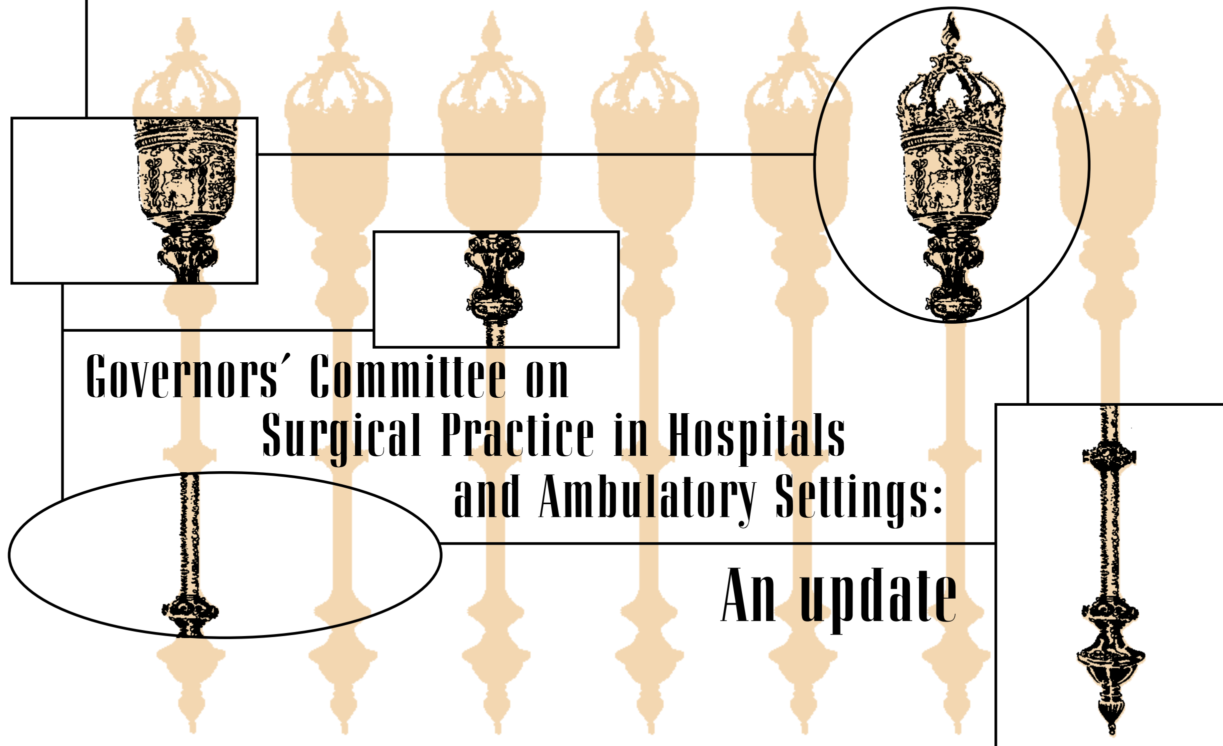

Governors' Committee on Surgical Practice in Hospitals and Ambulatory Settings: An update

by R. Phillip Burns, MD, FACS

The Committee on Surgical Practice in Hospitals and Ambulatory Settings is evaluating and confronting a number of issues that challenge us in the practice of surgery. The list is long, but the four prominent issues include patient safety, the Centers for Medicare and Medicaid Services' (CMS) revision of ambulatory surgery center exclusions with attendant changes in reimbursement, the growing crisis in inadequate surgical manpower, and changes in practice structure with surgeons becoming hospital employees.

Patient safety

Patient safety and improved care has historically been a direct or indirect result of the American College of Surgeons' activities. Patient safety has been a presumed intuitive outcome of progress in surgical education and research. Virtually all scientific presentations, displays of new technology, critical analysis of patient outcomes, and new programs such as the National Surgical Quality Improvement Project ultimately focus on improved patient care without specifically mentioning patient safety as an outcomes endpoint. Recently, the College has become more specific and focused in its recommendations regarding patient safety and has championed a number of programs and/or protocols with an improvement in safety as an anticipated result. In 2002, the ACS approved a specific statement that outlined recommendations for a preoperative checklist with the goal of ensuring correct patient, correct site, and correct procedure surgery. Continually accumulating data indicate that wrong site surgery is still a problem and several states have enacted more aggressive programs and accounting procedures to identify and, hopefully, reduce this incidence. Recent reports of The Joint Commission, modifying current requirements for preoperative patient identification, are being studied by our committee. These Joint Commission regulations will reportedly be more rigid regarding who will mark the surgical site

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and what is the allowed location in the operating suite where surgical site marking occurs. Several surgeons are prominent in the critical analysis, research, and development of programs about this important issue. The Committee on Surgical Practice in Hospitals and Ambulatory Settings will continue to vigorously evaluate the safety issue and Joint Commission regulation changes and provide suggestions to the Board of Governors.

