The future of general surgery

- “Impending disappearance of the general surgeon”
- Trends for the future from medical schools, residency and fellowship training programs
- Current data on practice patterns and compensation
- The impact of the Affordable Care Act
- Future trends and principles for general surgery
The graduating general surgery workforce is shrinking

- About 1000 general surgeons complete training each year, after 4 years of medical school, 5 clinical years of residency, and lab research time
- Usually graduate age 33 to 35 with $150-250 K of debt
- The number of training programs has been stable since 1970's
- Interest in surgical career by medical students has decreased
- 70% of graduating residents specialize, only 300 - 400 new general surgeons a year
Data from the 1990-2001 National Resident Matching Program – 68 unfilled categorical positions in 2001

Increasing trend of general surgery graduates to pursue fellowships

**Fellowships Lure Chief Residents**

*By Jeff Davis*

*Oklahoma City Medical News*

**VITAL SIGNS**

Groups With the Largest Increase in Surgical Fellowship Rates

<table>
<thead>
<tr>
<th>Programs</th>
<th>Small</th>
<th>Large</th>
<th>U.S. Medical</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>53%</td>
<td>57%</td>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>2005</td>
<td>59%</td>
<td>76%</td>
<td>87%</td>
<td>96%</td>
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</tbody>
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Note: Based on a survey of the identifications 11,680 PGY6 chief residents.

Source: Dr. Karen Berenson

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**Why do general surgery residents specialize?**

- To become thoroughly competent in an expanding knowledge base
- Perceived economic rewards are greater
- Lifestyle - Effect of the 80 hour workweek

However, the acute nature of general surgical problems is more intense due to an aging population, and complexity of care.

The overall population continues to expand...
Additional challenges to the future general surgery

- A crisis in access and delivery of emergency surgical care, especially in rural areas
- Increasing complexity of care, and specialization
- Declining reimbursement
- New legislation (ACA) that could overwhelm the delivery system by adding 32 million more Americans

A crisis in emergency care – the Institute of Medicine
"A growing crisis in patient access to emergency surgical care"

The single most important factor shaping the surgical workforce issue today is declining reimbursement

A crisis in surgical care in America

Critical shortage of general surgeons (especially in rural areas), to provide care for 54 million patients, and insufficient supply to meet demand

- Rising medical liability
- Earlier retirement
- Increased use of ED for primary care by underinsured
- A trend to practice in ambulatory surgery centers

A challenge of high demand and insufficient capacity
Resource Based Relative Value Scale (RBRVS)

- RBRVS implemented in 1992, CPT replaces UCR
- The dual intent: to control rising healthcare costs and redistribute income from specialists to generalists
- This was achieved by increasing reimbursement for E/M codes used primarily by internists, while reducing reimbursement for surgical procedures.
- General surgery initially did not participate in RBRVS
- Rates of reimbursement have decreased for general surgery procedures, even after adjustment for inflation

Median general surgery compensation

$327,600
Median production: 7,200 wRVUs
Total comp per wRVU: $45.50

*Based on a weighted average of median in the Annual MGMA and AMGA Physician Compensation and Production Surveys.

### Survey: Average daily on-call compensation for surgeons

- General surgeon: $739
- Cardiovascular surgeon: $1,221
- Neurological surgeon: $1,936
- All other surgeons: $1,217


### The emergency care crisis and the negative effect on quality of care

21% of patient deaths or permanent injuries can be attributed to ED treatment delays due to shortages of specialists, reflected in the increased need for patient transfers to UCSF from community ED's as no general surgeon is available.

ED patients wait longer for specialized care, and are often forced to travel long distances for care of urgent but routine conditions.

Transfers leads to a financial loss for the hospital, as well as increased costs to the health care system through the use of medical transport and triage.
The Surgical Hospitalist: A New Model for Emergency Surgical Care

John Max, MD, FACS, Jonathan T. Carter, MD, Jessica E. Gonnell, MD, Robert Wachtel, MD, Hobart W. Harris, MD, MPA, FACS

BACKGROUND: Quality of acute surgical care in the US is threatened by a shortage of surgeons performing emergency procedures because of rising costs of uncompensated care, liability concerns, declining reimbursement, and lifestyle considerations. In July 2005, we structured the general surgery service at our medical center into a hospitalist model to improve patient access to surgical care.

STUDY DESIGN: We hypothesized that a surgical hospitalist program could improve timeliness of care, emergency department (ED) efficiency and physician satisfaction, resident supervision, continuity of care, and revenue generation. We reviewed our program after 1 year, including patient demographics, diagnosis, and time to consult.

RESULTS: Three surgical hospitalists cared for 951 patients during 1 year. Patients ranged from 17 to 100 years of age and presented with abdominal pain (66%), infection (18%), malignancy (6%), burns (9%), and trauma (3%). Fifty-seven percent of consults originated from the ED; 8% came from other surgeons. Mean time to consult was 20 minutes. A survey of ED physicians reported shorter ED length of stay, better patient satisfaction, improved professionalism and resident supervision, and better overall quality of care. Average waiting time for patients with acute appendicitis to undergo operation was reduced from 16 ± 10 hours to 8 ± 4 hours (p < 0.05). Forty-two percent of consults resulted in an operative procedure, and revenue increased in the number of billable consults rose by 150%.

