that their costs can be better controlled when they insist that hospitals and physicians provide quality, results-oriented services with well-documented outcome assessments. The medical profession will have to provide strong evidence of the value of its technology, or reimbursement for procedures deemed minimally effective or too costly will be eliminated. We have clearly entered into what Arnold Relman, MD,

the recently retired editor-in-chief of the *New England Journal of Medicine*, calls "the third revolution in medical care" an unprecedented growth in activity directed at the assessment of outcomes, the analysis of effectiveness, and quality assurance. HCFA, through the newly established Agency for Health Care Policy and Research, has launched a program directed at gauging the effectiveness of medical interventions and developing guidelines for medical practice. The government has encouraged participation by specialty organizations, and almost all societies (including the American Society for Surgery of the Hand) have established committees to investigate the methodology, funding, and implementation of outcomes research and the strategies for the dissemination of results. While the effect of these studies may be slow in coming, I predict that your hand surgery practices will be greatly influenced by the information that they will generate.

Well, how are you doing? Still excited about your future? Let's consider the medical liability predicament. As you might guess, efforts to revise medical-legal statutes have been driven more by the high pass through costs of physician liability insurance and expenses resulting from defensive medical practices then by any genuine concern for the plight of physicians. President Bush has recently introduced a proposal designed to encourage states to enact medical liability reform legislation. In the last 6 months of the 102nd Congress, members of both the House of Representatives and the Senate have shown widespread interest in reform, either as part of an overall health care reform agenda or as freestanding legislation. Probably the best of several reform proposals is the Ensuring Access Through Medical Liability Reform Act, coauthored by Senator Orrin Hatch and supported by a growing list of medical organizations. Thus some encouraging possibilities for tort reform are on the horizon. How far legal reform legislation can go in a Congress dominated by lawyers is, of course, highly questionable.

What can be done about the cumulative trauma quandary? I really don't know the answers to that one. I suspect that we must better define exactly what these disorders are and set meaningful, fairly uniform protocols for their management. By establishing a near contractural relationship with these patients at the onset, with time-specific, job-specific objectives for returning to work, and by working closely with industry to make appropriate job changes and accommodations for those patients whose symptoms persist or recur, we may be better able to get more of these individuals back to work and prevent the unfortunate mindset that all too frequently results in a lengthy or permanent loss of income and personal dignity.

Let's quickly swing back to ethics. Changing unethical behavior is difficult, if not impossible. Almost all professional societies such as ASSH have codes of ethics that are really just printed lists of what most of us intuitively know to be right and proper physician/surgeon conduct. With the possible exception of expulsion from membership, societies' actually have little punitive capabilities, and a "slap on the wrist" is about all we can offer for our unprincipled colleagues. We must rely on state licensure boards and county and state medical societies to discipline those who have violated the rules of professional behavior, and we all know how reticent these groups are to bring such action. It is hoped that the recent publication and expected adoption of intraoperative global service data by HCFA and other payers will reduce the ability to successfully "unbundle" fees for surgical services. Health insurance payers are becoming increasingly aware of those physicians who overuse and overcharge for certain surgical services and already are beginning to disapprove surgery or deny payment to those individuals.

These measures do not truly address the underlying unethical behavior, though, do they? I am aware that many of my colleagues disagree with my position on some of these issues and believe that they are not a breach of ethics but a necessary response to an untenable socioeconomic climate. Others feel that ethics are a matter of personal values and cannot be changed or modified. I may be wrong, but it seems to me that ethics are universal, not individual principles of conduct and that the ethical practice of medicine is our responsibility, as it has been since the time of Hippocrates. Martin H. Fischer perhaps simplified it best some 30 years ago when he said: "Only one rule in medical ethics need concern you—that action on your part which best conserves the interests of your patient." If we are to deal with surgeons who overoperate, overcharge, or in other ways violate accepted standards of medical conduct, then we will have to stop turning our back on such behavior and stand up and identify those individuals and, when necessary, initiate sanctions against them. Left uncensored, they corrupt us all.

By now, my friends, you must be tired of hearing me expound on socioeconomic problems. I just wanted you to appreciate the changing conditions that face medicine in general and hand surgery in particular. You will be able to exert some influence on the resolution of some of these problems; others you will be unable to control. Most you should relegate to the deep recesses of your brain and get on with the work and know best—the practice of medicine. To be sure, the American system of health care delivery will undergo significant change in the next decade or so, but I really believe that the impact on your professional and personal lives will not be that great.

