Presidential address 1996: "Dear ministers of health...."

Bryce R. Taylor, MD

The Canadian Association of General Surgeons, representing community and academic general surgeons throughout Canada, is concerned about the widespread effects of health care restructuring on clinical care, education and research. The general surgeon remains one of the critical members of the health care team and should have an adequate voice in ongoing discussions regarding health care reform.

L'Association canadienne des chirurgiens généraux, qui représente les chirurgiens généraux des milieux communautaire et universitaire, s'inquiète des profondes répercussions de la restructuration du système de santé sur les soins cliniques, l'éducation et la recherche. Le chirurgien général demeure un membre vital de l'équipe de soins et devrait être adéquatement représenté dans les discussions entourant la réforme.

The past 12 months, during which I have been your president, has been a time of exciting change, affecting the practice of every single general surgeon in Canada. A new definition of insanity is "To do the same thing in the same way and expect the outcome to be different"; so we expect change and welcome change. It is inevitable and in fact desirable.

But sometimes change is effected urgently, with limited planning and with consequences that ultimately undermine the objectives that we all have — a durable health care system in which all the vital components, including people like us, are working together enthusiastically. In the last year, some general surgeons have become frustrated and disillusioned, some angry and despairing; but at the very least, we all are concerned and must have our concerns heard, acknowledged and discussed.

So my presidential address is actually in the form of an open letter to all of Canada's provincial ministers of health.…

Dear Ministers of Health:
I write to you today on behalf of the Canadian Association of General Surgeons, a professional association in existence for almost 20 years, whose membership comprises the majority of Canadian general surgeons who practise in small towns, in moderate-sized cities and in large metropolitan areas. My purpose in communicating with you is to apprise you of concerns of all general surgeons in our country in view of ongoing and massive changes in health care delivery in each jurisdiction.

The Canadian Association of General Surgeons

The Canadian Association of General Surgeons (CAGS) was created in 1977 to represent and inform all general surgeons in the country and to develop policies in the areas of clinical care, education and research that would be useful to the surgeon, the Royal College of Physicians and Surgeons of Canada, the provincial ministries of health and the Canadian people. We are "multidisciplinary" general surgeons practising in remote areas, we are comprehensive surgeons practising in small cities, and at the same time we are academic surgical leaders, who may combine a focused clinical practice with clinical or basic research and a responsibility to teach future general surgeons. Over the last

From the Division of General Surgery, Department of Surgery, University of Toronto, The Toronto Hospital, Toronto, Ont.

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Correspondence to: *Dr. Bryce R. Taylor, Eaton Building 9-232, The Toronto Hospital, 200 Elizabeth St., Toronto ON M5G 2C4*

5 years, the CAGS has developed a number of policy statements that are critical to the practice of general surgery in Canada, and which I will highlight in this communication.

The importance of the clinical general surgeon

General surgeons occupy a number of crucial positions in the delivery of health care. They face a broad range of clinical problems, a variety of challenges in the emergency situation and, from a developmental standpoint, are critically involved in many major interdisciplinary programs such as critical care medicine and trauma, surgical oncology, transplantation, endoscopy, laparoscopy, head and neck surgery, colorectal surgery and hepatobiliary surgery. In other words, the general surgeon is the valued generalist in a rural setting and is also the highly focused specialist in areas of academic development and delivery of tertiary care. The current shift of acute health care delivery in hospitals to wellness in the ambulatory setting is an important evolutionary process that is welcomed and must be supported. With these changes, however, the fewer but higher-acuity institutions that remain are becoming more surgically focused, with many nonsurgical problems being managed in other settings. This emphasizes the growing importance of general surgeons in the future Canadian acute-care hospital.