ASC exclusion and reimbursement changes

CMS has recently proposed a rather sweeping set of changes to govern the list of allowable procedures for ambulatory surgery centers (ASC) and to restructure reimbursement. Many members of the College perform all or a preponderance of their surgical cases in ASCs, so this issue remains important for this committee. As this list of changes has only recently been produced, the impact of these changes is unclear. It appears this action will lead to pressure on the profit margin in ASCs and, in some cases, may threaten the viability of the center.

Although this may not be deemed a negative by some, a shift of substantial outpatient procedures back to the hospital setting would, in most instances, add more pressure to a burgeoning operative case volume. In some circumstances, surgeons have been denied the opportunity to become partners in outpatient ASCs. Whereas some may deem this outcome appropriate, others would argue that there are significant efficiencies derived from independent ASCs, and surgeon ownership may be an encouragement for individual and group efficiency and stimulate enhanced cost containment.

Surgical manpower

Surgical manpower needs appear to be growing in virtually every surgical specialty. Previous estimates of excessive numbers of surgeons predicted by various studies of the past 25 years missed the mark. Although there are pockets of significant surgeon shortages in urban locations, the problem is more profound in smaller towns, especially in rural areas. Reduction in available surgical personnel will likely lead to closure of or restriction of services at affected hospitals, which will cause even greater pressure on tertiary care

facilities that are typically overflowing with work. Currently, many of these larger institutions are on divert status a large percentage of time and additional patient loads will further pressure the efficiency and effectiveness of the health care system.

General surgery is particularly threatened by manpower shortages. Finding surgeons willing to accept emergency consults and provide emergency room call coverage has become problematic in virtually all communities as many surgeons have either opted to narrow their scope of practice, limit work hours, or reduce liability (for a multitude of reasons). Add to this cross-section of challenges the progressive incidence of subspecialization fellowships sought by surgical program graduates, and a "perfect storm" of manpower shortage appears to be brewing. Short-term resolution of this problem will be especially challenging in view of a number of ongoing demographic changes such as surgeons retiring earlier in their careers. Multiple long-term strategic initiatives are under consideration, including the suggestion that surgical residencies rapidly expand the number of available positions and the recommendation by the Association of American Medical Colleges that medical schools consider a 30 percent increase in student numbers. Many question if such actions will totally correct the shortfall in available medical manpower and if these actions will only address the issue long term. Rapid progress in medical and surgical technology and streamlined quality initiatives may help stabilize manpower requirements in the future by making health care more efficient and effective, but this problem is likely to require attention for the foreseeable future.

Structure change of surgical practice

Reports from several areas of the country indicate a sweeping transition in many areas that involves hospitals buying surgeon practices. Although some modification of this arrangement has been the case in academic and in private practice in some areas of the country for many years, it has not been as prevalent a trend as recent reports indicate. If this trend continues, this could lead to a huge change in the delivery of surgical care. Whether such new developments are a result of hospitals recognizing the growing shortage of surgical manpower and thereby a need to protect their assets by having available manpower—or if they are related to a movement to totally reorganize the structure of surgical practice in this country—is an interesting question to ponder. It seems clear that such a trend will change many aspects of surgical practice such as practice management, control of office staff, and selection of employees, to mention but a few.

Such a trend raises many questions, not the least of which is this: If surgeons become institutional employees, can the need or impetus for organized, collective bargaining be far behind? How such trends affect the role of the ACS in the framework of change in health care delivery will be interesting and perhaps problematic. Now may be the time to enact prospective studies by organizations such as the College to gain real-time data regarding the causation of such a trend. Whether the efficiency and outstanding productivity of the U.S. surgical workforce will be sustained given such a change in structure will be but one of many interesting questions. If productivity and efficiency change, then the manpower shortage and availability of surgical care to the public will be further threatened. The Committee on Surgical Practice in Hospitals and Ambulatory Settings will discuss this issue, as the long-term consequences may be deleterious to the current structure of the American College of Surgeons. Ω

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