Work-hour restrictions, debates about whether residents are employees or students, debt repayment, and lower reimbursement are some of the nagging issues of concern to today's surgical residents and young surgeons. Having recognized that young people entering surgery today are dealing with more difficult and urgent issues than ever before, the American College of Surgeons formed the Candidate and Associate Society of the ACS in 2000 to provide residents and young surgeons with a forum through which their concerns could be brought to the attention of College leaders.

During its June 2004 meeting, the Board of Regents approved a proposal to change the name of that organization to the Resident and Associate Society to better reflect a more visible status for the group. The following articles, as well as the column by ACS Executive Director Thomas R. Russell, MD, FACS, on page 3, are intended to underscore the importance of young surgeons in training to the future of the College and to the surgical profession as a whole.

RAS-ACS is shaping future College leaders:

An interview with Jeffrey S. Upperman, MD

by Diane S. Schneidman, Senior Editor

Author's note: *The Candidate and Associate Society of the American College of Surgeons (CAS-ACS) was formed within the College in 2000 to benefit the surgeons of the future through their involvement in ACS activities. The CAS's mission has been to: (1) familiarize residents and young surgeons in all surgical specialties with the College, its programs, and its leadership; (2) provide an avenue for participation in College affairs; (3) enable members to develop and use leadership skills in organized surgery; and (4) provide opportunities for the opinions and concerns of residents and young surgeons to be heard by the College leadership. The society was renamed the Resident and Associate Society (RAS-ACS) during the June 2004 Board of Regents meeting.*

Jeffrey S. Upperman, MD, chaired the society until he was called to service in Iraq in April of this year. Before he left the country, Dr. Upperman agreed to be interviewed for this article, which is intended to inform the College membership about the current and future direction of RAS-ACS. The interview took place by telephone on March 31, 2004.

What are your thoughts regarding the status of the RAS-ACS at the present time, and what direction do you think it should be moving in?

I think the Fellows, Associate Fellows, and Candidates who originally designed CAS wanted an advocacy organization and a home base within the College for surgical residents and young surgeons. They wanted CAS to provide the members of the Candidate Group and the Associate Fellows with a voice within the College and to serve as an educational training ground for developing young leaders. At this point, I think we've begun to codify how that vision would work.

As we move forward, we're trying to develop a series of programs to support that initial intent, but we also want to take RAS to the next level and actually teach residents some useful skills and get them into the decision-making pipeline. That is to say, we're attempting to develop an organization that will be recognized as providing young surgeons with the training and the background in College activities necessary for them to eventually serve as Regents or other College leaders. In other words, I view RAS as sort of a dynamic pipeline that provides growth opportunities for young people who are interested in getting involved with organized medicine.

What is your main goal as Chair of RAS-ACS?

My main objective as Chair has been to try to get as many residents and "Fellows in training" on as

many College committees as possible—not that they would sit with these committees necessarily to deliberate, but to learn. Again, if they are part of the leadership pipeline, they will come to understand how a multi-million dollar advocacy organization works, and I think they will be better prepared citizens when the time comes for them to join the ranks of the College's leadership. I don't see why they should have to wait to learn all these things until they attend their first Board of Governors or Board of Regents meeting. Why don't we start preparing them now?

What groups other than the Board of Governors and Board of Regents would you like the residents to get involved with?

I think residents should be able to participate in meetings of all of the College's standing committees, except for the Central Judiciary Committee (CJC). The CJC fulfills one of the core functions of the College and handles very proprietary information that the residents don't necessarily need to be exposed to. Again, they don't have to vote. They would just attend committee meetings and be involved at some level, so they can gain the experience and an understanding of what's going on within the organization.

What are some other initiatives you believe the RAS-ACS needs to carry out in the development of the leadership pipeline?

As an initial step, we're looking at how we deliberate and how we can usher through new ideas proposed by a resident or a group of residents. So, we're dealing with the nuts and bolts of governance.