Current atmosphere of change

Restructuring of our health care system is currently taking place in all provinces. Specific initiatives have varied under the direction of premiers, ministers of health and district health councils, and have included consolidation and rationalization of services, closure of acute-care institutions, regionalization of delivery and disruption of outdated and rigid mind-sets on the parts of both consumers and health care personnel alike. At the same time, the Canadian public demands the highest level of care possible, the most advanced technology available and an improved efficiency of the final product, that is, the unit of health care delivery. We regard those demands as reasonable and realize that surgeons as well as ministers of health must be accountable to the Canadian patient. We recognize and are bound to the conditions of the Canada Health Act and support our common goals of universality, accessibility, comprehensiveness, portability and public administration. We want to work with you, resolutely and enthusiastically to solve the problems of our health care system, especially as they relate to general surgeons and the practice of our specialty.

Many members of the medical profession are vigorously opposed to any proposed modifications. However, we general surgeons, while accepting that change is necessary, all share a desire to serve our patients. In so doing, we must have reasonable input into decision-making in the future of our profession, and in recognition of our extended training and heavy daily workloads we should maintain a reasonable lifestyle with reasonable remuneration. We recognize that, on balance, the Canadian health care system has in the past outscored its American, British and European counterparts, and our overarching desire is to maintain that favoured position.

In *The Tenth Insight*,[1] the current no. 1 best selling novel, Redfield declared:

> Law and order and respect for human life are on their way out. The world is degenerating into a mob mentality, ruled by envy and revenge, and led by shrewd charlatans, and it's probably too late to stop it. But do you know what? Nobody really cares. Nobody! The politicians won't do anything. All they care about is their personal fiefdoms, and how to retain them. The world is changing too fast. No one can catch up, and that makes us just look out for number 1, and get whatever we can as fast as we can, before it's too late. This sentiment permeates the whole of civilization and every occupational group.

This doomsday approach is one that our association abhors, and we feel confident that with appropriate teamwork, alternative solutions to current vexing problems can be found. Having said that, however, we must not lose sight of the fact that an overworked isolated community general surgeon could very easily gravitate toward this mind-set and leave our country for apparently greener southern pastures.

Areas of concern

We wish to bring to your attention our concerns as general surgeons in the following 8 areas, relevant to the current revolutionary process in health care: quality of health care; maldistribution and job opportunities; recruitment and retention in our specialty; lifestyle and workload of the general surgeon; educational programs; remuneration and academic programs; representation on decision-making bodies; and an improved mechanism for conflict resolution.

Quality of health care

The public is now demanding, and is entitled to receive, the best available quality of care, and this excellence of service must be documented. However, when the extent of quality control on a regional basis involves simply

the numbers of operations and the types of operations performed without further investigation as to the explanations for differences, and with little or no regard to outcome other than hospitalization and death rate, information is clearly incomplete and easily misinterpreted. It must be recognized by the public through their governments that the listing of numbers of procedures (such as the information provided by the recently published Institute for Clinical Evaluative Sciences maps)[2] is only the first step in a comprehensive review of health care delivery. Unfortunately when these results are prematurely published in the print media, gross misunderstanding can occur, and mistrust of the practice of surgery is the ultimate result.

Evidence-based medicine is here to stay and is applauded by all general surgeons, who strive to care for their patients appropriately; however, to carry out timely and accurate reviews requires time and the financial support of institutions. The ongoing systematic documentation of the quality of patient care will require your support; the CAGS will encourage its members to enthusiastically embrace the concept of the newest quality improvement and evidence-based medicine initiatives but anticipates that adequate financial and expert assistance will be provided to assist in that monitoring. General surgeons also remain enthusiastic about the development of practice guidelines — the standardization of investigation and management for a given surgical problem, which will enhance quality of care presumably at the same time that costs are minimized.

In particular, the Association advises extreme caution when specific surgical guidelines, such as a rigid percentage of a certain operation that must be carried out on an ambulatory rather than an in-patient basis, are instituted. Guidelines are produced using specific populations of patients, and our institutions across the country will, by the very nature of consolidation, be remarkably different from each other in terms of the type of patient who will present for the same procedure. The CAGS has articulated guidelines for ambulatory care that we believe are fair to patients, to government and to surgeons. (These are produced by the Clinical Practice Committee and may be obtained through the CAGS office in Edmonton.)

