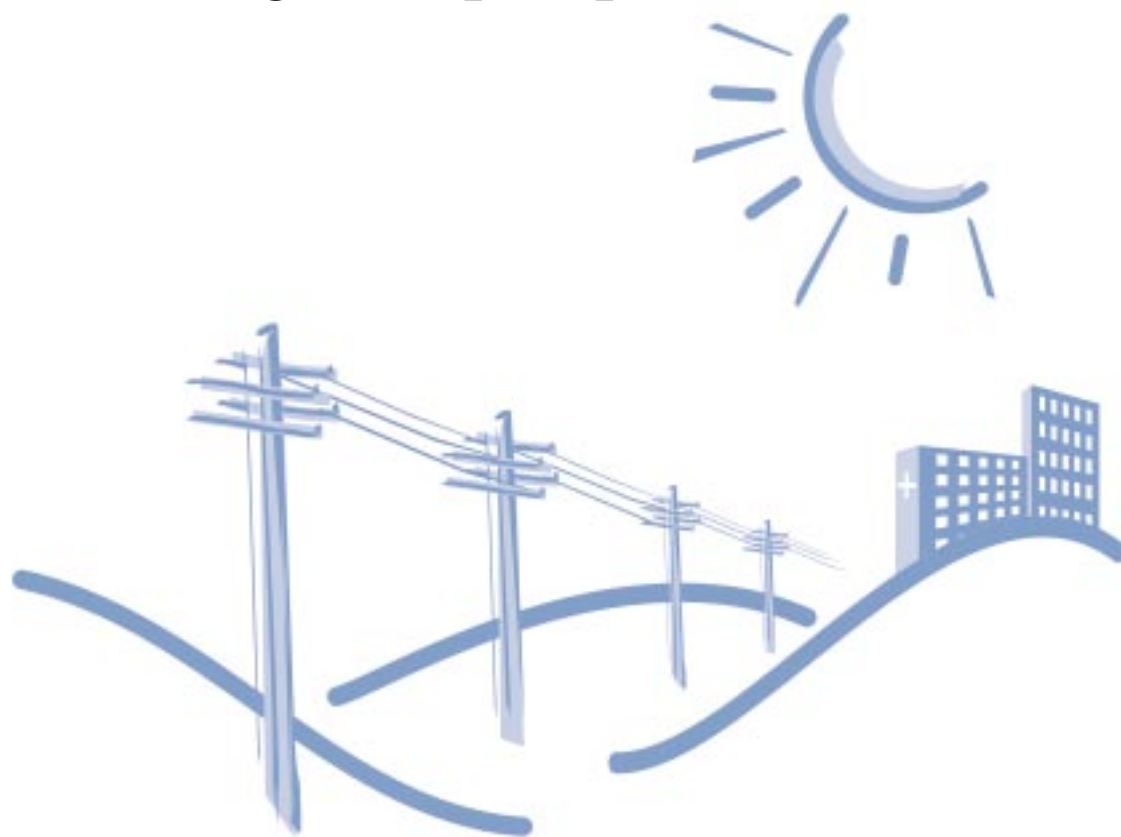


Securing the future of general surgery: A rural surgeon's perspective



by Richard A. Armstrong, MD, FACS, Newberry, MI

Many issues challenge the future of this profession, not the least of which is the steadily declining interest in general surgery among young people. While this trend is of concern to all surgeons, it is particularly disturbing to those of us who practice in rural areas of the country, which have long suffered from a dearth of surgeons.

A number of factors prevent young physicians from entering general surgery and confound those of us who have been in practice for a num-

ber of years, regardless of practice location. Those inhibiting circumstances include reimbursement reductions, coding hassles, evolving issues in graduate education and training, and new expectations for general surgeons.

The College is undertaking a number of initiatives to address these problems. In light of these continuing endeavors, I am offering the following thoughts and observations regarding these matters and their implications for specifically rural surgeons.

Reimbursement

All of my colleagues have expressed concern about the lack of equity in payment to rural surgeons as compared with their urban counterparts when they provide identical services. The College has been a strong advocate in urging Congress to change the flaws in the Medicare fee schedule that make possible the disparities in payment to rural and urban physicians. The goal of these negotiations should be to raise the level of payment for surgeons in rural areas to match payment to surgeons in urban environments. In other words, reducing reimbursement to urban surgeons would not be a viable solution.

It is important to note that private insurance companies do not set their payment rates on the basis of the surgeon's geographic location. Only the Medicare program makes this distinction.