CONCLUSIONS: The surgical hospitalist model provides a cost-effective way for general surgeons to provide timely and high-quality emergency surgical care and enhance patient and referring provider satisfaction. (J Am Coll Surg 2007;205:704-711. © 2007 by the American College of Surgeons)
Expansion of surgical hospitalist programs in the US and worldwide

The ACS priorities – Dr. Hoyt

1) Payment reform & SGR fix
2) Accountable care organizations
3) Center for Medicare & Medicaid Innovation
4) Bundling
5) P4P and NSQIP

“ACA is the blueprint for a whole new care delivery system.....it is up to us to do everything that we can to make sure that the final structure is sound and equitable for surgeons and patients.”

How will we ensure an adequate trained workforce to care for 32 million more Americans?
Positives from the Affordable Care Act

- Trauma & Emergency Medical Services—Reauthorized Trauma-EMS program, creating pilot projects for regionalizing emergency care, and supporting existing trauma centers
- Bonus payments for general surgeons in Health Professional Shortage Areas
- Redistribution of Graduate Medical Education slots to general surgery—in addition to primary care

Where the future of medicine will be decided....

A pitched battle is being waged, and we need to learn the tools.

We need to change, learn about the law and finances, and end the perception of being money driven—SGR, tort reform, payment.

We need to enlighten the discussion in Congress, restore balance and reason, and safeguard the truth.

Perhaps there is disillusionment with the individuals, but not by the institution and overarching principles of government.

We have reached the end of the beginning.

Healthcare is a mirror to what is wrong with our legal, political, banking, insurance industries, and society at large.
Unsolved challenges after ACA

- Creation of Independent Payment Advisory Board
- Absence of meaningful medical liability reform
- Lack of solutions to surgical workforce shortage
- Failure to permanently repeal the flawed Medicare payment formula—the sustainable growth rate (SGR)

What you can do through the ACS

- Contribute to the ACSPA
- Attend federal lobby day
- Write your congressperson
Surgeons and physicians in government

- Lawyers have defined a career path in government
  US Supreme Court, Attorney General, District Attorneys, State Supreme Courts, Municipal and County Judges, and 70% of Congress
- In contrast healthcare positions are few: CDC director, HHS Director, NIH Director, AHRQ Director, FDA Commissioner, Coroner
- The need to define a new career path for MD’s in government to extend the fields of health care policy and public policy
- Doctors must be involved to enlighten the debate, and to suggest changes to the costs of medical education and residency training.

A Call to Action

Is There a Doctor in the House? . . .
Or the Senate?
Physicians in US Congress, 1960-2004

Context: The legislative and fiscal influences of Congress, as well as the continuing overall growth in health care spending as a portion of the gross domestic product, make congressional representation by physicians important because physicians have unique expertise in the impact of legislation on patient care and medical practice.

Objectives: To describe physician representation in the US Congress between 1960 and 2004 and value the results to past representation of physicians in Congress.

Design and Setting: A retrospective observational study of members of the US Congress from all 43 states and 11 representative territories, who served from January 1960 to April 2004 (including 108th Congress), using data available in public access databases and compression at nationalategorical records.

5 of the signers of the Declaration of Independence were physicians
21 Physicians in 111th Congress – hopefully an MD as President someday

1) Representative Charles Boustany (R-LA) CT surgery
2) Representative Tom Price (R-GA) Orthopedics
3) Representative Phil Gingrey (R-GA) Ob-Gyn
4) Representative Michael Burgess (R-TX) Ob-Gyn
5) Senator Tom Coburn (R-OK) Ob-Gyn
6) Representative Dan Boulter (R-MD) General Surgery
7) Representative Ron Paul (R-TX) Ob-Gyn
8) Senator John Barrasso (R, Wyo.) Orthopedic surgeon
9) Representative Larry Bucshon (R-IN) Thoracic Surgery
10) Representative Phil Roe (R-TN) Ob-Gyn
11) Del. Donna M.C. Christensen (D, Virgin Islands) Family Practice
12) Representative Jim McDermott (D-WA) Psychiatrist
13) Representative Paul Broun (R-GA) Family Practice
14) Representative John Fleming (R-LA) Family Practice
15) Representative Andy Harris (R-MD) Anesthesiologist
16) Representative Bill Cassidy (R-LA) Gastroenterologist
17) Senator John Boozman (R-AR) Optometrist
18) Senator Rand Paul (R-KY) Ophthalmologist
19) Representative Nan Hayworth (R-NY) Internal Medicine
20) Representative Scott Desjarlais (R-TN) Family Practice
21) Representative Joe Heck (R-NV) Emergency Medicine

Time to convene another Constitutional Convention?

When in the Course of human events, it becomes necessary for one people to dissolve the political bands which have connected them with another, and to assume among the powers of the earth, the separate and equal station to which the Laws of Nature and of Nature's God entitle them....