Maldistribution and job opportunities

The Association believes that general surgeons are of critical importance to communities of all sizes in this country and that there exists a persistent maldistribution of qualified individuals. There is clearly a shortage of generalists in small towns, where the surgical needs of communities are being met only by extremely talented but overworked general surgeons. In the last 2 years, the CAGS has worked with the College of Family Practice of Canada to define a series of guidelines whereby general practitioners in certain areas may undertake responsibilities normally held by general surgeons. We feel that this is an important initiative and continue to support the concept, despite the reticence of some other surgical specialties. The guidelines represent a realistic attempt to train the general practitioner in areas of critical need in outlying areas, without placing an unreasonable burden on the individual doctor in surgical domains for which he or she is not fully trained. Such issues as minor surgery and initial care and resuscitation of the traumatized or acutely ill patient are emphasized. In addition, the Association is endeavouring to improve communication with all general surgeons in the country.

With the cooperation of the Royal College of Physicians and Surgeons of Canada we are currently structuring a page on the worldwide web that will be accessible to all certified general surgeons in the country, providing, among other information, up-to-date listings of permanent job opportunities in all provinces, temporary locums to replace individuals in outlying areas who wish to go on vacation or educational leave and educational opportunities available in all of our 16 medical schools. To date, this information has not been available in a complete or timely enough fashion, and the initiative should go a long way to match vacant positions to available surgeons. The current lists provided by provincial ministries and associations, and advertisements in journals are unfortunately often outdated by the time they are distributed.

With the support of the Royal College, all 16 postgraduate general surgery programs in the country are now making available community options so that our residents in training will have an opportunity for exposure to the kind of atmosphere they might experience in a future community career. Strategies that offer financial rewards to young surgeons working in rural communities have met with uneven success, but other plans may bear fruit; we look forward to working with you in developing other initiatives to attract general surgeons to smaller centres, and to avoid the kind of frustrating situation the well-publicized young general surgeon found himself in last year in western Canada.[3]

Recruitment and retention

We have a crisis of recruitment from a number of standpoints. The "brain drain" from Canadian provinces mostly

to the United States, is chronic, and in some cases, like Alberta,[4] is increasing. In addition, a recent Medical Opportunities '96 Job Fair in Ottawa attracted a number of physicians who heard from recruiters promoting opportunities in Asia, the Persian Gulf, Saudi Arabia and New Zealand.[5] In fact, a number of our valued academic and community general surgeons across the country have already left for opportunities in locales from the US to North Africa.

We have concerns about the level of contentment with a medical life and what appears to be the prevailing mood among practitioners. A recent survey of physicians reported that only 63% regarded medicine as still "fun," and only 44% would recommend medicine as a career to their children.[6] Approximately the same number of Canadian medical students in another survey were considering leaving the country after graduation.[7] This potential threat to the work force in medicine in general faces us in general surgery even more acutely, because of the anticipated 54% retirement in the next 10 years.[8] These retirees will not nearly be replaced by the output of our general surgery programs, which approaches 65 per year. It must be remembered that only about one-third of general surgery graduates practise general surgery as a career choice; 40% move into other specialties and 25% pursue a subspecialty within general surgery such as colorectal surgery or surgical oncology.[9] Whereas professional groups will always disagree, for a variety of reasons, with manpower studies, the situation with the generalist general surgeon, it is agreed, will reach crisis proportions early in the next century. It must also be emphasized that the true generalist in the rural community almost always falls into the more senior group. Any attempts to decrease numbers of general surgery training positions in our 16 programs must be resisted — the general surgeon and the practice of general surgery are integral parts of all surgical training, just as they are integral to the delivery of care to our patients.

