I want to thank all the members of the American Association of Neurological Surgeons (AANS) for the honor of serving as your president this year. I am privileged and humbled to stand in the line of succession of the outstanding leaders who have preceded me, and I owe many of you a particular debt of gratitude for your help and support throughout this year, a debt I cannot possibly repay.

I want to thank the members of the AANS Executive Committee, the Board of Directors, and in fact, all of the AANS committee members who have worked for the organization this year. Few will know and none will fully appreciate the contribution and sacrifice you make to neurosurgery. And I want to acknowledge and thank the AANS staff who are so extraordinarily professional and dependable.

I want to thank my associates in Lexington for supporting me and covering for me in my absence. I particularly want to recognize my associate, Bill Brooks, a friend and colleague for 35 years, whose support and encouragement, and whose intellectual integrity and commitment to research, have been a perpetual inspiration to me. And I want to recognize Russell Travis, our AANS president in 1999, without whose example of leadership and political sense I would not have come this far.

I also want to recognize my family: my parents who are here today from Florida; our children, Jeff, here from North Carolina, and his wife Kirsten and our grandchildren; Alison and her husband Nick, here from Baghdad; and Lucy, here from Washington. They are the joy that fills our lives, even as they are scattered on the winds of fortune.

And finally and most importantly, I want to express my love and deepest affection and appreciation to my wife, Debbie, with whom I have shared the joys and trials of the journey this year, and our life together for nearly 40 years. “She is so conjunctive to my life and soul, that as the star moves not but in his sphere, I could not but by her.”

I want to welcome you all to San Diego. It’s a perfect site for the meeting. As you look around outside, you see a world-class harbor, a major naval base, an ideal climate, and, in fact, a world-class center of neuroscience research. This city is a crossroads of international commerce. In fact, the meeting site reflects the meeting theme: “Shaping neurosurgery’s future: a global enterprise.” Because, just as the field for commerce is global, so the market for medical science is worldwide. And recognizing that fact, the AANS has renewed its commitment to extend its reach and resources to our colleagues around the globe. We’ve changed the content of this meeting to create an international exchange of ideas, and to recognize international achievement. I want to welcome our international colleagues, and ask you to help us build stronger the bridges that unite us across the borders and barriers that divide us around this troubled globe. As part of the bridge, the AANS will sponsor the World Federation of Neurosurgical Societies Congress in Boston from August 30th to September 4th of this year, and I look forward to seeing each of you there for a phenomenal international scientific exchange.

The State of Neurosurgery Today

So, what about neurosurgery in the US? We are a specialty at the top of our game. Look at the scientific
We are accused of unnecessary surgeries, because of geographic variation in the numbers and types of surgical procedures we perform. The Dartmouth Atlas of Health Care in 2006 showed that the rate of lumbar laminectomies and fusions vary as much as 6–8 times across different regions. The reason may be a simple averaging artifact, but it is blamed on surgeon choice, or as some would charge, financial incentive.

We are accused of wasting money. The Congressional Budget Office estimates that fully one-third of health care spending, $700 billion a year, is either unnecessary or at least unproven to be effective.

We are refused use of innovative technologies. New surgical procedures have been denied payment coverage by Medicare and private payers. Their claim? Inadequate evidence of effectiveness.

We are charged by Congressional and Justice Department investigations with conflicts of interest, of violating Medicare kickback statutes, and placing our own financial interests above patient welfare.

Our payments have been cut. Since 1997 we have experienced Medicare payment reductions of 35% for spinal procedures and 20% for cranial procedures. The current sustainable growth rate formula projects an additional 40% reduction in payments over the next 7 years, and 21% in 2010 (just 7 months away), unless the formula is changed or overridden again by Congress, as it has been every year since 2002 (K. Orrico, personal communication, 2008).

We are still the unshielded targets of plaintiff attorneys. Our liability premiums are the highest of all medical specialties, and Federal medical liability reform, our hope 6 years ago, is on life support.

The list goes on, but the theme is constant. We are a profession under assault. Our professional work is devalued by statutory fee reductions. Our professional judgment and autonomy are usurped by insurer preauthorizations and denials. Our public trust withers under allegations of pervasive conflicts of interest. Our reputation is tattered, and our image is tarnished. How did we get to this point? Let’s look back from whence we began.