Medicare's method of setting payment for rural physicians at a lower rate has the perverse effect of encouraging surgeons to practice in urban areas and of avoiding practice in the places where they are needed the most. My plea to Medicare officials would be to simplify this complex payment system, so that surgeons who do the same amount of work get paid the same amount of money. While my private practice has not suffered financially in 18 years, we do know that our volume of cases needs to be much greater than our urban counterparts to achieve the same income.

If the Medicare program is insistent on including practice location as an element in its payment equation, perhaps the program should factor in whether the surgeon has provided the service in an academic setting. Without question, performing a procedure in a teaching hospital with a resi-

In-hospital practices could expand access in rural areas



The article that this piece accompanies spotlights issues that are of concern to all surgeons, with an emphasis on how they uniquely affect rural practitioners. In this item, I propose that some of the problems facing rural health care could be addressed through the development of general surgery practices run within critical access hospitals.

According to recent estimates, 25 percent of the U.S. population resides in rural areas. However, only 10 percent of general surgeons currently practice in rural locations, and experts say 19 percent of general surgeons should be practicing in these areas to ensure adequate access to care.

Critical access hospitals

Critical access hospitals were established in the U.S. to allow many small rural facilities to remain open despite continuing financial pressures. Currently, 782 critical access hospitals are operational

nationwide. They must adhere to specific guidelines to remain eligible for special treatment under Medicare. For example, acute care is limited to 15 beds and an average length of stay of 96 hours. Although these facilities may maintain emergency services and surgical services, they cannot house intensive care or obstetrical services units. They must be 35 miles from the nearest hospital (15 miles over rough terrain) and must have transfer agreements with a local referral hospital in place.

Many critical access hospitals have no or limited surgical coverage, and those services that are available are provided by visiting consultants. In many cases, it is economically infeasible for these hospitals to offer 24-hour on-call emergent care. However, it is possible for these facilities to provide day surgical services based on the freestanding ambulatory surgery center (ASC), including short inpatient admissions.

dent learning how to do the operation requires more time and resources than would be necessary when doing the same procedure in a private facility with fully trained assistants. So, it makes sense that surgeons who operate in a teaching facility should be paid at a higher level.

Coding and billing

Nearly all surgeons, regardless of whether they are practicing in an urban or a rural environment, surely agree that our current billing and coding system is too cumbersome and complex. The College has done a superb job of teaching surgeons how to code and bill appropriately, largely through the practice management workshops that the organization presents. However, a worthy goal would be to develop a system that would allow a surgeon to send a bill for a certain procedure, say

laparoscopic cholecystectomy, and know exactly how much would be paid. Under our current system, intermediaries often deny entire claims or “down code” certain billings based on their own payment policies. To secure full and proper payment, many surgeons need to have a billing and coding expert on staff to negotiate with the payors and to examine each claim meticulously.

A proposal to ban payors from denying or limiting payment for certain facets of a procedure may strike some people as idealistic, anti-competitive, and, therefore, the rhetoric of socialized medicine. But the fact of the matter is that Medicare is socialized medicine, and it makes little sense to run the program using anything other than a single, standard payment rate for each service provided to a beneficiary. Capitalism works in the private insurance marketplace, where beneficiaries and

Expanding the concept

These facilities could be expanded and put to better use for rural populations by allowing general surgeons to establish in-house practices. The development of in-house general surgery practices at critical access hospitals would benefit the facility, the surrounding community, and general surgeons.

For the hospital, keeping common surgical and endoscopic services within the facility is a perceived good, and patients and their families would be pleased to avoid driving 35 to 100 miles for a simple procedure, such as hernia repair or colonoscopy. Rural hospitals would no longer have to refer virtually all of their surgical consultations and cases to the regional medical center or discuss cases by phone with a consultant at the regional medical center.

How it could work

Critical access hospitals are generally staffed by a mix of primary care physicians and physician extenders, who are used to being on-call for the emergency admissions and may also staff the emergency room. Very few general surgeons would agree to practice in an environment where they had to be on-call all of the time. A critical access hospital, because it follows the ASC model, would offer an ideal situation for a general surgeon—one free of after-hours emergency on-call time requirements. The surgeon would still need to be available by pager and on-call to treat any patients admitted after an operation, but the need to contact the surgeon would be limited because the

majority of cases would be elective procedures.

