Presidential address 1998. Advocacy — answering old mail

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Since its inception in 1977, the Canadian Association of General Surgeons (CAGS) has struggled with its responsibility to represent general surgeons in practices across this country. The CAGS has tended to be mute in the presentation of many of its accomplishments, which have improved the role of specialists in community practice, training programs and the subspecialties of general surgery. With the forthcoming changes in direction for the Royal College of Physicians and Surgeons of Canada, based on a recent external survey, the CAGS has a golden opportunity to advocate for a clear identity, autonomous from the Royal College for the purposes of scientific meetings, continuing professional development, scientific and practice affiliation with other surgical specialty societies, and new developments with corporate sector support for advancements in science technology and education. Advocacy for general surgery must be stressed as the priority for the CAGS into the future.

Depuis sa création en 1977, l'Association canadienne des chirurgiens généraux (ACCG) s'efforce de s'acquitter de sa responsabilité de représenter les chirurgiens généraux actifs d'un bout à l'autre du pays. L'ACCG a eu tendance à être muette lorsqu'il s'agit de diffuser ses nombreuses réalisations qui ont amélioré le rôle des spécialistes en pratique communautaire, dans les programmes de formation et dans les sous-spécialités de la chirurgie générale. Compte tenu des changements imminents à la direction du Collège royal des médecins et chirurgiens du Canada, et si l'on se fonde sur un récent sondage externe, l'ACCG a une occasion en or de préconiser une identité claire, autonome du Collège royal, aux fins de réunions scientifiques, du perfectionnement professionnel continu, des affiliations scientifiques et pratiques avec d'autres sociétés de spécialités chirurgicales et des progrès réalisés avec l'industrie dans le domaine des sciences, de la technologie et de l'éducation. Pour l'avenir, l'ACCG doit accorder la priorité à la promotion de la chirurgie générale.

On a Saturday morning in August, 26 years ago, I was about to leave home to go to Sunnybrook Hospital [now Sunnybrook and Women's College Health Sciences Centre] in Toronto, when my 4-year-old son looked up at me and said, "Daddy, why are you a doctor?" I can't tell you how many times I have remembered that question. But I can tell you I was too naive then to understand that this was the youngest and most indelible advocate for change that I would ever encounter in my career!

I would like to address some other advocacy positions in the practice of general surgery that I have come to know through my time with the Canadian Association of General Surgeons. Two years after returning to Toronto from a fellowship in England, I was privileged to participate in the historic developments advocated by Dr. Donald Wilson, a cardiovascular surgeon and the R.S. McLaughlin Professor and Chairman of the Department of Surgery at the University of Toronto. In 1975, he catalysed meetings of groups of general surgeons to establish a unique society that would represent the specialty and be freestanding from the Royal College, which had always been consid-

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ered the voice for general surgery. Through Dr. Wilson's efforts the Canadian Association of General Surgeons (CAGS) was created. An executive was formed from Canadian university heads of general surgery and the first scientific program was presented to 300 members in Toronto in 1977. Subsequently, bylaws were established that espoused the primary purposes of the new organization: to maintain and improve the standards of care in general surgery; to support both primary and continuing educational programs in general surgery; to advance knowledge in the field of general surgery; and to represent the views of the general surgeons of Canada.

Community issues

As information about the CAGS and its objectives spread through the specialty there was concern about the perceived lack of recognition for practising general surgeons in a predominantly university-administered organization. In 1979, 3 young turks delivered a letter to the CAGS Executive, presenting options believed to address the anxieties of the community of general surgery. Their issues were: visible and rapid involvement of non-university general surgeons on the Executive and committees; proportional representation on committees based on provincial general surgeon numbers; consideration of a temporal and geographic dislocation of the CAGS annual meeting from that of the Royal College to improve the identity of the new association; and a scientific program that would be clinically oriented and include structured postgraduate courses. The Executive considered the authors to be minority advocates at the time and advised that their presentation would be addressed as necessary in the future. Perhaps prophetic, many of these issues presented by the 3 (subsequent Presidents Hinchey, Turner and Keith) became part of the organization of the CAGS — others did not!

Committee and subspecialty activities

During the following years, committee activities of the CAGS produced many positive results. In 1980 a letter was received from Dr. Don Willoughby of Halifax which recommended the formation of an annual test for nationwide in-training assessment of general surgery residents. Through their efforts as a committee, 5 CAGS members, who were either present or past chairs of the Royal College Examining Board created an examination based at Dalhousie University. For 20 years, up to the present, this examination has been used by all universities and has evaluated over 7000 candidates. General surgeons across Canada should be grateful to Drs. Currie, Falardeau, Hinchey, Inglis, the late Don Willoughby and, especially, Steve Norvell for their contributions in this regard.