We're also looking at what we can do in terms of programming. We're trying to come up with a menu of programs focused on leadership development, including a leadership training course for chief residents. In these times of diminishing work hours, new requirements for academic competence, more and sicker patients in the hospital, and so on, chiefs find themselves in a situation where it's more challenging to learn and be active in the hospital environment. So, I think we need to develop our leadership in ways that are different from what was done in the past. Residents used to learn how to be chiefs by spending an inordinate number of hours making a lot of mistakes and figuring out how to avert those problems in the future. Now that there are rules against residents operating on their own and staying up for long hours, we need to develop programs that support chief residents in their efforts to figure out how to make it all work.

So, do you think that the College needs to emphasize this type of leadership training because, with the resident work-hour and other restrictions, the training programs just aren't going to be capable of providing that sort of educational experience?

That is what I believe, and I think RAS offers a unique forum and set of opportunities that training programs aren't necessarily going to be able to provide. I'm talking about preparing the type of leaders who, essentially, ACS Executive Director Thomas R. Russell, MD, FACS, is trying to develop—"a cast of clones," if you will. Under his model and ours, you're not leaving leadership to chance. Instead, you're trying to build a cadre of residents and junior members who understand the language, who understand what plays on Capitol Hill, and who have a sense of what works in dealing with other medical and surgical organizations.

They also will be able to deliver the message to surgeons and residents that the College is working for them: "This is what we're doing; these are the types of activities we offer. Stand with us shoulder to shoulder, and this is what we can deliver." The traditional attitude of believing that we can stand alone is just not working. There's been an erosion on a lot of fronts, and the issues that surgeons face are very complex. Unless some organized approaches are applied within our culture to develop young surgical leadership, there's a possibility that they could go down the same wrong path when they become the leaders of this organization, or they might not know which path to take at all.

With whom in the College's leadership have you discussed the RAS's objectives, and what sort of response have you received?

I have spoken with Dr. Russell, Paul Collicott, MD, FACS, Director of Member Services, and others, but we've had no formal discussions about creating Candidate Group seats on College committees at this point.

Part of a strategic planning discussion that we plan to have during the Spring Meeting will include RAS's educational agenda and strategies for accomplishing it. We also will discuss how we're going to govern ourselves, how we're going to restructure ourselves, and how we're going to carry out the leadership development activities that we've been talking about. Hopefully, by putting these systems in place, RAS chairs—myself and those in the future—will be able to go in front of the Board of Regents and tell the leadership that "this request comes from your Resident and Associate Fellow leadership." We can tell the Regents that these are the issues we think are important for the College to address, and these are the ways we think we can resolve them. We're thinking about how we can enter into these discussions and about how we can really build this pipeline. *[The strategic planning session that Dr. Upperman mentions took place on April 25, 2004, subsequent to this interview. For more information about the outcome of that meeting, see the related article on page 21.]*

I've also talked with Claude H. Organ, Jr., MD, FACS, ACS President, about all of these matters as well, and we were very pleased to see that the theme for his Presidential year is "the year of the resident." That's exactly the type of statement we were looking to have the leadership make. We thought there were so many changes going on, and we needed support. We needed someone to put our concerns out in front. And, in this case, we didn't even have to ask. It was right there.

The RAS typically presents a session at the Clinical Congress. What will this year's program be like?

Our symposium at the Congress traditionally has been one in which we address a controversial subject or set of subjects by putting together a panel of speakers who are knowledgeable in the area to address the issues, and a Candidate or Associate Fellow moderates the program. We try to flesh out an area that is posing some sort of conflict.

This year the symposium will focus on the concept of "residents as employees or students" (see related article, page 14). We believe this program is important at this time because there has been a movement afoot to go after residents when problems arise in a case. We think that in such instances some questions need to be answered: Were the residents doing what they were told to do? Should residents be sued or held liable when they just happened to be on call the night a patient received the wrong medication? Are they fair game for lawyers to go after? There has been precedent set in some states where residents have had to foot the bill, if you will, for liability claims.