Surgeons' workload and lifestyle

A recent survey by the Can-Meds 2000 Group indicated that general surgeons work an average of approximately 50 hours per week in Canada and are on-call another 46 hours per week.[10] Rural general surgeons must endure isolation, even longer working hours, few possibilities for continuing education and the heavy demand of emergency on-call duties.[11] This is especially important for individuals in community settings, where the general surgeon may be the on-call expert in metabolism, plastic surgery, orthopedic surgery, neurosurgery and obstetrics, as well as the general surgeon and traumatologist. Many of our general surgeons in such situations are reaching retirement age and are less capable and less willing to tolerate the kind of workload they have faced in past years. The CAGS has prepared guidelines (available through the CAGS office in Edmonton) for clinical workload and on-call time recommended for general surgeons in all areas, emphasizing that for delivery of excellent patient care, requisite leisure, family and educational time must be protected. In addition, we have outlined the kinds of resources (available through the CAGS office in Edmonton) that must be present in an acute-care institution for a general surgeon to be able to provide adequate care for his or her patients. We believe strongly that these guidelines should be respected when consolidation and reorganization of the system in each province take place. Fundamental to the consolidation and rationalization process is the consideration and provision of modern tools with which the general surgeon can work to serve the Canadian patient.

On the academic side, reorganization of tertiary services in some centres has impacted extremely negatively on the lives of academic general surgeons. For example, in Edmonton, tertiary surgery has been concentrated in two major institutions,[12] so that a surgeon managing a variety of patients (as most of us do), may have to travel daily to 2 or 3 hospitals. This has become common in many areas of Canada and has a profoundly negative effect, especially on those who have responsibilities for emergency coverage as well as elective procedures, not to mention their many rigid academic commitments in education and research. If this lack of attention to workload and disruptive environment for the general surgeon continues, quality of patient care and quality of education and research will inevitably suffer.

Education

The Royal College task force to review fundamental issues in specialty education[13] advised last year that all specialty residency programs should introduce and reinforce throughout the residency period the concepts of generalism. This further emphasizes the importance of the field of general surgery, which, along with few other specialties, embodies the notion of generalism, thereby playing a role in a wide variety of health problems. In fact, general surgery is the platform on which all surgical specialty training is built, and the general surgeon is one of the essential players in medical student education as well.

There have been a number of changes in the delivery of health care quite independent of current restructuring processes that have impacted adversely on the delivery of education

at the undergraduate and postgraduate levels. This is especially evident in surgical education, where preadmission clinics, same-day admission and same-day discharge procedures are becoming more frequent. A challenge has thus faced all surgical educators and is being met with appropriate educational modifications so that the teaching standards of students and residents can be maintained; in general, these radical changes have been very positive for patient care, orientation away from acute-care institutions, utilization of home-care services, cost containment, and so on. However, other hospital-based cutbacks have challenged significantly our ability to educate students and surgical residents adequately. The strategy of cutting operating-room time has been common throughout the country, a step that directly compromises the education of residents. Operations performed by residents with the assistance of university teaching surgeons inevitably take longer, and at the same time it is extremely common for an academic surgeon to be assigned only 1 day per week in elective operating time. You as minister of health may cite this as an internal problem that could be corrected by rearranging a specific hospital's resources, but that in fact has not been the common solution to date. We simply require more operating time in academic institutions to educate the general surgeons of the future; continued pressure to complete procedures in the interests of adhering to a time schedule to avoid added costs erodes our ability to provide the next generation with well-trained confident operating surgeons.

The aforementioned consolidation of acuity in teaching institutions is also posing a problem in program design. Even though we are trying to counteract this in many of our universities by sending residents for a community experience, residents are exposed within the university system to a skewed practice (such as the extremely acute cases for an extended period in a single institution and nothing but ambulatory surgery in another), and at the end of this patchwork training they are supposed to miraculously integrate all of their experiences into a balanced amalgam. In other words, it is difficult for the resident to be taught surgery in an institution where the practice of the specialty is a representative example of what may be expected in a future career choice; the greater the consolidation of surgical delivery, the greater the problem.