True surgical emergencies occurring at night or on weekends would still be transported to the local referral center. Of course, this arrangement would mean that the general surgeon would handle few trauma cases, but he or she should be willing to assist in the ER when available and in updating the ER personnel on current Advanced Trauma Life Support® guidelines.

Furthermore, a general surgeon would be of tremendous importance to the hospital and the community by offering a myriad of services that would otherwise be unavailable. Virtually all procedures that can be performed on an outpatient or short-stay basis and almost all endoscopy could be done in a critical access hospital. Office-based ultrasound for breast and thyroid procedures would be particularly suited to this type of ambulatory practice.

Conclusion

This proposal to make general surgeons key members of the critical access hospital staff may be one solution to the problem of encouraging surgeons to practice in rural parts of the country. As we struggle to address some of the most vexing issues regarding rural surgical practice, we must open our minds to new and innovative possibilities. Creating new practice opportunities and pleasant work environments may help us attract surgeons who otherwise might avoid rural practice.

—Richard A. Armstrong, MD, FACS

providers choose which health plans in which to participate, but it is contradictory to the aims of the Medicare program to have competing intermediaries. We need to develop a system that ensures that the surgeon in private practice gets paid an honest wage for an honest day's work.

Education and training

We live in an exciting time with respect to the changes taking place in surgical education. It is wonderful to witness what is almost a renaissance in thought regarding the training and continuing education of all surgeons. As we consider means of improving the graduate medical education system, we need to focus on the development of the whole person. The most successful surgeons seem to be those individuals who begin their careers with healthy minds and bodies. Our profession requires mental and physical stamina. As educators, we should be concerned about the overall fitness of the individuals who enter surgical training and their ability to cope with periods of major stress. It's a given that medical school is tough and that some people will find this part of their education difficult enough to make them think twice about choosing such a taxing line of work. Nonetheless, as educators we need to be able to spot the top performers by taking into consideration not only how well medical students fare academically but also their resilience when under pressure.

Furthermore, we should create a training environment that is conducive to both professional and personal development. Program directors need to be more sensitive to people who want to have families and enter practice at the same time—a topic of real concern to the growing number of female medical school graduates. We also need to promote good health. Some program directors and chiefs of surgery have long recognized that residents and attending surgeons who are physically fit and well-rested tend to perform more competently.

Too many of my colleagues complain of being “burned out” and wish that they could just quit practice. This is a sad comment to hear from people who once were excited and enthusiastic about surgery. This disappointing attitude possibly could be averted if the surgical lifestyle was less exhausting and more rewarding.

In the special circumstance of training individu-

als for rural practice, it is imperative that we provide opportunities for medical students and residents to attain experience in this setting. Studies indicate that the best time to attract physicians to a specialty or practice type is while they are still in the formative stages of their career. An excellent prototype for a training program that allows young surgeons to get a taste of rural surgery has been developed by John G. Hunter, MD, FACS, and Karen E. Deveney, MD, FACS, at the Oregon Health & Science University. (See “Training the rural surgeon: A proposal,” *Bulletin*, 88(5):13.) Rural surgeons need to emphasize to those individuals who do a rotation under their leadership that practice outside of metropolitan areas affords them the opportunity to manage a broad range of cases and to have greater control over their own destinies.

General surgeons

We need to carefully reconsider the core definition of what it means to be a general surgeon. This reexamination of the concept of general surgery is especially pertinent to any discussion of rural practice because physicians in more remote locations so often are called upon to handle cases that require knowledge and skills outside of their traditional purview. For example, they need to be able to perform routine obstetrical-gynecological procedures, including cesarean sections. They need to have enough orthopaedic trauma training to handle common orthopaedic emergencies. Competence in the treatment of critical care, trauma, vascular, and thoracic procedures is essential. Fortunately, I became familiar with this broad range of surgical procedures while training in the Navy, but I'm not sure that all training programs offer such wide experience.

One of the greatest challenges in rural areas is call coverage, especially if a group of less than three surgeons is serving a location. This is a topic that requires further discussion, but one potential solution is to have surgeons in neighboring communities network to provide call coverage. Additionally, rural primary care and emergency room physicians should be trained to deal with common surgical problems, to recognize when a surgeon is truly needed, and to know when to seek the experience and advice of a surgeon. This arrangement would limit the times rural surgeons are called.

Due to the limited number of surgeons who practice in rural areas, the few who do decide to practice outside of metropolitan areas must be exceptional people with a broad range of surgical interests, a deep sense of self-confidence, and plenty of common sense. They should want to be actively involved in patient care and be willing and able to do their own critical care management, in addition to the technical aspects of their work.

