Think Different: Presidential Address at the 2009 Eastern Association for the Surgery of Trauma

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Here's to the crazy ones. The misfits. The rebels. The troublemakers. The round pegs in the square holes.
The ones who see things differently.
They're not fond of rules.
And they have no respect for the status quo.
You can praise them, disagree with them, quote them, disbelieve them, glorify or vilify them. About the only thing you can't do is ignore them. Because they change things. They invent. They imagine. They heal.
They explore. They create. They inspire. They push the human race forward.
Maybe they have to be crazy. How else can you stare at an empty canvas and see a work of art? Or sit in silence and hear a song that's never been written?
Or gaze at a red planet and see a laboratory on wheels?
We make tools for these kinds of people.
While some see them as the crazy ones, we see genius.
Because the people who are crazy enough to think they can change the world, are the ones who do.[1]
—Apple Computer.

I am humbled and honored to serve you as President for the Eastern Association for the Surgery of Trauma (EAST). Pat Reilly, your President-Elect, noted that I would not be here without the help of many people, many of whom I am pleased are in the audience.

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Pat mentioned mentors and so will I. It would be impractical to mention individuals, because so many of you had an impact on me in large or small ways, may be in ways you do not even know, that have allowed me to advance in this journey.

Certainly, my fellowship with you, the members of EAST, has been vital, particularly its leaders who guided me on a lot of different levels, both professionally and personally. I thank the Society of Trauma Nurses, of which I am a proud member, that established a very close relationship with the Association, really changing the flavor of what we are trying to engage in here.

Pat mentioned my friends at the Florida Committee on Trauma, many of whom were also trained at Jackson Memorial Hospital, and we will always have that Miami connection. Most recently, my classmates and my educators at the University of Tennessee College of Business changed not so much my career, but my whole outlook on life for the better.

There are two people who will never know I thanked them, but I do need to thank. One is Steve Jobs of Apple Computer, without whom I would have had a whole different career. My first experience in independent research, if you will, happened at an earlier EAST meeting here in Orlando. I was privileged to present on the topic of "Trauma on the Internet" using a desktop Macintosh[2] for which the presentation was roundly chastised and criticized by the members in the audience as promotion of a passing fad. The other person is Walt Disney, whose vision produced all of what you see around you and without which I probably would not have a job, and we would be sitting in a cow pasture right now.

On a more serious note, I need to thank my family, my parents, Rosamunde and Louis Finkelstein. Both escaped the Second World War and its tragedies and taught me to overcome adversity of unimaginable magnitude. Each of them subsequently lost their spouses when they were very young. They met, married, and subsequently raised me. Louis is in the audience with us today. My mom is not here; as some of you know she passed away unexpectedly this past September, making for somewhat of a gloomy presidential year.

My close family, of course, has supported me all the way along. I have to thank my "EAST Kids," Geoffrey, Andrew, and Marissa, who learned to appreciate what I do, if not respect it. Most importantly, I must thank my bride, my sweet pea, Susan, who has obviously endured a lot of travel. Every time I say something like "I know I'm a board-certified surgeon, but I might want to go to night school to become a basic EMT" she replies, "Sure, it'll be an adventure." That is what she always says and for that I cannot ever possibly thank her enough.

When I was putting my talk together, I was struggling to have my messages fit together. David Feliciano was kind enough to stop me and ask me how it was going, and I told him that I was having some challenges. He suggested that I simply talk about what I know best. You will see that the positive, forward-thinking attitudes of these individuals that I did mention, shapes much of what we will analyze today.

Think Different was an advertising promotion of Apple Computer validating the use of its relatively infrequently selected personal computer. It was a well-received campaign and made light of IBM's Windows-based PCs that used National Cash Register Company's classic "THINK!" campaign to brand their Think Pads.

One of our former critical care fellows was kind enough to call me late last night and remind me, as obsessed as I am with English grammar, that my address should read think *differently*. No, it is Think Different, a fanciful expression, like "think green" or "think global."

Think Different is the topic of discussion, but it is not just about thinking differently. It is different to be Jewish at Christmas time. One thing my family knows is that I will always be working on December 25th, covering for my partners. It is a standard formula to our lives, and when I come home we go out for Chinese food and to the movies.

Christmas can also be a lonely time for us, a time we recognize how different we are from many of the people around us. In our early years in Orlando, one December, we were admiring some of the beautiful window displays for Christmas. My kids noticed a diminutive little token exhibit honoring Hanukkah in a corner. One of our kids looked up and said, "Dad, why are we always different? Why is everyone else Christmas and we're Hanukkah? Why does everyone else use Windows and we use Macintosh? And Dad, some other parents are doctors but you're a trauma surgeon, whatever that is!"