In undergraduate education, most centres have now gravitated toward problem-based learning, a system that presumably will produce more independent-thinking physicians and surgeons for the future. Unfortunately for the general surgeon, who is often intimately involved in this process because of a more global orientation to the whole patient, problem-based learning is much more time-consuming than past undergraduate educational endeavours. Just as in the case of patient care, surgeon-educators are becoming more accountable and must consequently spend more dedicated time with their students, whereas previously the bulk of education could occur simultaneously during the process of patient care. And let us not forget continuing education. Maintenance of up-to-date high-level service depends on the clinical surgeon's desire and ability to remain informed, and the educator-surgeon's desire and ability to continue providing an academic service virtually free of charge. For effective continuing education to take place, both these individuals must be offered the time, the encouragement and the compensation to continue a vital process.

The hospitals involved in education have traditionally had higher base budgets because of responsibilities for tertiary care and the higher cost of education; however, recent strategies to cut spending in various hospitals seem to have ignored that many costs in educational institutions remain disproportionately high; for example, recent budget cuts in Toronto have been similar for both active teaching hospitals and community hospitals.

The CAGS urges you to realize that educational responsibilities affect an important sector of our members and that threats to the educational process can only be met by open and frank discussions leading to compromises on both sides.

As Jim Thompson stated recently in his 1995 presidential address[14] before the Southern Surgical Association, with compromise of educational programs due to restriction and diversion of resources away from education, we may be "eating our seed corn. If we fail to invest in future education and research, we may have a medical famine."

Remuneration and academic programs

As I said, the Association believes that the general surgeon is the most valuable surgical caregiver in our medical system, given the breadth of service provided and the multiple settings in which general surgeons are critical to health care delivery. As you know, general surgeons remain near the bottom of median-billing calculations for surgical specialties,[15] and when lifestyle and emergency work are factored into the equation, it is understandable how our constituents are extremely sensitive to massive and unilateral fee cuts. In addition, all surgical specialties have been unable to increase total billings and workload because of the persistent and continued cutting of operating

time in acute-care hospitals. Therefore, in provinces such as Ontario where general surgeons' billings have been stable or decreasing, we have been forced to suffer significant clawbacks as a result of overruns created by non-surgical specialties, and some surgical groups such as ophthalmology and cardiovascular surgery. We feel this is highly inequitable, even though we recognize the absolute need to contain all costs, professional fees included. We submit, however, that if one considers that all physicians' fees constitute less than 20% of health care spending, that general surgeons' incomes have been stable, and that we occupy a critical position in health care delivery and in academic activities, those across-the-board cutbacks are grossly misplaced.

And please don't continue to resort to gross billings reporting. By the time we pay expenses, share academic commitments and generate our own modest pension, we are left with after-tax income that definitely does not afford the lavish life.

In Canadian academic institutions, which are home to many North American leaders, approximately 90% of a surgeon's total gross income comes from fee-for-service billings. Since the ability to generate fees is compromised in those institutions because of many non-remunerative academic responsibilities and a decline in resources available, such as operating time, our academic programs are progressively in jeopardy. A significant proportion of our total income is directed toward the support of education and research, and further erosion of that gross income will significantly impact on the academic objectives of all of us. While availability of research funds from all sectors steadily declines, our personal support of our own academic programs has been a critical factor in our maintaining a high profile in academic surgery in North America. In the US, where managed care and the business approach to medicine have supplanted traditional delivery, many academic programs are in ruins, in all aspects of their activities, including clinical care, education and research. Whereas the disturbing examples of academic chaos south of the border may be dismissed as just the results of capitalism gone wild, we must nevertheless be aware that abandoning our balanced approach to clinical care, education and research in favour of short-term fiscal issues that are not well planned may well have long-term effects.

