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Presidential Address: On Resisting the Narcissism of the Present

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Human beings, by nature, are self-focused. We fixate on whatever it is we are experiencing right now, right here. We tend to get stuck inside our own perspectives. Esteemed presidential historian and biographer, Jon Meacham, often tells a story about a conversation he had with a colleague feeling beleaguered by the state of American politics, complaining that they have never been worse. "Really?" Meacham replied. "You don't think the Civil War, maybe, was a little worse?" Well, maybe, the colleague conceded. Meacham warns us all to beware of what he describes as the narcissism of the present. It blinds us to the lessons of the past and the possibilities of the future.

The narcissism of the present. It is a paralyzing condition that prevents us from moving forward—the idea that what is happening to us now should be our reference point for all that is good and for all that is not. We lose touch with the fact that where we are now is just a moment that fits into the broader, ever-changing cycle of time. About 5 years ago, I mentioned that the future of breast surgery was uncertain in light of the rise of non-operative breast cancer management. A colleague at the time said, "Oh, operative breast cancer will never go away." I beg to differ. Everything changes. It is simply uninformed to believe otherwise. Sir William Osler, widely regarded as the founding father of modern medicine, thrived on change, and so did his work. "The search for static security—in the law and elsewhere—is misguided. The fact is, security can only be achieved through constant change adapting old ideas that have outlived their usefulness to current facts." Change is what leads us all into the future.

Physicians, all physicians, want to advance science that provides the best care for patients. As a doctor, you never want to hinder that. If we can cure breast cancer, we have to, but we cannot stand by and watch others steer the science that will directly affect our patients. If we can cure breast cancer, that care needs to be delivered by a breast surgeon. In 2015, the American Society of Breast Surgeons became concerned about the future of medicine, especially our place in it, and formed a type of think tank, the 2025 Working Group. We want to try to understand what kind of change may be coming our way and to prepare for it, and we do not just look at our disease. If we focus only on what breast surgeons are doing and how things are currently happening in our world, we are going to miss what is going to affect us from the other sides of the issue, and miss out on a huge amount of information and influence. We are projecting forward 5 and 10 years down the line, asking ourselves how we make sure that the breast surgeon is the primary point of referral, not a secondary referral point. That is important. We do not want to become an afterthought because we were afraid of change. The 2025 Working Group is trying to work behind the scenes to assess the challenges that are headed our way, take note of what others are doing and thinking, and work on solutions to problems that are not quite here yet. You do not hear much about us. We are anonymous. I am the chairman so you get to know me, but the rest of the committee members will remain unknown. Our thinking is that we can work best without undue influence and the resulting bias. Four years ago, the year 2025 seemed a long way off. Now we feel a greater sense of urgency. The healthcare landscape is changing. If you are 30 right now, you especially need to think about this. We need to be proactive, not reactive. We do not want to look back 1 day and ask ourselves what we should have done.

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Change. What are the three big changes that I think are coming? The first major area of change is how we will be paid for providing care. The largest payer for healthcare is the federal government. Approximately 50% of Americans have healthcare coverage though Medicare, Medicaid, Tricare, or an exchange plan. The government has issues. The most critical is that Medicare Part A will likely be insolvent in 2026. In addition, the Social Security Trust Fund will likely be depleted by 2035. When Medicare Part A becomes insolvent, they will be dipping into General Revenue, the fund that pays the majority of Part B (which includes physicians' fees), for a large part of their funding. In other words, by 2026, in order to survive, we will be competing more directly with hospitals for resources. How do you solve this looming problem? To add another 25 years of solvency to Medicare requires increasing the payroll tax by 16% or decreasing spending by 11%. Right now, half the hospitals that take Medicare lose money on Medicare patients. How do you cut their spending by 11%? Well, they are talking about it. One way would be to kill readmission payments, while another would be to risk shift, to put the burden on the Advantage plans, to bundle payments and institute a cap. There would be repercussions. Suddenly certain legislators would be out of office or healthcare policy makers would no longer work for HHS. What has Social Security got to do with the healthcare crisis? Within two decades, net revenue for the government will likely cover only Social Security spending, Medicare, Medicaid, and interest on the debt. Any solution for managing entitlement spending will have profound effects on healthcare delivery. It will affect us; however, it will not affect just us, it will affect private payers and everyone else out there. If you are not a direct hit, you will be collateral damage. It is coming.