My father, an inspiration to me, is also someone who is different. He was different at the early part of the last century as a Polish Jew persecuted under tragic circumstances. Of all the things my father is different in, one of the things I am most proud of is a tattoo he bears on his forearm from that time. It confirms that he is a survivor of the Holocaust, where through cunning and intelligence, by thinking differently, he survived internment at Auschwitz.

Germany in the 1930s to 1945 represented one of the more sinister moments in Europe's history. Hitler and the Nazi party attempted to rid the German territories of what they thought were the unfit. These principles were not solely those of the politicians and the soldiers. Realize that physicians, our peers of that era, supported the concept of "eugenic," racial healthcare as opposed to individualized healthcare that we deliver currently.[3]

Eugenic theory was justified, unfortunately, by true science: Darwinian theories of survival of the fittest and Mendelian genetics. If you visit the US Holocaust Museum, you may encounter an exhibit called "Deadly Medicine." In the display, the curators recount how in the First World War, two million young and healthy Germans, the best of the best, died on the battlefield. Following World War I, there was political and economic turmoil and a falling German birthrate. At the same time, German facilities that took care of the mentally ill were the finest in the world, and tremendous amounts of public money were spent on these individuals.

Public policy was swayed by a propaganda blitz criticizing the costs of managing the ill. For example, one leaflet mentions that 60,000 deutschmark was used to take care of an individual with a hereditary defect over the course of his life. The public was reminded that less funding was available to

rehabilitate their young, their best, who were coming back from the front. In some dark corner of our minds, it makes sense that we should be putting our money toward the best rather than the sickest. In America, we were not so innocent either. A similar interest in the theory of Eugenic happened in this country as well. Eugenic was a concept that was only trumped because when the Germans invaded our allies in Europe, it was a position no longer popular.

In the 1930s, in Germany, there was a gradual progression toward looking at other attributes that were perceived to be genetic inferiorities: racial groups, sexual orientation, and developmental delay. This reasoning led to the justification for sterilization, in the hope of improving the gene pool. The next steps led to euthanasia, putting people out of their perceived misery, and subsequently, human experimentation and widespread slaughter of innocents.

Of this tragedy, of the six million Jews and the millions of gypsies, homosexuals, and other groups that were persecuted, came some good. We have a better understanding of how to ethically perform medical research in this country. The Nuremberg Code and subsequent evolutions have truly changed the way all of us do clinically based research, protecting human subjects. But I am not here to talk just about research. I am here to talk about differences and being different as a patient.

The ACS Patient

In medicine, no one is more different from the acute care surgery (ACS) patient. Emergency patients of all kinds, surgical and medical, are somehow seen in this country as different, less important. While many people are concerned that there are racial undertones, financial motivations for this perception or that trauma patients are classified as behavioral deviants, these worries are only part of a growing problem in healthcare.

It does not matter anymore whether a patient with a surgical emergency is insured or not. Physicians are less and less interested in seeing these unwelcome impositions on their finely honed elective practices. In addition, the relationship between on-call physicians with their referral source, in this case emergency medicine technicians and emergency room physicians, is increasingly strained.

It is not uncommon that the specialist is called by the emergency medicine physician, only to respond by chastising and berating the referring doctor. The on-call physician or surgeon may communicate to the emergency department physician in harsh words how foolish they are, even though they likely graduated higher in their medical school class than the specialist did.

In trauma centers, we are often not much better in treating these patients. It is not uncommon to hear people still talk about *Maximum Resident Benefit*, such as the emergency room thoracotomy, performed even though there is no hope. Some of us justify intubating, placing central access, and performing tube thoracotomy in a patient of blunt trauma who has clearly passed, whose ghost has left the body, for the purposes of education. This dehumanizing of surgical patients is rarely seen on other elective teaching services.

Some trauma providers make fun of patient tattoos and piercings. Body art is currently popular among superstar models, but somehow on the trauma and emergency patients, it is seen differently. It is also shocking to observe how the emergency patients are perceived as less likely to experience pain. Instead we say they have drug-seeking behavior. There are the invariable jokes about substance abuse: "Did you see the alcohol level on that patient? Is 0.36 an in-house record?"

In the lay world, there is something called the Darwin Awards, which you hear about every year in the popular press. It is a compilation of rather sad and pathetic stories that reflect risk-taking behavior and what these individuals have done that results in their death. This is truly not too far removed from the events of Germany that I have detailed for you. If you look at the 2008 Darwin Awards all of the top 10 involve surgical problems specifically trauma.[4] These stories repeated on blogs and emails as a source of humor, when on a more somber level we are reporting someone's death. No similar humor is seen from death related to preventable disease (e.g. smoking and cancer).

