

# From my perspective



**T**he December 2003 issue of *Cardiovascular Surgery* features the provocative article “Introduction: The decline of surgery” by Steven G. Friedman, MD, FACS.\* In this article, the author points out the realities of surgical practice today and shows how market forces have eroded many of the guiding principles of the profession. Although surgery has remained relatively unscathed by corporate scandals and other aspects of modern society, Dr. Friedman maintains that a number of factors are leading to the decline and fall of our profession.

## *Decline*

For example, he notes that surgery remains a male-dominated profession, which often has been unwilling to accept into its fold females and members of other minority groups. As a result, we have too few role models to offer the increasingly diverse medical student body, more than half of whom are women.

Other problems that Dr. Friedman highlights are socioeconomic in nature, including the huge expenses that trainees incur due to the length of residency training. Debt-ridden young surgeons then enter into practice only to be further encumbered by restrictions on reimbursement. In addition, he notes that professional liability premiums and lifestyle issues are among other serious problems that clearly face our profession.

All of these factors, Dr. Friedman says, have culminated in a declining pool of medical students who are interested in pursuing a surgical career. As he points out in his article, one effort to make surgical residency more palatable to medical students—and to lessen public concerns about the possible effects of fatigue on caregivers—is the recently implemented mandate from the Accreditation Council for Graduate Medical Education, which requires all residency programs to adhere to an 80-hour workweek. Dr. Friedman notes that this requirement will have profound effects on the training of surgical residents. He quite eloquently suggests that one way to change the way surgeons are trained is to shorten the number of years in residency and thus allow surgical residents to more quickly attain their goals.

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## *Ascent*

While I acknowledge that Dr. Friedman raises some very important issues for our consideration, his article seems to present a rather bleak vision for the future of the profession. Clearly, in his scenario the glass is half empty. I happen to hold a more optimistic view of the future of our profession. In fact, I believe that if one looks at the situation from a different perspective, the glass is half full. Indeed, I would offer a counterpoint article and title it “The Ascension of Surgery.” In it, I would demonstrate that for many of the problems Dr. Friedman discusses, there are solutions that we need to pursue and reasons why we should be sanguine about the future.

First of all, let us remember that surgeons in all specialties will always be in demand. Unfortunately, surgical diseases and conditions are not going to disappear any time soon. Allied health care providers have neither the skills nor the training to perform operative procedures safely and effectively. Hence, an adequate surgical workforce will continue to be necessary.

Medical students apparently are becoming increasingly aware of the stability of surgical practice, as demonstrated in recent data from the Na-

\*Friedman SG: Introduction: The decline of surgery. *Cardio Surg*, 11(6):449-452, Dec. 2003.

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tional Resident Matching Program. The various surgical specialties continue to have high match rates. For example, in 2003 general surgery residencies filled 99 percent of their slots, and 83 percent of individuals who matched are graduates of U.S. medical schools. Similarly, match rates in other surgical specialties were as follows: neurosurgery, 97 percent; orthopaedics, 99 percent; otolaryngology, 94 percent; and urology, 95 percent. In contrast, only 76 percent of the family practice positions filled, and the match rate for all specialties was 90 percent.<sup>†</sup>

In many ways, we have been the profession's own worst enemy. Our unwillingness to accept the fact that we need to make changes in the way we approach medical students and the way we train residents has prevented us from attracting more people to the profession.

As professionals, we must act as positive role models. We need to avoid dwelling on the problems in our health care system when talking with medical students and, instead, we must focus on some of the favorable aspects of our profession, such as the joy and pleasure we derive from using our hard-earned skills and knowledge to alter the lives of our patients in a positive way.

Additionally, we need to make surgical rotations more interesting for medical students. One way in which that goal can be accomplished is through efforts such as technical skills testing in laboratories. Interactive approaches to learning are likely to stimulate medical students in their development of technical and cognitive knowledge. Moreover, as good mentors, we should seek not to develop clones of ourselves, but to simply introduce medical students to the excitement and pleasures of a surgical career, which can span the horizon from ophthalmology to orthopaedics, and not necessarily focus on our own specialty.

As we forge ahead, we also must be aware of the lifestyle issues that are very much on the minds of medical students today. Clearly, the way we train residents in the future will be very different from the traditional process. The 80-hour workweek is just the beginning. To attract a more diverse group of residents, we will need to account for changing lifestyle concerns and the fact that many younger people will want to split practices or work in a less

intense environment in order to accommodate their lives outside of the OR.

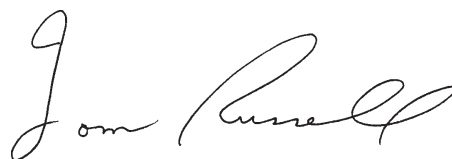
Currently, most of the surgical specialties are participating in active dialogue about training pathways for the future, and are discussing efforts to shorten the number of years and to allow a more direct track to gaining expertise in a certain area of surgery. Some tension will come out of this dialogue, but I believe the discussion will yield better ways to train surgeons—methods that will be at least as effective and certainly more efficient than those used in the past.

### *Change comes from within*

As we reflect on the way we were trained, most of us realize that change is necessary if we are going to appeal to the caliber of students that will be required in the future. Many of us are “recovering surgeons,” trained in an era of total immersion in our profession to the exclusion of other aspects of life. This process trained generations of dedicated and competent surgeons, but it will no longer work.

Claude H. Organ, Jr., MD, FACS, President of the American College of Surgeons, has stated that he would like his term to be remembered as the year of the resident. Dr. Organ has continuously repeated this sentiment in his talks around the country, recognizing that now is the time when we must begin to address the needs of the residents so that they will find a career in surgery to be fulfilling and rewarding in all of its many aspects.

As the profession evolves and begins to implement these modifications, I believe we will discover that the glass truly is half full. I am confident that we will continue to see the ascension of surgery as fundamentally and critically important to our nation's patients and its health care system.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).

4 <sup>†</sup>National Resident Matching Program, 2003 match data.