Commercial insurance is the second big issue. Commercial insurance right now is economically credentialing you. Medicare may not know who you are but big business does. They know who you are, what you spend, and what tests you order. As a matter of fact, they know who you refer to and what tests they order. If you are afraid right now of big data and what they see in your browsing history, think about what they will do with the information they collect about your spending history and an inventory of every test you order. Recent studies project that in 2020, one-quarter of all major businesses will bypass insurance and contract directly with providers. Think Cleveland Clinic. All of those patients for spine and joint were sent by business directly to Cleveland Clinic, bypassing local providers in their hometowns. Big data is behind the next generation of that approach. It is happening right now at Walmart for oncology care. Not long ago, Walmart made a pitch to a medical facility in my system. They knew what each one of our doctors spent. They had data on all of us, data that was specific to each one of our providers. Think about that. They know when I get up in the morning and when I go to bed. They have got data on us, and it is impressive. You are going to be credentialed economically by hospitals and by health plans, and by the businesses that use them.

The third big change coming is a new industrial revolution. Last year, a Citigroup executive predicted that by 2025, artificial intelligence and automation will reduce the number of financial sector jobs by 30%. That is happening in medical facilities too. In your own hospitals, you may run into those delivery robots delivering things all over the facility. The manufacturers claim that for a price equivalent to one hospital employee's salary, each of those robots will do the work of three people. And they do not take sick days or vacation. Why does that concern us as physicians? Well, those robots do not carry health insurance, nor do they contribute to payroll taxes. For every living, breathing human employee displaced by artificial intelligence or automation, the systems essential to healthcare delivery will slip deeper and deeper into financial crisis. This will affect who we treat, how we treat them, and how we will be paid for the medical treatment we provide.

Henry Kuerer may be one of my favorite people. He is brilliant, he takes risks. Surely you have heard about his HER2 trial. Imagine you have a patient with a HER2-positive breast cancer. You give her neoadjuvant therapy and monitor with breast imaging. Currently, you perform a percutaneous biopsy to confirm no residual disease but, at some point, you will not even need a biopsy, just an MRI or a blood test. You find that there is no residual disease, you will perform radiation and you are done. Inevitably, Henry will offer this trial to people with triple-negative cancers. What Henry is showing us is that minimally invasive breast cancer treatments are coming, and, when they do, approximately 20% of your breast cancer surgeries will go away. This is going to happen. Henry's research will bring new hope to cancer patients. It will also greatly impact your operative volumes.

Other developments that are going to affect operative volumes are intralesional therapy and ablation. Right now, the 3-year data on a cryoablation trial currently underway indicates that for properly selected patients, cryoablation may be as good as or better than breast-conserving surgery—and there goes another 20% of your surgeries. How we manage tumors is going to require skills you are not even aware of today. There is a revolution brewing in the area of diagnosis as well. Right now, research involving two different blood tests looks to determine how detection rates parallel those of mammography. Blood screening prior to mammogram and biopsy is going to happen. It is a matter of when, not if. The portion of your practice that is

based on inaccuracies and false positives will decrease. Again, these developments are wonderful for patients, but they will change your practice.

So, for all of us, the question is this: what happens if breast cancer surgery becomes nearly irrelevant? What happens if we cannot figure out how to navigate the new delivery systems or the cancer management? I posed these questions to an old mentor of mine recently. He looked at me and replied, "You take out gallbladders." The reality is that our situation is actually worse. Because, even if you were willing to change course and start cutting out gallbladders, you cannot get credentialed without the proper ongoing prior surgical experience. If we allow ourselves, as breast cancer surgeons, to become irrelevant, we get to do what, to me, is the most horrid thing in life—wound doctoring. Let us not allow that to happen.

From the Society's perspective, we must lead the change that is coming our way. We must embrace and lead percutaneous management of cancer as it develops. We cannot wait for other disciplines to master the technology and then try to adopt it into our practice. It is imperative that we lead the way. We must embrace oncoplastics. The surgery we offer needs to be more thoughtful than merely the resection of a tumor. Consider the choice of incision and final cosmetic outcome. Be comfortable working on the patient's contralateral breast so it matches her affected breast when her disease management is complete. We must position ourselves to be the primary resource for breast cancer patients. Do not shy away from prescribing endocrine therapy. Become comfortable managing a patient's full array of medical needs. We must work proactively with coding and reimbursement committees to have a voice in determining how we get paid for our services. It is important that we are nimble enough to adapt to impending drastic changes in physician reimbursement. Lastly, we must become more cohesive as a specialty. We have forums where it is essential that the membership comes together to help each other solve our problems. We can help each other solve problems as they arise. Other subspecialties have faced similar changes; some have remained relevant, others are struggling. We are fortunate—the Society provides the platform and the mechanism for us to work together, to change together, to ensure that the fellows today will be able to enjoy long careers as breast surgeons.

Change is coming. That is not necessarily a bad thing. If we embrace the future of medicine, refuse to be paralyzed by uncertainty, and allow ourselves to be energized by the challenge, we will survive. If we work together to anticipate what is coming, we can position ourselves to help influence what direction it takes, how it affects our patients, and how it affects us, and we can help create a future where we will thrive. The first, most necessary step is to resist the narcissism of the present.