And the session will take into consideration the evolution of the whole work-hours issue. We know the 80-hour workweek is here to stay. If part of the reason the work-hour restrictions were implemented was due to concern for employee health and safety, then why didn't the hospitals step in earlier and say, "It's a risk and a danger for residents to drive home with so little sleep?" Why didn't they provide van pools? I was speaking with one resident who told me that the way his hospital is organized, there is no place where residents can sleep if they are tired after their shift. Well, a hospital can't have it both ways. If the administrators are worried about safety, then they need to do some things to ensure the well-being of their "employees."

What other programs does RAS plan to develop?

We're looking at the possibility of offering a "leadership fellowship" to those residents who are interested in organized medicine. It would allow the recipient to take a year or two off from the lab to get a master's degree in public health or to otherwise study advocacy. Maybe the recipient could spend that time training under the direction of Dr. Russell in the College's Chicago headquarters or of Cynthia Brown, Director of the Division of Advocacy and Health Policy, in the Washington Office, to gain an understanding of the inner workings of this organization and of how it interacts with the government. A number of other organizations do it. Why not us? Again, this would be a way for the College to develop the next generation of surgical leaders.

The one thing that no other organization in American surgery that I know of has done is to really try to nurture this concept of developing surgical resident advocates, and this is why we think RAS is so important. For example, surgical residents essentially were not at the table when the various medical groups decided that we needed work-hours reform. That's not to say that the work-

hours issue was mishandled. It's just that our lifestyle and our training needs are a little different from those of some other specialties, and I think it would have been good to have had a voice when those discussions were taking place and those decisions were being made.

What is the most important thing you want Candidates and other surgical residents to get out of these programs?

I think one of the things that has hampered surgeons for a very long time is that we just don't know how to behave in the policymaking forum. We're used to coming into the operating room and taking the attitude that, "I'm the boss. It's my way or the highway. I'm making the call here. I'm stopping the bleeding." When you're in an organizational setting or in an advocacy position, it's about give and take. It's politics. You've got to be willing to take a little bit of the pain. You've got to be willing to compromise, and obviously some people do it better than others. In any event, these are the qualities that make people successful in the political advocacy realm and in organized medicine. So, surgeons in training and young surgeons need to be exposed in an overt fashion to how they should handle themselves so that, when they come to "the hallowed halls" and are going to be Governors or Regents, they don't think their role is going to be some facsimile of their experience in the OR, where they can tell the staff and the leadership how to do things. They need to understand the inner workings of the organization and the channels through which decisions are made.

Many of the programs and initiatives we've discussed center on residents. What efforts are under way to help surgeons who are just entering practice beyond what the College already has in place, such as the job bank?

We're trying to do a lot more for young surgeons who are just entering practice, and that's why, for example, our last newsletter included a piece on the restrictive covenants, or the noncompete clauses, that are a common part of contracts between physicians and their employers. These clauses restrict the right of physicians to practice medicine for specified periods of time or in specified areas upon termination of their contract with the employing entity. Often, young surgeons make the mistake of ignoring these clauses or of thinking that these provisions are illegal or unenforceable.

We're also concentrating on some educational programs focused on practice management. To that end, we are working with Charles Mabry, MD, FACS, an ACS Regent who presents many of the College's courses in this area. So, we're trying to be a conduit for information on practice-related subjects and not recreate the wheel, given that some activities that are important to Associate Fellows already are carried out by the College. We're just trying to get the word out, and let people know what the College offers.

What are some of the issues of the future that you think these young leaders need to start addressing now?