As you go out into practice, I suggest you first stop

and reflect on just what decisions brought you to this point in your career: You wanted to go into medicine because it was a respected profession where you could help others, make a decent living and for a host of other altruist and humanitarian reasons that you probably haven't thought about for quite awhile but, hopefully, haven't forgotten. Those reasons still apply, you know. Despite all the complex problems that medicine faces, it remains a gratifying profession, as Sir William Osler said in his famous essay entitled "Aequanimitas: "In the records of no other profession is there to be found so large a number of men and women who have combined intellectual preeminence with nobility of character." Also from Osler's "Aequanimitas"; "To prevent disease, to relieve suffering, and to heal the sick—this is our work."

Somewhere along the way, you also decided to take up surgery or one of its specialties. Remember why? Probably because you liked the idea of directly altering or eliminating pathologic conditions with your own manual efforts. You were fascinated by the prospect of using operative methods to heal difficult conditions that cannot be cured by any other means. You liked the idea of not being bound by rigid medical treatment protocols but, rather, being able to select from an assortment of surgical options, each requiring technical experience and skill. And, hopefully, you realized that, as Martin Fischer put it, "A good surgeon is a medical man who can cut."

In *Letters to a Young Surgeon* (New York: Simon & Schuster, 1983), Richard Selzer wrote: "It is surgery that, long after it has passed into obsolescence, will be remembered as the glory of medicine."

Finally, you chose hand surgery. Think back to why you made that decision. Probably you were fascinated by the intricacy of the anatomy of the upper extremity and the delicacy of the surgical art that blended the best of general, neuro-, plastic micro- and orthopedic surgery into one multiskilled specialty. Or, perhaps you were captivated by the tremendous spectrum of surgical procedures designed to provide improved function and appearance to the congenitally deformed extremity; to salvage, restore, revise, or reconstruct the hand damaged by trauma; to transfer power and add stability and use to the paralyzed arm; to relieve the pain, sensory dysfunction, and weakness resulting from nerve or tendon compression; or to replace joints devastated by the ravages of arthritis. And, almost certainly, you were impressed by the fact that every hand surgeon that you ever met was incredibly enthusiastic about the specialty.

The reasons for all these career decisions may have been somewhat idealistic, but they were morally and ethically strong ones. It will be important for you to pause every now and then and review those reasons once again, because they sometimes get lost in the complex and feverish personal and professional lives that we create for ourselves.

Well, now you've done it! After many hard-working years, you are finished and ready to enter practice. You should be very proud of who you are. But, I must caution you to also be very aware of who you are not. Although you have a smattering of training in many areas, you are not a family practitioner, you are not an internist, you are not a rheumatologist, you are not a dermatologist, you are not a neurologist, you are not a psychiatrist or even a psychologist, and you are not a therapist. With the sophistication of today's medical specialties, it is best not to engage in these areas beyond your training or you will lower the overall service that you are providing.

Remember that you have no obligation to treat every pathologic condition involving the upper extremity. I can promise you that you will stay out of trouble and enjoy your practice much more if you avoid the long-term management of nonsurgical conditions and refer them back to more knowledgeable specialists. For instance, refer patients with pain without objective symptoms or patients with chronic soft tissue inflammation of the upper extremity to their referring physicians or to a rheumatologist. Experience tells me that most of these patients will not do well with surgery, and if we become involved in their treatment we will soon have an office full of dissatisfied patients. If you stay fairly rigidly within the confines of your surgical training, your patients will be happier—and so will you.

You should also avoid the compulsion to treat every symptom of every patient. There is a tendency to think that each ache and pain requires both a diagnosis and a remedy; that you must do something for everyone, anti-inflammatory drugs, an injection, a splint, therapy, or surgery. Many complaints cannot be helped by those modalities or by surgery. You will be pleasantly surprised that patients will respect you if you admit that you don't know their diagnosis or that you don't think that what you as a hand surgeon has to offer will help.

Please also remember that you have trained only to be a physician and a surgeon. That means that you are not a businessman, or a hospital administrator, or an accountant, or—God forbid—lawyer, or a public relations or advertising executive, or a stock broker, or a manufacturer, or any other nonmedical professional. The more that you stray into these fields, the more you will subordinate your interest to the interest to the interest of those you serve. You cannot integrate values

of medical practice with the entrepreneurship required to be successful in these businesses. Skilled professionals are available for consultation and should be used whenever you need help. Spend time with your family and develop outside hobbies and interests, but remember that professionally you are a physician and surgeon—a hand surgeon. Don't be anything else.