The CAGS would therefore stress to you, the minister, that both the community general surgeon and the academic general surgeon should be considered as special cases whose unique contributions must be recognized.

Representation

In 1993, the Canadian Medical Association (CMA) ad-hoc working group on regionalization stated, "Overall, regionalization of health care can be a very positive and effective strategy for health care delivery… or not."[16] Regionalization can, on the one hand, offer the flexibility to locate authority and accountability for health care at various levels of government from central to local, depending on the type of activity and needs of the population. On the other hand, according to the findings of this study, regionalization should be implemented with caution. Unless appropriately established and implemented, regionalization, particularly decentralization, can lead to a fragmented system plagued with problems of access, mobility and poorly aligned authorities and accountabilities.

In the 1995 CMA *Physician Resource Questionnaire*,[17] 66% of respondents said that they had been neither involved nor consulted to any significant degree; 56% of respondents said that the medical profession has had no ongoing input into regionalization; and only 21% said that the profession had continuing input, varying from 17.5% in Alberta to 23% in New Brunswick.

Although, admittedly, as general surgeons we may have abdicated to some degree our responsibilities in self-education on the macroeconomics of health care delivery, we certainly do know about delivery of health care in general to the patient and the practical aspects of health care delivery such as the functioning of emergency rooms, operating rooms, intensive care units and acute-care wards. We know about the generalist approach to the patient, and we know about triage of patients in acute-care institutions. There are few other specialists who are as well qualified to assist the ministry in all of these particular areas. Given that with restructuring, hospitals will increasingly become occupied with high percentages of patients under the general surgeon's care, and given that the general surgeon's interests have always been in the whole patient, we believe the general surgeon should have a greater role in designing solutions to problems. We, as an association, would therefore make a plea to include adequate general surgical representation in restructuring plans in each area of your provinces. As gatekeeper to the system, we should play a crucial part; we offer one of the most balanced views available to you.

Mechanism for conflict resolution

And finally, ministers, because we have many contentious issues to face and because we are all approaching the same objectives, albeit from different perspectives, we need in each province

an effective mechanism for conflict resolution. The Canadian people need and deserve timely and efficient health care delivery, and we, as general surgeons, are committed to provide just that. However, the teamwork required among the people, the ministers and the caregivers will depend on well-articulated methods by which we all reach difficult agreements. We implore you to set in place such vital tools, and in so doing you will recognize the necessity of making decisions with our input. This will become increasingly important in the ongoing design of alternative payment plans,[18] a concept we look forward to investigating with you.

We, the general surgeons of Canada, play an important role in the delivery of a variety of health care services to our public. We also are acutely aware of the need for a careful and deliberate restructuring of our health care system to meet the declarations of the Canada Health Act, while containing spiralling costs. We sincerely hope that by facing these problems together in a coordinated fashion, we can assist you, the ministers of health, in bringing about change that will be fair to the patient and to the service provider.

Sincerely,

The Executive of the Canadian
Association of General Surgeons

As Christopher Heughan said in his CAGS presidential address last year,[19] "We general surgeons have many virtues and advantages. We are flexible, broad-based in our outlook, and our services are cheap. We are a coherent group, not an amalgamation of subspecialists like the internists. We should have a major voice in the evolving configuration of health care...." I hope that through this communication to our ministers of health, we will be able as an association to articulate some of our concerns and successfully indicate a willingness to be involved in the solutions to our collective problems.

I am pleased and honoured to have served as your president for the last 12 months and only hope that my contributions have merited your confidence. I am always indebted to the rest of the able executive including Julius Stoller, Bill Mackie, Ed Monaghan, Chris Heughan, Roger Keith and especially, Tom Williams, without whose efforts and constant guidance the CAGS would long since have ceased to exist.

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