Surgeons and Emergency Care

Many of us, including your speaker, were stimulated to enter a career in the medical field by the television show "Emergency." Coincidentally, our guest speaker at the Scott Frame Lecture, EAST member Will Chapleau, RN, EMT-P, also talked about this television program yesterday in terms of a model of delivering emergency care. What interested me when I was a kid was the character of Kelly Brackett, MD, FACS, as the name appeared on the credits. First of all, he was really handsome, something I still hope to be one day. He certainly looked like a doctor and had the MD after his name but what I never understood was what that "FACS" thing about?

I later learned that FACS, of course, is a great honor bestowed on practitioners of surgery. These television emergency room doctors, that fueled so many careers in emergency medical care and in trauma surgery, were surgeons. Surgeons, at that time, were leading the charge in care of the emergency patient. Somewhere along the line, we dropped the ball.

I am not advocating that surgeons should be running emergency departments. Emergency medicine has become so complicated, so vast, that would be impossible. But as a group, we have abdicated our responsibility on many levels to that patient population.

The Institute of Medicine Report looking at emergency medical services examined the role and the impact of the emergency department within the hospital and looked at significant challenges in the delivery of emergency medicine in this country.[5] Of greatest interest and concern to this group ought to be workforce issues, because workforce issues translate into access into specialty care. Let me show you what I mean. Many of you probably have already seen this analysis of data from the American Medical Association (Fig. 1, *A* and *B*). It appeared in the *Bulletin of the American College of Surgeons*, looking at physicians by self-designated specialty from 1975 to 2004.[6]

As you can see, general surgery has flat lined in terms of number of practitioners. Over this 30-year period, the population of this country has increased from about 213 million to almost 300 million. Other specialties, internal medicine, and general and family medicine have increased

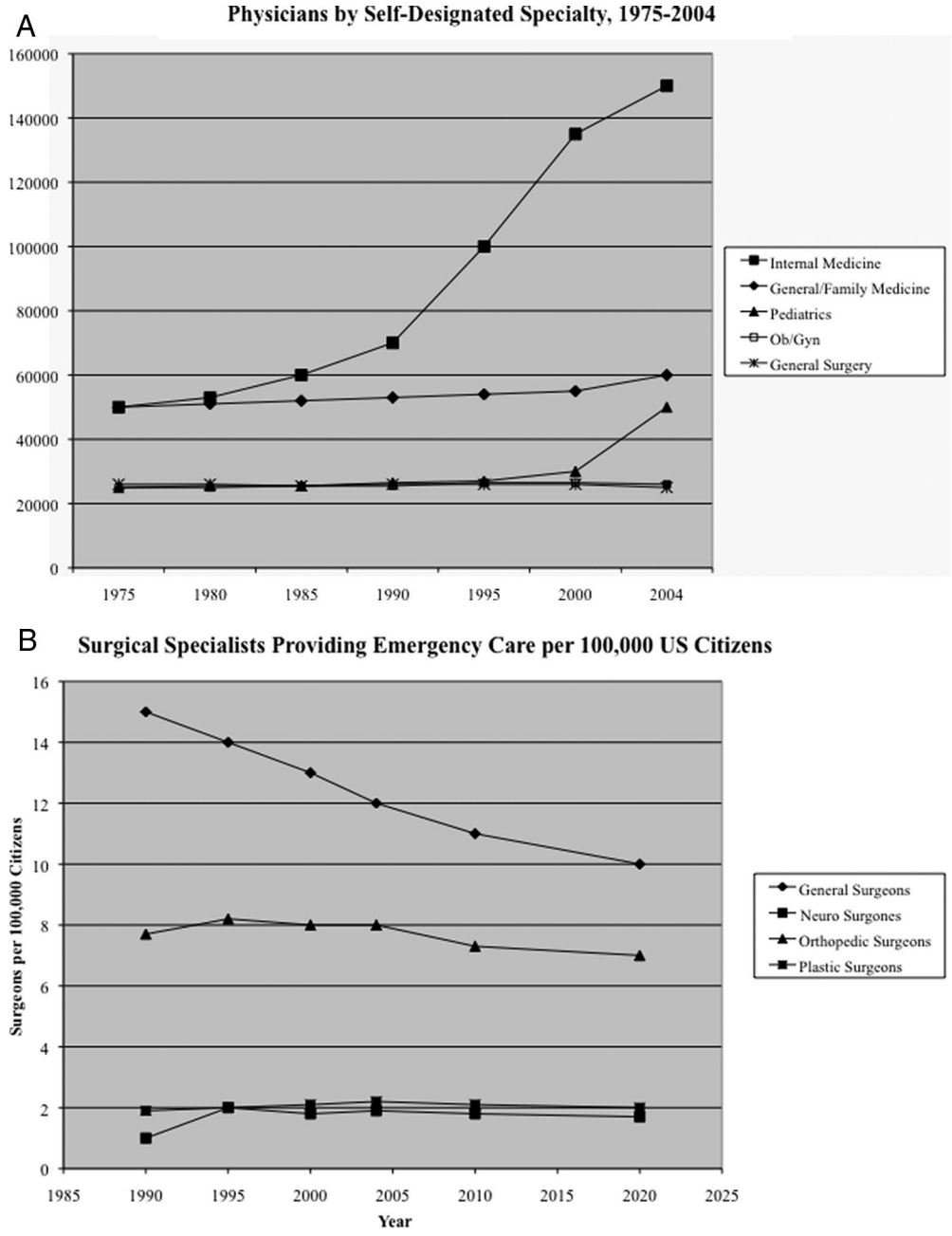

Figure 1. (*A*) Physicians by self-designated specialty show increase in internists but plateau for general surgeons. (*B*) Surgical specialists providing emergency care per 100,000 US citizens.