Canadian general surgery is one of the few national specialty groups in the world that can provide evidence, based on training content and certification by Royal College examination, that general surgeons are competent gastrointestinal endoscopists. A collaborative liaison was slowly forged through letters with specialists in Canadian gastroenterology between 1981 and 1986, which has assured the reality of the pertinent statement of competence by the Royal College for general surgeons who successfully complete residency training in approved Canadian programs.

Fragmentation of general surgery was an issue in the 1980s that affected the fabric of the base specialty. Trauma surgery regained attention as a multidisciplinary interest after the Vietnam war and became a focus for general surgery, orthopedic surgery and neurosurgery. Dr. Charles Burns was appointed in 1978 as the founding member of the Trauma Committee for the CAGS. He was a strong advocate for the general surgeon's role in the management of the multiply injured patient. He subsequently advised the creation of a Canadian coordinating committee on trauma to be affiliated with the Association. This effort ultimately resulted in the formation of a freestanding multispecialty society for trauma which is the Trauma Association of Canada. Dr. Ted Young as a CAGS member in 1983 advocated the formation of a committee devoted to maintaining head and neck surgery as an integral part of general surgery in opposition to the direction championed by otolaryngology. To his credit, as well as to that of the late Wayne Beecroft and Lorne Rotstein, the Canadian general surgeon has sustained capabilities in surgery of the head and neck through CAGS sponsored Royal College requirements for residency training in general surgery.

From 1982 the Royal College, intent on preventing further proliferation of subspecialties from the primary specialties, developed a capped program of accreditation without certification with strong support from John Duff, then vice president – surgery, of the Royal College and a future president of the CAGS. Three candidate subspecialties were working to achieve such status under the umbrella of general surgery. Colon and rectal surgery requested subspecialty recognition within the CAGS in 1982 under the guidance of Phil Gordon, then formed the Canadian Society of Colon and Rectal Surgeons in 1983. The first training program started at the University of Toronto under Zane Cohen in 1984. General surgical on-

cology, which originated as a CAGS committee under Henry Shibata in 1984, established the Canadian Society of Surgical Oncology in 1987 and was accepted as a candidate Royal College accreditation program in 1989. The third accreditation program was critical care whose general surgery interests were advocated from 1988 by Dr. Stewart Hamilton. Each of these subspecialty groups had their original foundation as committees of the Board of the CAGS. In spite of their current freestanding status as accredited specialties and their recognized subspecialty societies, each has maintained an alliance with the parent organization. This is of significance as we look to the future for the CAGS.

The CAGS and the *Canadian Journal of Surgery*

The principal vehicle for Canadian surgical news and scientific publication has always been the *Canadian Journal of Surgery*, owned and published by the Canadian Medical Association (CMA). It was coedited through most of its history by Drs. Lloyd MacLean and Barber Mueller. In December 1988 the Royal College announced a phased withdrawal of their funding for the Journal. The next year the Board of the CMA announced it could no longer maintain the Journal, which was not financially self-supporting. In response, CAGS President Jean Couture and other members of the CAGS Executive prepared a written proposal to the CMA in 1990. This was accepted and effectively salvaged this journal for Canadian surgeons for the past 8 years and, it is hoped, for the future.

This is one of the many important areas where the CAGS has been an effective, albeit quiet, advocate for the betterment of general surgery practice in Canada.

Effects of budget constraints

With the 1990s came the era of resource constraint and the impact on health care delivery, especially affecting in-hospital services such as surgery. For general surgery this meant an increasing exodus of specialists, more early retirements and fewer community practitioners. Currently, hospitalized patients have higher acuity indices, wait longer in hospital to reach the operating room and have more after-hours operations, then leave hospital earlier and are readmitted more frequently. Urgent and emergent surgery admissions are increasing and waiting times for scheduled surgery are becoming longer. Like all other medical associations, the CAGS has been ineffective in changing the course of action determined by fiscal policy established by federal and provincial ministers of health. So long as the practice of medicine is controlled by the global budgets of health districts across our provinces, the voices of medical practitioners and their associations will be countered by better politicians than ourselves who claim we should do more with less, because their accounts are in deficit.

