

From my perspective

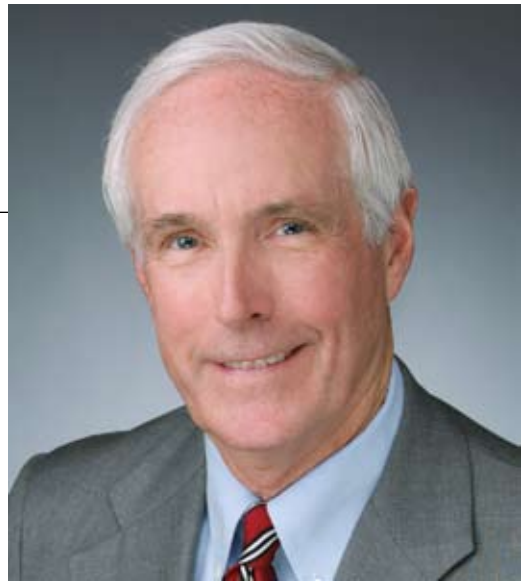
As the nation moves forward with efforts to address the inadequacies and inconsistencies in health care delivery, we must stay focused on helping patients and improving access to care. While we all have professional and personal concerns that tend to be at the top of our own agendas, we must seek common ground wherever possible. Many topics under discussion in the ongoing health systems improvement effort are multifaceted, and, hence, each medical and surgical specialty may have realistic and unique and divergent concerns about both the catalysts of the problems and some of the proposed solutions. It is important that we air these differences of opinion. Indeed, a little tension often stimulates creative problem-solving and enables us to arrive at more satisfactory conclusions.

However, we work only to the detriment of the profession and our patients when we allow rhetoric to get in the way of action and emotion to take the place of reason. During times of transition such as this one, we must be at our professional best, listening to all sides of the debate and showing restraint in our reactions.

Emergency workforce issue

One of the most compelling issues in surgery at this time is the looming workforce shortage, particularly in our hospital emergency departments (EDs). All stakeholders have some specific views about the causes and effects of the problem. The American College of Surgeons is taking this matter very seriously, and in March 2005 and March 2006, we hosted meetings with leaders of the surgical specialty societies to examine gaps in surgical coverage in EDs.

These meetings provided valuable insights into some of the reasons for the decline in surgical specialists taking emergency call. Forces cited include the provision of uncompensated care to uninsured patients, low reimbursement rates that inhibit surgeons' ability to cross-subsidize charitable care, increased medical liability risk and expenses, interference with elective practice, and unreasonable scheduling demands. Other surgeons point to expectations that they provide care beyond their scope of competence; inadequate standards for patient transfers; and the perverse effects of regulations related to the Emergency



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Medical Treatment and Active Labor Act (EMTALA), the 1986 federal law intended to prevent “patient dumping” by hospital EDs.

In some specialties, the situation has already reached crisis proportions, and trauma patients are feeling the impact. Furthermore, the shrinking emergency workforce is leaving those surgeons who continue to participate in the emergency care system with unsustainable professional and personal burdens.

Exploring possible solutions

The ED workforce shortage now is capturing the attention of health policymakers. At press time, the Institute of Medicine was scheduled to release a report on emergency workforce in June. To help members of Congress and the Administration understand surgery's concerns, the College has also released a report titled “A Growing Crisis in

Patient Access to Emergency Surgical Care.” This document was drafted with significant input from the surgical specialties and draws from our collaborative efforts to develop true emergency care systems that will ensure the provision of optimal, timely care to patients with major injuries and other life-threatening conditions.

For example, the College and surgical specialties largely agree that regionalization of critical specialty care would relieve EDs of the expectation that they handle every type of emergency at every hour of the day and night. In addition, we are suggesting implementation of patient transfer protocols based on the College’s Advanced Trauma Life Support® and Rural Trauma Team Development Course models. These guidelines would enable emergency health care professionals to better assess whether a patient should be sent to another facility for immediate, definitive specialty care or should be stabilized for conclusive treatment the following day.

Of course, surgery alone cannot address all the contributors to the problem and certainly is prohibited from independently implementing far-reaching, long-term solutions. The College and the specialty societies intend to work with regulators to continue refining laws, such as EMTALA, to remove disincentives for specialists to provide emergency care. We also are encouraging the federal and state governments to develop mechanisms to provide adequate financial compensation to surgeons who provide charitable care in EDs. To encourage more young people to take emergency call, we will call upon Congress to create a health professions support program that will cover medical school debt for young surgeons who provide surgical care in community or rural hospitals/trauma centers.

Acute care surgery

One of the more controversial ideas under discussion is the potential development of a new specialty called “acute care surgery.” Surgeons who specialize in this type of care would be trained in the range of procedures commonly performed on patients who have experienced a traumatic injury and critical surgical conditions, such as appendicitis. Typically, acute care surgeons would be salaried employees of the hospitals where they work, rather than private practitioners struggling

to balance their elective caseloads with emergency call. As “surgical hospitalists,” they also would be guaranteed an annual salary and have paid liability coverage. (See related article on page 40.)

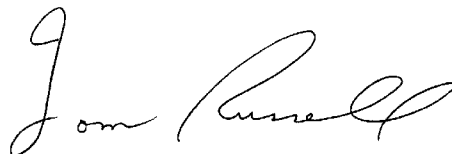
The surgical specialties have diverse opinions about the necessity of creating this new specialty and about the curriculum for individuals who choose to enter this field. We all must be sensitive to each other’s concerns as we move to address this issue, and the “house of surgery” must stand together and avoid unnecessary, unproductive internal tension.

If we do pursue the development of this specialty, we must make certain that these acute care professionals are trained in the patient transfer protocols, assessment skills, and stabilization competencies discussed previously. In addition, all specialties should have input regarding the new training curriculum for these individuals.

Putting patients first

Again, it is important that all sides have the opportunity to voice their perspectives on acute care surgery and other frustrations stemming from the workforce crisis. But ultimately we must stay centered on achieving some sort of consensus about which approaches will ensure that surgical patients receive appropriate care by the right person at the right time and in the right place.

Fortunately, we are finding more commonalities than disparities. On those occasions when we are unable to yield to a different perspective, we must remember the one constant, universal goal of all emergency care professionals: providing life-sustaining care to the people who are rushed to EDs each day. We must always be mindful of our patients’ needs, particularly when they are faced with a surgical emergency.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.