proportionately. Thus, there is not only a flat lining in surgical support, but also a decline in access per capita.

Let us look at surgeons more recently, from 1990 to 2004 and then projecting into 2020. Surgical specialists providing emergency care per hundred thousand US citizens are on the decline. It is slightly on the decline for orthopedic surgeons and stable for neurosurgeons and plastic surgeons.

Some of this is demonstrated in the previous graph and is related to population-based issues. We see no increase in general surgeons' while you see an increase in population overall. General surgeons and other specialty surgeons are dropping out of the call roster, either through qualifying through hospital bylaws, because of age or number of years of service, or they are simply leaving the field. They are entering into industry and administration. All of these are worthy career options, but it is a disturbing conclusion that access to clinical care is in jeopardy.

The shortage of general surgeons is apparent to the lay public. Even *USA Today*, the paper of the public, knows about a shortage of surgeons.[7] This article reported not only that surgeons are dropping out, but also that their loss affects the hospital and its patients. In the last 2 weeks, I interviewed

a medical student candidate for our residency program who not only was aware of this article, but also was furthermore aware that he was going to become a very valuable person. He lived in a rural state; in a rural hospital, when they lose their last general surgeon, that hospital closes. This is truly a crisis.

There are many market forces pushing surgeons away from emergency call. I would not discuss all of these, but we can agree that declining physician reimbursement is a factor as is unfavorable payer mix in the emergency department. These are facts.

Gen-Xers have a different approach to work-life balance. Your opinion on that view may be good, bad, or indifferent, but their priority of lifestyle over work hours/income is a fact.

I am going to discuss two forces that are affecting the on-call surgeon: super specialization and medical liability concerns. The first is super specialization. "I'm not comfortable" is the key expression used by a referring physician on the transfer line to mean that the patient needs a higher level of service. It is not just general surgeons that are encountering peers who cannot or will not address complex disease processes. We hear our orthopedic trauma colleagues talk about how the general orthopedic surgeons in the community are unwilling to take care of even the most simple of open fractures.

Last year, one of our residents went to an outstanding fellowship program specializing only in breast disease. That will be her practice, and it creates a conundrum where 10 years from now, she may be uncomfortable about complex gallstone disease, just as I have forgotten about many aspects of my training.

In fairness, if you are a patient in shock from a bleeding ulcer, and you had a breast surgeon on call, that surgeon probably may not be the best choice for you. This is not about surgeons abdicating responsibility but it is just the world of technology, and clinical acumen has become so immense.

These surgeons, as specialized as they are, and the hospitals with unfilled call rosters turn to our trauma centers as their last, best hope for the patient. But again, you will often hear an uncomfortable, degrading discussion between the receiving specialist and the emergency medicine physician, who is just trying to help the patient in front of him. Instead of placing the patient first, years of mutual distrust result in layers of accusations of pushback versus dumping. We need to repair this relationship.

The trauma centers have specialists, specifically surgical specialists who are mandated through the verification and designation processes. These emergency department physicians and outside community hospitals know this and turn to them for help. One of the things trauma centers do well is take care of sick patients.

How often do you get a brochure in the mail highlighting a job opportunity, where the banner headline is "No Trauma Call?" The arrangement is stated with pride as a perquisite of the offer. It is remarkable. As a trauma surgeon to receive it, it is even more remarkable.

One of your past Board members, Tom Esposito, published a landmark article in 1991, "why surgeons prefer not to care for trauma patients."[8] I would suggest that many surgeons prefer not to care for emergency surgery patients of any kind for many of the same reasons. Interference with elective practice was the most common reason cited in this study. Many elective practices are not set up for the intrusions of emergencies in the operational planning.

Reimbursement for trauma is less was also noted. Even in the best of opportunities, payer mix for nontrauma emergencies is bad. Trauma patients were also seen as being more labor-intensive; the same is true for nontrauma cases.