Hand surgery is a paradox. We strive to be perfectionists, but we rarely achieve perfection with the results of the difficult procedures we must perform. You will be tormented by occasional surgical errors and complications, but please realize that these unfortunate professional conscience pangs are common to all good surgeons. We all make misakes, we all experience bad results, and we all agonize over them. Only the calloused, uncaring surgeon is not bothered by his or her errors and failures. Let me share with you the ultimate medical disaster, from a book (*Great Medical Disasters*. New York: Dorset Press, 1986) by Dr. Richard Gordon, the author of *Doctor in the House:*

> In the 1840s, Robert Liston was regarded as the fastest knife in the West End of London. He could amputate a leg in two and one-half minutes. He was six foot two and operated in a bottle green coat with Wellington boots. He sprung across the bloodstrained boards upon his swooning, sweating, strapped down patient like a duelist, calling, "Time me, gentlemen, time me!" to students craning with pocket watches from the iron railinged galleries. Everyone swore that the first flash of his knife was followed so swiftly by the rasp of saw on bone that sight and sound seemed simultaneous. To free both hands, he would clasp the bloody knife between his teeth.
>
> Liston's most famous case was said to have been when he amputated a leg in under two and a half minutes. The patient died afterward in the ward from hospital gangrene as they usually did in those pre-Listerian days. At the same procedure, he inadevertently amputated the fingers of his young assistant who also died afterwards on the ward from gangrene; as they usually did in those pre-Listerian days. He also slashed through the coattails of a distinguished surgical spectator, who was so terrified that the knife had pierced his vitals that he dropped dead from fright. Liston is therefore thought to have carried out the only operation in medical history with a 300% mortality.

If I can coach you in just one quality when you enter practice, it would be humility. There is a natural inclination for a young surgeon, armed with years of training and skilled in the most modern techniques, to be somewhat disparaging toward other physicians whom he or she views as less well trained and behind the times. Believe me, your practice will develop in a satisfactory and progressive pace if you do not project yourself in a haughty and pretentious manner to your medical colleagues, nurses, therapists, paramedical personnel or—most important—your patients. An anonymous quotation is accurate: "The egotistical surgeon is like a monkey; the higher he climbs, the more you see of his less attractive features." Or, from Robert Tuttle Morris; "A vain surgeon is like a milking stool, of no use except when sat upon."

You are all good people. Just don't get caught up with your importance when you start practice. Believe me; nobody else will.

It was Douglas Jerrold who said; "it seems so easy to be good natured. I wonder why anybody takes the trouble to be anything else."

I envy your chance to participate in all the exciting new developments that will occur in hand surgery during your career. Computers will allow instant access to current medical information, generate efficient patient reports, produce rapid impairment ratings, provide accurate patient evaluation, enhance the collection and processing of data for outcome studies, and give prompt access to interactive education programs. You will probably witness methods to precisely resurface and rebuild destroyed joints; imaging systems that will create holograms, three-dimensional simulations, and perfect models of patient pathology; chemical control of scar formation and of tendon and joint adhesions; techniques for the recognition and management of genetic factors that cause or predispose upper extremity deformity and disease; in utero correction of congenital malformations; minimally invasive methods of fracture stabilization and ways to improve the speed of bone healing, nerve repair and graft methods that will result in near complete recovery; new methods of rapid microvascular anastomosis permitting fast, predictible replants, and a wide array of free tissue transfers and, yes, hand arm transplants. How exhilarating!

Well, you've heard enough from me. Get out of here. From now on, I am not your teacher; just your good friend. Go out and enjoy the magnificent specialty of hand surgery. The incredible diversity, the intricacy and delicacy of surgery, the teaching, the friendships, and, best of all, the close relationships which you will develop with the patients you touch and treat. As for me, in spite of all the problems that loom on the socioeconomic horizon, if I knew that I could start all over again and that a career in hand surgery would be half as fulfilling as this one has been, there is no question that I would do it again.

I close with words from Will Rogers; "A man makes a living by what he gets; a life by what he gives."

It has been a tremendous honor and privilege for me to have served as president of the finest professional organization that I know of, the American Society for Surgery of the Hand.