It's probably sort of an overused concept, but time management, prioritization, and working with teams of people are going to be paramount to the success of the modern-day surgeon. They no longer are going to be managing a team of junior surgeons who are going to be looking to them as the sole source of answers. They're going to be part of an integrated team of nurses, nurse practitioners, physician assistants, and other types of allied health care professionals. They're probably going to have to work more closely with faculty because, in some cases, those individuals may be pulled into the front lines to provide some services. It's just a different model than the last couple of generations had to work with.

I think, within the paradigm of professionalism, communication and interpersonal skills are going to have to be worked on in an organized way, in addition to being learned "on the fly." Training programs are charged with providing residents with opportunities to attain those skills, but I think that the College can serve as a resource of programs big and small aimed at helping surgeons to become more proficient in these areas, so they can come to the "Mecca" and presumably learn all the great things and all the models that work. I think we have the exposure and the resources to pull in the appropriate experts who have made the transition and who can show them how it's done.

Have there been special efforts during your term or during your predecessor's term to recruit new members into RAS?

We have made no special efforts to go out and specifically recruit. However, we are trying to work with program directors and Division of Member Services staff to keep the word out front, and we're really looking at this special issue of the *Bulletin* as a way to get our face out there. People are reading the *Bulletin*. I get e-mails from people all the time asking me, "Did you see this or that in the *Bulletin*?" So through this special edition, the Fellows will see what we're doing, and they can pass it on to their house staff and say, "Look, you need to be a part of this organization."

RAS has about 7,000 members right now. Is that number meeting the group's expectations?

We think it's reasonably on target. One of the things I know Dr. Collicott is interested in is the whole concept of getting the residents into the pipeline and keeping them in once they enter practice. One of the factors that may cause some surgeons to drain out of the pipeline and not keep moving forward is that they might wonder what the College can really do for them. These surgeons may also figure that if their patients aren't concerned about whether their surgeon is a Fellow, because they don't know what Fellowship means, there's no need to be part of this organization. So, I think our goals with regard to membership are in line with the greater goals of the ACS. We want people to become and stay part of the ACS and to support it. We need to show them that trying to stand alone really may not be in their best interests.

Are there any other programs that you think the College should consider implementing to help the residents?

There may be folks out there who have an undergraduate educational background or some other type of knowledge base that is outside of surgery, and we should provide them with opportunities to develop those interests within and to the benefit of the College. For example, say a young surgeon has an undergraduate degree in English. Is it possible that this person could have an opportunity to, say, do an internship at the *Journal of the American College of Surgeons* or something else along those lines, assuming there's enough work for them to do? Some programs that are being developed, such as the new Web portal and a new media relations program focusing on television, may also provide a variety of novel opportunities for those folks who have different outlooks. These experiences might allow a young surgeon to contribute beneficial skills to the organization, to learn, and, again, to be a leader.

In addition, we are thinking about distributing a membership survey to determine the Fellows' interests and to see just what our leadership looks like. We're thinking about maybe using that information to show medical students and residents what types of people really participate in this organization. I've talked to medical students, and many of them say, "I really want to go into surgery. I really want to do it, but, you know, I want a life." You hear that over, and over, and over. Now that the *Bulletin* has started running its series of articles on surgeons' lifestyles, I can say, "Look at this surgeon. She runs marathons. Or, look at this couple who make a two-surgeon family work." I can put the information right there in front of them and give them tangible examples of how modern-day surgeons are able to practice surgery and still pursue other interests.

Any final thoughts?

Basically, I would characterize this as a time for youth, a time for young leaders to step up to the plate and be a part of the College, to contribute to the RAS agenda, to be part of this new look, to be part of this vibrant leadership-developing haven for surgeons in training. That would be the message I would want to emphasize and to convey to young surgeons. Again, in talking with some of the young folks, I just get the sense that they don't know who represents them. They want to know what the College does for them. The reality is that the College is doing a lot for them, but some of that work is going on behind the scenes. We just want to make sure that they realize that RAS is a very vocal, vibrant, and viable resource for them within the College. What I've been telling people is that we have a "new look and feel" College, and they should be part of it. Ω