A Retrospective Look at the Medical Profession

The medical profession blossomed early in the 20th century. With standardized medical school education, rigorous residency training, and specialty board certification, this country produced generations of physicians whose competence and judgment were automatically assumed.22 From these beginnings grew a virtually mythical image of the medical profession as an altruistic enterprise, committed by moral purpose and technical competence to patient welfare. Over the course of several generations the profession acquired a deep reservoir of public trust and confidence.

But medicine received a wake-up call in the 1960s and 1970s. Critics examined the gaps between professional claims and performance. They called medicine a monopoly, seeking money and power. They claimed performance varied widely and quality was spotty, and each physician his or her own judge and critic. They saw little scientific basis for much of medical practice. And they said that despite claims to the contrary, physicians were heavily influenced by economic and market forces.

Physicians believed themselves to be exempt from federal scrutiny, to say nothing of prosecution. But in 1975, the Federal Trade Commission charged the medical profession with being an anticompetitive monopoly, because of American Medical Association (AMA) ethical restrictions on advertising, patient solicitation, and contract practice. Physicians were stunned to learn that the pride of their profession, their ethical code, meant no more to the Federal Trade Commission than a concerted conspiracy to monopolize and control the health care market. The ruling dispelled the belief that medical practice operated under rules different from other commercial businesses, and it hastened the transformation of the medical profession from a powerful guild to a competitive business.

Money propelled the transformation. In 1986, Arnold Relman, the former editor of the New England Journal of Medicine, and Uwe Reinhardt, an economist and our Cushing Orator, published a series of letters in Health Affairs. They debated the status of the profession in a market economy. They each had a seat on an IOM committee studying for-profit hospital chains. And they had a fascinating debate, which is as pertinent today as it was when the letters were exchanged 25 years ago.

Dr. Relman shifted the focus of the discussion from hospitals to the medical profession. He said that physicians are altruistic by training and vow, and that to protect public trust in physicians’ selfless motives, they had to remain untarnished by commercial interests. Reinhardt rebutted Relman’s argument from an economist’s point-of-view. He questioned whether for-profit health care actually created a conflict with medical ethics, as Relman claimed, or whether the conflict actually lay within medical ethics. He asked whether health care “providers” are really fundamentally any different from “other purveyors of goods and services” in a commercial market. He asked...
whether Relman's conflict with commercialism was really just ambivalence over medicine's own entrepreneurialism, a denial of the obvious profit incentive and consequence of fee-for-service practice.

Relman claimed that physicians historically had struck a deal, which was now disintegrating under the influence of for-profit medicine; a "social contract" that earned public trust in exchange for selfless motives. Reinhardt asked whether this social contract was simply an illusion, what he called "a bargain struck in a seller's market," the seller being the physician.

Reinhardt stated that professionalism suffered as a casualty of contradictory social policy, what he called "an American Daydream" of "egalitarian distributive rhetoric" without funding. This belief that no person was refused care by physicians for financial reasons was an illusion. In fact, large discrepancies in care did occur, and those with financial resources enjoyed measurably better health and access to care. Physicians could and did decline to see patients without payment, and the right to choose whom to see or refuse to see was supported by the AMA Code of Ethics.

Finally, Reinhardt pointed out that physicians ironically bear the social and economic consequences of these contradictions between the ideal and reality. He said doctors are traditionally trained, and expected to act, under egalitarian standards, to serve all in need, but they are paid under entrepreneurial standards. Therefore, beneficence and charity are not rewarded. Fees have been reduced, and the excess revenue once used to subsidize uninsured and charity care has evaporated. So generosity and self-sacrifice are positively penalized. The physician who is a good businessman turns out far better off than the physician who is a Good Samaritan, because in a commercial market, success is measured not in terms of patient welfare or public praise, but in personal dollars.

The Challenges of Medical Professionalism

Professionalism carries commercial conflict within its constitutional makeup. This has been true since archaic Greek times. This conflict between ideology and reality is a principal source of the dissatisfaction, anger, and despair physicians in the US experience today. Commercialism profits by higher costs, and cost in health care has been a simmering crisis for more than 4 decades. Policies to restrain health care costs attack it as a commercial problem, and in doing so, they strike at the very root and soul of professionalism: its autonomy, authority, and trust.

And the cost problem won't go away. The Congressional Budget Office projections for health care cost increases over the coming decades, absent any change in policies and cost trajectories, force the US economy eventually into bankruptcy. Even before the current financial collapse and plummeting stock market, it forecast an unprecedented economic crisis based purely on future federal health care entitlements (Medicare and Medicaid), a future that requires fundamental public policy changes.