Quality of care and practice

In response to the needs of the membership, the CAGS has been active over the past 10 years in developing practice guidelines and advocating better workplace conditions for general surgeons. These are important issues involving quality of patient care on the one hand and practitioner lifestyle on the other. Both are deteriorating! It is from a basis of frustration over these circumstances that members most commonly question CAGS Board members: "What has the CAGS done for me?" Paraphrasing John F. Kennedy, the proper answer is most likely "What can you do for the CAGS?" There are 2 things that members can do for the CAGS and themselves. First, conduct and participate in sound health outcomes research in your region. Scientific data showing impact on the quality of care is impossible to refute. Second, maintain your role as the patient's advocate, but support your client's advocacy on your behalf. User dissatisfaction with the resources available must be appropriately reported to senior management, in this case government. An unhappy electorate is a very powerful political force.

New directions

What about new directions for the CAGS in the years ahead? The 1997 external strategic review of the Royal College of Physicians and Surgeons of Canada strongly indicated the need for a reorganization of its corporate structure yet recommended maintenance of its excellent role as a high-quality standard-setting organization; and it was recommended the College expand its advocacy role for specialist medical care. In order to shift direction, the Royal College would have to off-load certain responsibilities to affiliated organizations such as the national specialty societies. This presents an excellent opportunity for the CAGS to assume a leadership position in new areas of major significance for our members.

In April 1998, the Council of the Royal College passed motions that will establish a mandatory program for maintenance of certification for specialists, based on recorded continuing professional development (CPD). This program will be planned and implemented through Royal College partnerships with specialty societies, which include the CAGS for our active members. We are fortunate that

we already have a number of CPD tools in place, which have been tested and found to be valid as well as user friendly. They include:

- the CAGS in-training examination, used as a self-assessment tool
- postgraduate courses at the annual meeting
- the self-assessment program at the annual meeting
- CAGS-sponsored regional meetings
- the *Canadian Journal of Surgery*.

The CAGS Education Committee will need to be an active membership advocate by integrating these programs with the development of new educational tools, which will allow participation by our members under this maintenance of certification program. This in turn will facilitate nationwide validation of CPD for Canadian licensing and credentialling bodies.

As the direction of the Royal College changes it is apparent there will be opportunity for national specialty societies to conduct scientific meetings beyond the umbrella of the Royal College, a message the CAGS received, albeit from a different source, some 20 years ago.

One of the reasons the CAGS has continued to meet with the Royal College has been for mutual financial benefit. By divesting itself of multispecialty annual scientific meeting responsibilities the College transfers the costs of organization and planning back to affiliated specialty societies. The specialty societies will gain more autonomy of program planning and potential for affiliation with specialties of like interest. Specifically for the CAGS this is a golden opportunity to meet again with our society colleagues from colon and rectal surgery, general surgical oncology, trauma and critical care. Expecting transition to this meeting format, it is anticipated that increasing numbers of general surgeons who have become distanced from the CAGS would find benefit from again attending the annual meeting: to exchange knowledge of clinical matters and science focused especially on general surgery interests; in combination with that opportunity to obtain credits toward continuing professional development; and perhaps most importantly to profit from the enrichment generated by time spent in fellowship with surgical colleagues from across Canada.

To consider these changes for our specialty society without recognition of increased costs would be folly. Thus, the CAGS must carefully enter the arena of joint ventures with trusted partners from the corporate sector. This is not a new concept for the CAGS. Nor is it new for specialty societies or the Royal College itself. Beneficial examples of autonomy bundled with corporate partnerships have been provided by our colleagues in the specialty societies for gastroenterology and orthopedic surgery. Currently, the CAGS does receive corporate support for training fellowships, resident research and teaching awards, the annual program and symposia and other educational projects. However, corporate support cannot be considered as funds dedicated from the corporate sector to general surgery without accountability. Rather, the industry wishes to participate in the advancements of science, technology and education for purposes of mutual benefit. These companies have vast analytic capabilities, long-standing effective communication networks, prolific independent research laboratories and international links in the marketplace. To help focus developmental goals in their respective industries the corporate sector requires better insight into the directions surgery may be taking and valid knowledge of the resources available in the health care environment of the future. We may not have all the answers for each other's problems, but working together will get us both a lot closer to our goals than working in isolation. This type of teamwork is clearly the approach of the future.

Today is an opportune moment for the CAGS to advocate its leadership role in sharing resources with multipurpose corporate partnerships to enable continuing growth in education, research, health care delivery and quality of practice for general surgeons at a time when public funding stagnation is threatening to our profession! Over a quarter of my life has been involved in working within the CAGS organization. I have witnessed a great deal of change. I hope I might have contributed to some, and hindered less. I am thankful for the opportunity to have served as your president and have enjoyed the commitment in its entirety.