Nontrauma emergency surgical patients are truly sick and surgeons may question about greater liability risk. Previous studies did not show increased liability for trauma, but what about the general surgical population of emergencies? There is a nice study by Ronnie Stewart published in 2005, looking at over 62,000 operations over 12 years and lawsuits per hundred thousand patients.[9] He demonstrated that the rate of lawsuits does not vary among elective surgery, nontrauma ACS, and trauma surgery cases. Liability is truly not a problem. Nevertheless, the perception is out there in the community. At a minimum, given the poor payer mix, the risk to benefit for those small practices is affected.

Regionalization of ACS

EAST, along with American Association for the Surgery of Trauma (AAST), the American College of Surgeons, and other stakeholders, have created ACS out of trauma surgery, encompassing not only injuries and critical care but also surgical emergencies. This was not only to unburden their emergency departments but also to help resuscitate a heavily nonoperative surgical specialty. The arrangement is for the good of everyone.

More recently, we have been studying something called Regionalization of ACS. The subject was discussed and reviewed in a white paper produced by the American Association for the Surgery of Trauma following a meeting that included the Centers for Disease Control, EAST, Western Trauma Association, Orthopaedic Trauma Association, American College of Emergency Physicians, and other trauma specialists (Fabian T, August 7, 2008, personal communication).[10] This is a map looking at the hospitals in central Florida, where I practice. (Fig. 2). The blue H is Orlando Regional Medical Center and the red flags are other surrounding hospitals.

On any given night, in fact on every given night, each of these hospitals has a surgeon on call. Each has an anesthesiologist on call, a certified registered nurse anesthetist on call, a scrub on call, a circulating nurse on call, and a front desk clerk on call; all on call waiting for emergencies. In reality, there are not enough emergencies to go around to justify all these individual states of readiness. The theory behind regionalization is simple. Deliver patients who need ACS from surrounding emergency departments to nearby ACS centers, of which trauma centers will function as the backbone. The fixed costs of trauma center readiness (operating room, surgeon on call) are offset by new revenues, while the community hospital is unburdened of these costs. The community surgeons are relieved of on-call duties and impositions allowing them to focus on their elective patients.

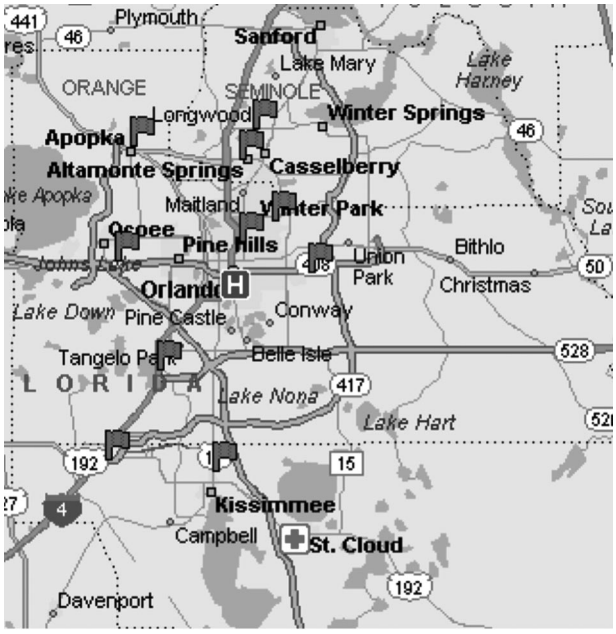

Figure 2. Map of Central Florida depicting trauma center (H) and other hospitals (flag). Each hospital maintains on-call surgery team.

The acute care surgeon is rewarded by the opportunity to provide nontrauma emergency surgery.

Many emergency departments receive a patient requiring surgical support every night. They have such emergencies every so often, but as a society, we staff each of these operating rooms because these hospitals are competing simply for the sake of competition. They are not competing because they deliver better value to the patient or better care.[11]

This fall, I was fortunate enough to present some information looking at the financial opportunities with regionalizing ACS at the AAST. You may have seen my image on a cover of the American College of Surgeons *Surgery News.* I do not mention this to fuel my ego or to reconfirm that I have a face for radio. I show it to you because of all the presentations at the AAST, this is the one, the editors chose to put on the front page.[12] And because of that choice, I would suggest that Regionalization is either very right or it is very wrong. I do not think it is off target and I am going to show you why. I will also point out that my EAST pin is proudly displayed in the picture. We will get to critical role of EAST in regionalization in a minute.

Because of the visibility in this article and other publications on ACS, some very critical fellow surgeons approach me at meetings and in the surgeons' lounge. They tell me why regionalization would not work and why it should not work. Let us look at three key concerns.

It Is Just General Surgery

Many surgeons tell us that nontrauma ACS is just general surgery. One of the sessions at this meeting had Dr. Hiram Polk discussing about how ACS is general surgery. Dr. Jerry Jerkovich, the AAST President, who attended the EAST Board meeting as our guest noted that topic and replied, "You're right that it's just general surgery, but there are no more general surgeons."