To get to the core of a complex issue such as professionalism, it helps to look for the central idea. During the Civil War, Lincoln commented to his secretary, John Hay, during an evening at the White House:

"For my part...I consider the central idea pervading this struggle is the necessity...of proving that popular government is not an absurdity. We must settle this question now, whether in a free government, the minority have the right to break up the government whenever they choose. If we fail, it will go far to prove the incapability of people to govern themselves."

At their core, things are not necessarily what they seem. The Civil War was blamed on several issues. But Lincoln saw it as a question not simply of slavery, or sectional economic differences, or states rights, but whether a free democratic government, the American experiment, could survive its own inherent weaknesses. Democratic government and professionalism share a similar feature; each bears within its nature a potentially fatal weakness. Democracy's weakness is its vulnerability to destruction by its own democratic process. Professionalism's weakness is its inseparable commercial side. Commercialism must be acknowledged and restrained, but cannot be denied.

The central question we face today as a specialty, and a profession, is not whether government should manage health care, or whether our fees are threatened, or whether commercialism is compatible with compassion; it is whether professionalism can or even should survive, or whether it is even a relevant concept any more. Have we become indistinguishable from "other purveyors of goods and services"? Is our profession a calling, or merely a financial opportunity? Is selfless service realistic, or altruism simply a relic? And, if professionalism should survive, in what form and with what assumptions? Our actions tomorrow depend upon our answers to these questions today.

Rosemary Stevens, a sociologist and historian, described this dilemma of professionalism as the dying of a myth; she wrote that, "Doctors, once heroes...had fallen from the pedestal of public adulation...[and] could no longer play the role of unexamined cultural hero..." She stated that the American doctrine that "professions, corporations, and government occupy separate, competing social spheres" misled physicians to believe a myth that they live in a "selfless, ordered, clean, idealistic world of charity and science," while business slogs about in the "selfish, messy, dirty, pragmatic world of commerce."

In Stevens' view, medicine must demythologize its self-image. The physician is not the idealized hero of the past, crusading against the intrusion of government and the evils of commercialism. The physician is a pragmatist who works with teams and systems, who shares in authority, but leads by balancing policy with ethic; one driven not by personal ambition, but by a social mission; a part of a peerage rather than a hierarchy.

But more than that, she envisioned a unique, changing role for the profession. Whereas government is responsible for creating and enforcing public policy, ensuring equal protection, and deciding on the meaning of distributive justice, the medical profession is responsible for setting standards of care, so that health care does not devolve to mediocrity, averaged to the lowest common denominator to save expense, unresponsive to individual needs. Similarly, the role of business is to provide orga-
nization, financing, and efficiency in health care, while the role of the profession is to preserve the ethical basis of care, ensuring that patient welfare, not simple profitability, is the guiding principle and motive in the business of health care (Fig. 1).

So, to consider the central question of whether professionalism can survive or is even any longer relevant, the answer lies in reexamining and even redefining professionalism. Professionalism that marks the relationship between a physician and a patient will never fall out of fashion. Competence, compassion, and selfless service are timeless needs, and will survive all other change. And commercial interests will never be fully stripped from professionalism; they can only be balanced by ethical restraint. But professionalism has a larger social dimension, and it’s not an obvious traditional role.

The American College of Physicians proposed a Charter of Medical Professionalism in 2002. It lists 4 social responsibilities of the medical profession; these responsibilities are: 1) define and measure quality in health care—prove it, don’t assume it; 2) create valid scientific knowledge by integrity in research and proof of effectiveness—show what works and use it; 3) ensure a just distribution of care by using cost-effective care—don’t waste resources; and 4) improve access to care by disinterested public advocacy—don’t ignore unanswered need. These responsibilities mark a transition in professionalism: the formal recognition of a larger role. So how do we embrace this new role?

We have to prove the quality of our care. Now, for example, we are offered a pay-for-performance program by Medicare, called PQRI (Physician Quality Reporting Initiative). For surgical patients, the criteria for quality are deep vein thrombosis prophylaxis and perioperative antibiotics. So if you take a patient with subarachnoid hemorrhage to surgery, clip the aneurysm and have a successful outcome, the quality of your care under this program is judged not by your results, but by whether you put stockings on the patient and administered antibiotics before surgery. The choice of operation, the outcome of surgery, or whether the patient even lives or dies is not even considered in this program: ridiculous, and a sad waste of time and toil.

