



The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the "From my perspective" column written by Executive Director Thomas R. Russell, MD, FACS.

Letters should be sent with the writer's name, address, e-mail address, and daytime telephone number via e-mail to sregnier@facs.org, or via mail to Stephen Regnier, Editor, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.

A startling transformation

In August 2003, an article endorsed by 7,784 physicians and medical students, "Proposal of the Physicians Working Group for Single-Payer National Health Insurance," was published in the *Journal of the American Medical Association*.¹ In his commentary on the article, Thomas Russell, MD, FACS, Executive Director of the American College of Surgeons, reminded us that "tremendous administrative costs and competition between plans that have a for-profit mentality have resulted in an arcane and costly system, which diverts money from patient care and breeds the corporate mindset that has become pervasive in the medical profession,"² a position espoused by me and thousands of my colleagues in Physicians for a National Health Program. However, Dr. Russell did not believe that "the crisis in health care has reached a threshold that would command such a startling transformation."² To this, I responded, "The crisis in our health care system may be below the threshold only because we keep elevating the threshold."³ Five years later, it appears that we may have finally reached the threshold, as evidenced by the re-

surfacing of health care as a major issue on the national agenda and in the presidential election.

Our present system of health care delivery is not sustainable. It may putter along for a decade or two, but it will finally collapse. And as it self-destructs, tens of thousands more will be hurt. Presently, the Institute of Medicine estimates that 1,500 Americans die every month due to lack of health care coverage. I would argue that it is not universal health care that is un-American—it is our present system.

Few in the surgical and medical profession would disagree that change is needed. Respected surgical leaders are speaking out. Donald Trunkey, MD, FACS, called the U.S. health care system the "best mediocre health care in the world."⁴ In a lecture at Rice University, the late Michael DeBakey, MD, FACS, stated, "Our health care system is in disarray and cannot be rectified by the incrementalism approach."⁵

The disagreement has to do with the type of change. You cannot build a second floor on a house with a rotten foundation. Although we have all the components to indeed have the best health care in the world, our health care delivery system is terminal. The problem of the uninsured is the most visible and perhaps the most profound. I travel frequently on surgical missions to east Africa. I am ashamed to say that I am starting to see here in California the type of late presentations and catastrophes I typically see in Kenya, Tanzania, and Zambia. But multiple other problems abound. Private insurers thrive by denying care and injecting tremendous inefficiency into the system. The burden of insuring the riskiest patients—the elderly, the poor, end-stage renal failure patients, Native Americans—is shifted to the government. Physicians practice with their hands tied

behind their backs. I cannot get a simple X ray or blood test on most of my patients until the test is authorized. Often, the patient has to be sent to another facility.

Patients are trapped in health care plans that treat them as widgets that can be manipulated for financial gain. Choice of physician has become a luxury most patients cannot afford. This, in turn, has created stagnation among some physicians who, consciously or unconsciously, know that they have a trapped audience. Continuity of care is easily disrupted if insurance shifts to a different plan or is lost altogether, the treating physician changes practice, or job changes occur. Resources are poorly utilized due to competition driven by market forces, not quality. While 46 million are uninsured and millions more are not getting the care they need, hospitals are closing under financial stress. Why would we want to take this system, which is already at the breaking point, and expand it to cover everyone?

Medicare for all! Despite all the criticisms directed at Medicare, it has survived for more than 40 years, given our elderly the peace of mind we all deserve, improved the health of its beneficiaries, avoided micromanagement of clinical interventions, preserved patient freedom to choose their physician, and sustained efficiency in claim reimbursement. It has done all that with virtually no shared risk, providing services for almost all its beneficiaries. Despite its difficulties, the program's popularity was recently evidenced by the congressional overturn of a presidential veto, an effort the College valiantly led. When we advocate for a single-payer model, our opponents immediately bring up waiting lists in Canada and other industrialized countries. Joint replacement is typically the sentinel operation used to demonstrate inadequate wait times in Canada.

Ironically, most joint replacements in the U.S. are also paid for by a single-payor system: Medicare! Under Medicare, waiting lists are not an issue because spending and system capacity are significantly higher than those in Canada. We should also remember that Canadians spend approximately half of what we spend per capita on health care, cover everyone, and have public health and some tertiary care outcomes superior to ours. Shrinking the waiting list is a national priority in Canada, as evidenced by last year's attendance of Prime Minister Stephen Harper at the annual "Taming of the Queue" conference. The Canadians have problems with their system, but they have a system.