This week, on the front page of the *Wall Street Journal* was the article "Surgeon Shortage Pushes Hospitals to Hire Temps."[13] The author catalogs the difficulty of the rural surgeon, Dr. Peppers, who is unable to make her practice survive financially. She now functions as a temporary surgeon, flying across the country, going from hospital to hospital. She does what we all do, "meatball surgery": bowel obstructions, appendectomies, draining pus. Once her duties are completed, she flies away to another underserved hospital. That is regionalization in reverse. This approach brings the specialty care in and then it abruptly vanishes. Follow-ups are impossible and there is an inconsistent availability of surgical support, but it shows you how desperate the times are and how desperate these hospitals must be.

What Do You Mean I Cannot Do an Appendectomy?

This was another comment with which one of my colleagues challenged me when one of the vascular surgeons asked a general surgeon about the concept. Now, this general surgeon is a better technical surgeon than I am (and I should know, I helped train him). His clinical skills are not the point here. The issue is that the non-ACS hospital, nontrauma center, may not be able to deliver as much value to the patients, even with something as straightforward as appendicitis can be.

If you look at high-risk procedures often seen as things that are technically complicated, such as esophageal surgery and vascular surgery, there is some evidence that low-volume centers may have higher mortality and different impact on resource utilization.[14–17] Other data suggest that the financial impact of removing high-risk procedures from the low-volume center is minimal.

We need to champion that emergency surgery is also a high-risk, low-volume procedure for many hospitals. There are not enough appendectomies around for all to become an expert at it, and I will show you what I mean by expert.

For appendicitis, there must be variability if patients with the disease are spread over 10 different hospitals. Any time in medicine, you have variability, there is an opportunity for improvement. It is a basic quality initiative. If you have variability, there are either increased costs or missed opportunities.

If a surgeon performs an appendectomy, and chooses or not to order a complete blood count the next day, there must be some way to validate either that the laboratory test was frivolous or that not doing it is harming the patients. This is a simple example but clarifies the potential for even greater financial savings to the system. There are tremendous opportunities to regionalize this care for standardization and cost reduction.

You Are Stealing My Patients

Another concern is that as ACS centers, trauma centers, we are interested in improperly poaching off the community practices. It is not as if these surgeons truly have ownership

of a patient who walks into a hospital emergency department. It is remarkable to think we can own our patients, but even were it true, let us review the impact of said theft.

I know my daughter is going to be laughing at this next, because our family talks about this on a personal level in our family. Basic negotiating strategy comes from simple sibling rivalries, such as how do you divide a pie?[18] The fairest way, of course, is for my daughter to cut it and for her brother to choose the slice. That is a fair division. That has a very bureaucratic approach to it. It requires no thought; just cut it in half and we are done.

In fact, what if the interests are different here? If one pie lover really likes the crust and the other really loves the filling, both parties are hurt by this so-called fair division. A smarter division gives one of them more crust and one of them more filling, letting each enjoy what they like best (Fig. 3).

The same is true for us in surgery. Those of us who love surgical emergencies would like to get more of them (Fig. 3, B). Those of us who do not want that should figure out a way to get less of those.

We Have Met the Enemy and He Is Us

Acute care surgeons remain unconvinced about regionalization. In fact, some trauma surgeons are not even sure about ACS. There is a concern about dumping. We have talked a little bit about that earlier, about the overspecialization of our colleagues and maybe why ACS actually represents an escape back to general surgery. ACS improves the operative volume of traumatologists and reduces the call burden of other surgeons, a classic example of growing the pie.

The first point on which our colleagues challenge regionalization is an argument from the patient perspective. Detractors claim that these patients will oppose being transferred out of their communities and shun an ambulance ride for a straightforward case of appendicitis. Let me show you a different example of how we can reject this fear.

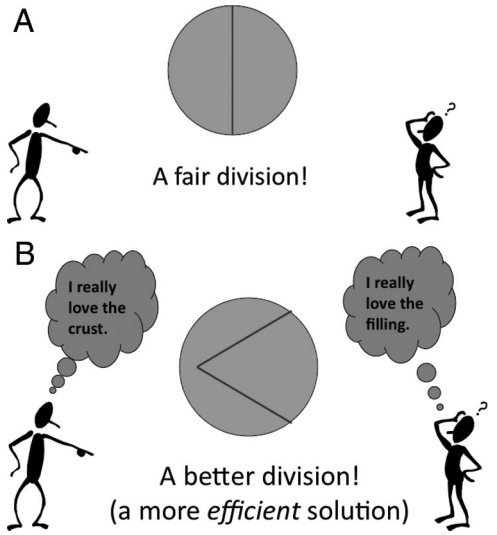

Figure 3. (*A*) Standard division of a fixed pie. (*B*) "Growing" the pie by dividing it based on interests.