As the health care system evolves, it is evident that all surgeons will also need to be knowledgeable about the entire course of disease processes—not just how to cure a condition by using an operative procedure. For example, I believe that today's residents should be exposed to a broad range of pathology.

Future survival skills

All surgeons of the future also will need to have a better understanding of quality of care issues, of how to monitor their outcomes, of interpersonal and communication skills, and of what it means to be a leader.

All surgeons, of course, must be able to arrive at sound judgments and be committed to achieving the highest quality in the performance of all the daily tasks we carry out. In fact, a surgeon's success depends completely on his or her devotion to quality. No other aspect of daily practice is as important as delivering optimal care in and out of the operating room.

Keeping track of one's cases and outcomes is a subject that has received considerable attention lately as part of the quality debate and the development of best practices. Surgeons must get in the habit of monitoring their practice patterns. Maintaining these records can serve as our best defense against those individuals who would limit our privileges. This case log does not have to be anything fancy or particularly formal. I have kept track of my morbidity and mortality data in a notebook that I store in my changing room locker, adding cases after each operation.

Perhaps the College could help surgeons just getting started in this area by developing a software program for maintaining a case log that is user-friendly and portable. Of course, some people might say we are better off wait-

ing to develop this type of computer program until we have a clearer sense of what specific information surgeons will be expected to maintain, among other objections. However, I believe we should at least initiate a program that can be modified over time to meet changing demands.

Surgeons of the future will need to be willing and eager to help their medical colleagues and to seek their consult in difficult cases. Likewise, they must be amenable to working with hospital and practice administrators, as well as patients, with the goal of providing optimal surgical treatment. Hence, their communication skills should be well developed. Furthermore, surgeons must understand the vital importance of humility. They must guard against their ego getting in the way of sustaining productive relationships.

While in the Navy, I had the opportunity to develop a relationship with excellent mentors and role models. These individuals demonstrated the ability to remain calm under pressure. In fact, most of them instilled in us the belief that the most important time to remain in control of your emotions is when dealing with a crisis. As a result, I don't have any tolerance for surgeons who lose their temper in the OR. We must keep these negative feelings in check, particularly when dealing with trainees.

Conclusion

We have the opportunity at this time to create an environment that encourages surgeons to pro-
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Dr. Britt receives distinguished educator award

ACS Regent L.D. Britt, MD, MPH, FACS, was awarded the Distinguished Educator Award by the Association for Surgical Education at its annual meeting, on April 2, 2004, in Houston, TX. This award is the most prestigious honor presented by the association to a surgical educator for a lifetime record of outstanding achievement in surgical education. It may be presented to an individual only once.

During the presentation ceremony, Dr. Britt was recognized for his many significant contributions to surgical education throughout his distinguished academic career. Dr. Britt's pivotal leadership role in taking educational activities of many prestigious national organizations to new heights and his numerous contributions to surgical education were cited. Dr. Britt's contributions to the educational endeavors of the American College of Surgeons, National Board of Medical Examiners, Association of Program Directors in Surgery, Residency Review Committee for Surgery, and the Association for Surgical Education were especially mentioned. Dr. Britt's leadership and vision, as well as



Dr. Britt (right) receives the Distinguished Educator Award from Myriam J. Curet, MD, FACS, chair of the Association for Surgical Education's Excellence in Teaching Awards Committee.

his stellar mentorship of many surgeons, surgical residents, and medical students throughout his illustrious career, were highlighted.

Dr. Britt has previously received other prestigious education awards, including the highly coveted Alpha Omega Alpha Robert J. Glaser Distinguished Teaching Award of the Association of American Medical Colleges, the Sir William Osler

Award, and the Dean's Outstanding Faculty Award.

Upon receiving the honor, Dr. Britt recognized the previous recipients of this prestigious award and dedicated his award to his late mother, who served with distinction as a high school teacher for many years. For further information about this award, please contact Ajit K. Sachdeva, MD, FACS, FRCSC, at asachdeva@facs.org

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vide quality patient care and that promotes the rewards of practicing surgery in all geographic locations. We have a chance to work with policymakers to develop a system that ensures that patients in rural areas have access to the same

level of care as city dwellers and that rural surgeons receive payment that matches that of their urban counterparts. These are exciting times, and I anticipate that they will yield positive changes for all surgeons and their patients. 