There is a better way. The AANS has initiated an outcome data registry called Neuropoint Alliance (NPA). It’s designed to document real clinical quality by examining real outcomes, and provide a way to compare ourselves among our peers. This is actual quality measurement. And if we look at our outcomes, we can see where we are, and look for better ways to do it. This is the road to quality improvement, not check boxes or proxies for quality. Our challenge is proving that the benefits of routine outcome tracking justify the time and cost required.

We also have to make science the servant of clinical care, by making scientifically valid evidence the basis of our procedures and protocols as often as possible. Our Joint Guidelines Committee, under the Washington Committee, is our tool for converting scientific evidence into practical clinical guidelines. Our challenges are 3-fold: first, to use methods of guideline development that are affordable and sustainable; second, to avoid the tyranny of the mean, in which significant benefit to a definable minority is obscured and lost in the statistical average; and third, to ensure that judgment and flexibility are not collateral casualties in the quest for uniformity.

We have to put our house in order to warrant public

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**Fig. 1.** Slide summarizing the unique social roles of government, business, and the medical profession in contemporary health care in the US.
A new professional paradigm

trust. We have to acknowledge conflicts of interest, and eliminate them where bias cannot be avoided. Let’s be clear: we don’t reject personal commercial interests—they are part of a professional’s life in a market economy. There is no escape from this reality. You perform a service, you are paid a fee. But commercial interests must not distort the fundamental purpose of our professional life, which is commitment to patient welfare, first and foremost, whether in research, education, or service. Some conflicts are incompatible with positions of fiduciary responsibility, and it’s our duty to recognize and remedy these conflicts. Disclose or even divest conflicts of interest, or recuse oneself if there is any question of bias.

We have to influence public policy. Effective federal lobbying requires coalitions and a unified message. But the medical profession is splintered. Today the conflict is between primary care and procedural specialties. Primary care organizations demand additional pay to prevent the death spiral of their discipline. Their demand, by Medicare budget neutrality rules, requires devaluation of surgical procedures. The AMA is torn between competing constituencies, and faces a prospect of alienating half its members by supporting one’s claim over the other, whichever choice it makes. We have to find compromise solutions that let us support each other, because “a house divided against itself cannot stand,”15 and a profession divided defeats its own hopes and devours its dreams.

We have to lobby in Washington, but we are subject to being used as pawns in party politics, and we were used in the struggle last summer to override Medicare fee cuts.12 That bill was a lesson in political manipulation. It passed with large majorities in Congress overriding a presidential veto. The AMA and other medical groups, except the AANS and CNS, hailed it as a victory, because the fee cuts were stopped. But the reprieve was only temporary, the formula remained unchanged, other unwanted provisions were loaded in the bill, and the biggest mistake was that medical lobbying became partisan.

Our policy aims and lobbying must be based on principle, not political expediency or partisan politics. We have to look for permanent solutions, not a quick fix. We have to be consistent in our advocacy and impartial in our political support. And we may compromise on means, but never on principles. One of the hardest propositions to agree upon is a role for professionalism as an agent of our society’s highest aspirations. The American political belief in justice, fairness, and equality leads logically to the notion of health care coverage for all as a guiding political principle: the belief that every person should have access to decent and affordable health care. As government control over health policy grows, and if history is any lesson it will, the position of the profession as an independent conscientious objector opposed to government intervention simply becomes more futile and ineffective. We cannot be a mere spectator in the political drama of transition.

In 2005, we adopted a position statement that reads: “The AANS supports health insurance coverage for every American.”14 The statement was crafted to express support for the principle of coverage for all without stumbling over the debate about single or multiple payers, or whether health care is a right or a choice or a privilege. To reach the ethical goal of health care access for all, we have to overcome our own traditional resistance to government presence in health care, and participate in crafting policy that ensures quality, respect for the individual, and efficient use of our resources. We must be the guarantors of high standards.

Conclusions

So, in response to the central question, professionalism is indeed relevant and will survive, but not necessarily in the form we thought we knew. We must understand its strengths and guard against its weaknesses. And we must expand and adapt it to meet the changing needs of an evolving health care system. We are on the verge of an awakening, a transformation that can reshape our identity, reorganize our pattern of thought and action, and redefine our relationship to the world of science and service.21 Through science-based truth and selfless advocacy, we can reclaim a cherished heritage.

And so, with high hope for the future, with pride in our past, and with confidence in the present we must face forward, whither destiny draws us: secure in our purpose, sure in our direction, and certain of our success. Whatever our present problems, the future beckons us brightly, and the best is yet to come. Thank you once again for the opportunity and privilege to serve as your president this year.

Disclaimer

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