One of the classic marketing errors, which my teenage boys would call an Epic Fail, was the introduction of New Coke.[19] Coke is one of the greatest companies created, but its executives made a mistake. They actually listened to their competitor's commercials. You may remember something called the Pepsi Challenge. What Pepsi did was entice loyal Coke drinkers to taste Pepsi and Coke. To everyone's surprise, Pepsi was preferred by a significant percentage over Coke. Remember, these were Coke drinkers that were trying it.

As it turns out, New Coke failed, and the reason was the testing. The metric used was something called a sip test, where you take a sip of Coke and take a sip of Pepsi and then tell people, which you like better. But that is not how we drink Coke and Pepsi. We drink Coke and Pepsi when we take the big carton home and enjoy it with a meal or enjoy the case over the weekend or however your usage is. As it turns out, only that first impression favored Pepsi. In regionalization, we need to look at longer-range interests.

What is it that emergency patients want? We have much to learn about patient satisfaction from our colleagues in Emergency Medicine who measure outcomes beyond physician-centered results.[20–22] Emergency surgery patients are unlike elective patients due to the acute nature of their disease. Surveys of emergency patients would suggest they are not concerned about the prospect of an ambulance ride in the grand scheme of things. What they desire is immediate attention to their concerns. Relief of pain is another priority, framing things in a plan, and knowing that someone actually cares about them. They want to then get back to their lives.

When patients are diagnosed with a serious illness, they desire care from a well-trained specialist rather than a generalist.[23] Regionalization of nontrauma ACS means having the referring emergency physician tell the patient that they will be sent to see a surgical specialist who is an expert in emergency care. This is a very different approach from the current situation. A hospitalist will admit the patient, and the surgeon will see them the following day for recommendations. Emergency patients, for obvious reasons, demand immediate care and action. This patient value is something the trauma centers can offer simply because we are there, ready and waiting. Fear of transferring a patient what appears to be straightforward surgery represents the sip test of surgical emergencies.

We also hear from trauma surgeons that they are far too skilled for the typical emergency. They wax philosophical on how well they can perform a gastrectomy, a colectomy, a thoracotomy, or a vascular case, but they do not wish to encourage referrals to drain pus at two o'clock in the morning. I will read you a thank you card I got from one of my patients after I performed another outstanding meatball surgery case. This is a young, 25-year-old law student with a small bowel obstruction, severe abdominal pain, and no previous surgery. At surgery, we found an obstruction related to an inflamed Meckel's diverticulum.

After a brief stay in the hospital, following bowel resection, she went back to school and sent me a card: "Dr. Block, it may seem odd for me to send a thank you card to a surgeon such as yourself, but I do not know of any other way

to express my gratitude. You saved my life and for that, I will forever be grateful. Also, as you know, you did an incredible job, which I am also appreciative of. Thanks again."

None of us should ever be too skilled nor too important to provide that level of patient service, even if they are cases that any good surgeon could handle. More importantly, we should challenge that it is not enough to be good. In the classic book of business strategy, *Good to Great*, the authors look at what "good" means.[24] Certainly, most surgeons in the country do a good job. In fact, some of them do a great job within their own subspecialty, just as my resident will in her practice of breast disease.

The membership of EAST as a group can do a *great* job in nontrauma surgical emergencies. We can reduce variability in our community so it is a more refined, efficient process. We can improve research on abandoned diseases. Unless it is a laparoscopic variation or a novel imaging technique, it is unlikely you will see a tremendous number of research publications in things such as appendectomies, small bowel obstructions, and so on. I am grateful to say that the Practice Management Guidelines Committee of this organization sees these diseases as opportunities for new and interesting information to study.[25]

Finally, let us consider unusual combinations, such as appendicitis and pregnancy. No one hospital can possibly get a large enough volume by their patients alone. If we refer all of them to only a few centers, there are some tremendous opportunities to improve patient care through good clinical research.

Good to Great also provides guidance on what to include in your delivery of great value. Expansion simply for the sake of growth will fail. One theory is to find the intersection of three circles. Determine what you do best in the world, what you truly have a passion for, and what is your economic driver. Managing nontrauma surgical emergencies fits all of those as regard to trauma centers. For our elective colleagues, I would suggest that these emergencies strike one or none of these targets.

Meatball surgery is an expression from the book *M*A*SH*. It was also something that one of our surgical leaders in this room, Dr. Larry Lottenberg, was told by his chairman when as a graduating senior resident. Larry told his chairman that he was thinking about going into trauma, and his chair basically told him "you don't want to do meatball surgery."

Dr. Lottenberg listened to him, went into private practice, and then years later came back to join us—meatball surgeons. That chairman was Dr. Robert Zeppa, one of my mentors as well, who actually ended his career by becoming a great advocate for care to the critically injured and ill.

But where our fellow surgeons are wrong, is that Meatball Surgery is a real specialty. I am going to read to you from the book *M*A*SH.* This is what Hawkeye said: "This is certainly meatball surgery we do around here, but I think you can see now that meatball surgery is a specialty in itself." He continues "Our general attitude around here is that we want to play par surgery on the course. Par is a live patient."[26] In the middle of the night, when I am up to my arms in blood or pus, I tell my resident, this is meatball surgery at its best. I am often criticized for that remark. That is not a pejorative comment. It is something I say with pride and with conviction. We should all be proud to be in meatball surgery. Our surgery may be inelegant at times, but we save lives.

Sometimes, ideas fail initially because they are just too new or too radical a departure. May be you have stayed in one of the hotel chains that pride itself on providing an Aeron chair. It is a bizarre looking thing and you can see all the mechanics moving. It is not big, and it is not covered with leather.

When it first came out, the marketing studies showed that the Aeron was going to be yet another epic fail. Instead, it won a few design awards and after people looked at it a second, third, and fourth time, they realized that it had some true value. Sometimes, important opportunities are not recognized initially.

In the motion picture *Monty Python's Life of Brian* and the Broadway musical *Spamalot*, the audience is treated to the song "Always Look on the Bright Side of Life". Although tongue-in-cheek, the lyrics suggest that with great adversity and even great challenges, like we see in medicine today, we need to be more positive. Great leaders are positive. They see the bright side of things.

This is a quote from Anne Frank, whose diary has been well cataloged as one of the triumphs of the Nazi holocaust: "In spite of everything, I still believe that people are really good at heart. I simply can't build up my hopes on a foundation consisting of confusion, misery and death."

This autumn, when my mom was in her last few weeks, I threw myself a rather pathetic pity party and this is what an observer said to me: "Everything is going to be great, just like always." That quote is attributed to my mom in one of her last lucid intervals, knowing what lay ahead for her.

If people like these can be so positive, so truly optimistic, how can we not be about what is obviously being given to us as a gift? Great leaders, like the members of EAST, must talk about how lucky we are. How lucky we are that there are other people who do not want to take care of these surgical emergencies! How lucky we are that our hospitals are committed to the injured and ill! How lucky that we found such a wonderful career, something we are passionate about and enjoy!

We are watching an act of progression and evolution for ACS. Surgeons can regain their responsibility to the emergency care patient beyond trauma care. Not as emergency room doctors but as the next step for that patient's progress. It is obvious that trauma centers, because of the inherent infrastructure support, can function as those receiving facilities. The current administration in Washington has indicated that reducing waste is a priority in reforming healthcare delivery. Regionalization will reduce variability and pay for itself financially, while delivering better value to our patients.

There are definitely challenges, capacity issues, efficiency issues, and physician availability, but EAST must be there leading the way. Why EAST? Why is EAST the organization that can help to a great degree in promoting regionalization?

Let us recall a small meeting room at a hotel called the Colony, where in 1992 I presented at the Alexander Paper Competition for an upstart organization called EAST. Look at the crowd around you. Look at the diminutive size of that room at the Colony. That is where we used to meet. We have over 500 registrants at this meeting. This is a growing organization. Your association is doing something right in this capacity and what is that right thing that EAST does?

One of our past presidents once told me something, one of those trivial little things that we say in passing that maybe you will remember forever. It was Mike Rotondo, who changed my outlook when he suggested that participating in EAST is about taking chances and making mistakes. EAST has always been about the young surgeon and may be that is the right time to take chances and make mistakes.

I will close by reminding you of some initiatives of our past leaders where they took chances, perhaps may have made mistakes, but changed the face of healthcare in this country through the vehicle of EAST:

Ultrasound Is a Tool for Surgeons

Grace Rozycki, MD, FACS, M. Gage Ochsner MD, FACS, (past board members, EAST).

Trauma Surgery Is a Business

Blaine Enderson, MD, MBA, (past president, EAST); Paul Taheri, MD, MBA, Brian Daley, MD, MBA (past board members EAST).

Evidence-Based Medicine Guidelines Affect Outcomes

Timothy Fabian, MD, FACS, Michael Pasquale, MD, FACS, Michael Rhodes, MD, FACS (past-presidents, EAST).

Prevention Programs Can Work

Glen Tinkoff, MD, FACS, (past board member); Robert Barraco, MD, (board member, EAST).

Trauma Surgeons Must Lead Disaster Management

Erik Frykberg, MD, FACS, (past president, EAST), Lawrence Lottenberg, MD, FACS, (board member EAST); David Ciraulo, DO, FACS (past-board member, EAST).

Nurses as Partners

Deborah Harkins, RN, MBA, (President STN and EAST member); Kate Fitzpatrick, RN, MSN, (EAST Foundation Trustee); Patrick Reilly, MD (President-elect, EAST).

> . . . because the people who are crazy enough to think they can change the world, are the ones who do.
>
> Think Different.

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