The conventional wisdom is that a single-payor system is not popular with the public or physicians and cannot be realized in the U.S. But in a recent survey by the American Academy of Pediatrics, one-third of pediatricians favored a single-payor system, a substantial finding given that it is very difficult to get this many physicians to agree on another specific alternative. In a survey of 904 Massachusetts physicians randomly chosen from the American Medical Association master file, almost two-thirds of respondents identified single payor as "the structure that would provide the best care for the most people for a fixed amount of money."⁶ In poll after poll, a majority of Americans favor a universal health care system, even if financed through increased taxation.

Americans, the public, and their physicians have a major decision ahead. Will health care continue to be treated as a commodity bought and sold according to means or as a service sought and delivered according to need? American surgeons should continue to lead the world in innovation and creativity, but they should also apply the

results of their resourcefulness to any patient in need, in an atmosphere of evidence-based care, patient freedom to choose their doctor, and resource optimization, free from micromanagement and bureaucratic hassles. I don't believe this can be achieved through expanding or amending our current nonsystem.

As called for by an idealistic, young surgeon in the August *Bulletin*, "When physicians place the health of our patients as our first consideration, we reclaim our autonomy, our morale, and ultimately our dignity as a profession."⁷ A radical shift in our approach and our priorities—a shift that would produce a startling transformation—is necessary!

References

1. Proposal of the physicians' working group for single-payer national health insurance. *JAMA*. 2003;290:798-805.
2. Russell TR. From my perspective. *Bull Am Coll Surg*. 2003;88(10):3-4.
3. Emil S. Crisis in health care [Letters]. *Bull Am Coll Surg*. 2004;89(1):53.
4. Trunkey DD. A growing crisis in patient access to emergency care: A different interpretation and alternative solutions. *Bull Am Coll Surg*. 2006;91(11):13-22.
5. DeBaake ME. The role of the government in health care: A societal issue. *Am J Surg*. 2006;191:145-157.
6. McCormick D, Himmelstein DU, Woolhandler S. Single-payer national health insurance. Physicians' views. *Arch Intern Med*. 2004;164:300-304.
7. Kuy S. Stand up for patients. *Bull Am Coll Surg*. 2008;93(8):23-24.

**Sherif Emil, MD, CM, FACS
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The art of medicine?

I find it interesting that Dr. Pauline Chen ("The art of medi-

cine at the end of life: The challenges ahead." *Bull Am Coll Surg*. 2008;93[2]:19-21) can relate the story of a resident being forced (forced!) to remain in the hospital to tend to an unstable patient without noting the irony that nowadays it is the surgical attendings who are being forced (forced!) to let that same resident leave the hospital so that somebody else can care for the patient.

The art of medicine? It will not exist in the future. The resident Dr. Chen describes learned a valuable lesson about patient care that (hopefully) remained with him throughout his career. I am certain it shaped his sense of responsibility. I believe the current crop of surgeons-in-training will not hold those same values when released into the real world.

If they have not commiserated with the patient and the family over a difficult outcome from beginning to end, but only from time to time as their schedule allows them, then I do not see how the future surgeons will become truly caring or compassionate.

**Charles Eisengart, MD, FACS
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Getting to know ACS staff

As a Fellow and avid reader of the *Bulletin*, I wanted to first compliment Jon Sutton for his recent article, "What surgeons should know about...Fairness and transparency in contracts" (*Bull Am Coll Surg*. 2008;93(8):8-9,48). The article covers a difficult topic for surgeons. It provided key concept clarification and will serve as an excellent reference for my practice in our next negotiation.

Secondly, I would also give kudos to all the College staff members who provide reviews of topics to surgeons who would have few other places to turn for such salient information.

I would, however, offer one criticism. Whenever a surgeon writes

an article for the *Bulletin*, there is always a photo at the end of the article. It helps to put a face on the thoughts of the writer. Why, then, do you not put photos of ACS staff when they write an article for the *Bulletin*? I would very much like to know their faces. I would then recognize who they are at the Clinical Congress, just as I recognize Dr. Cameron and Dr. Healy. Putting a face to the staff would also help Fellows know the people out there working day to day for our profession.

**Christopher K. Senkowski,
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Transparency

The article by F. Dean Griffen, MD, FACS, in the March 2008 *Bulletin*, "The impact of transparency on patient safety and liability" (pages 19–23) has interesting facts, but I disagree with the conclusion that implementing this system nationally will reduce litigation cost.

Dr. Griffen's finding that transparency caused more injured patients to receive less compensation and the fairness of attorneys not to sue for noneconomic loss when surgeons disclose errors is admirable, but naive.

If this practice becomes widely publicized, the increased number of claims will cause a feeding frenzy for free, no-cost lottery dollars that will overcome any initial savings and the true greed of the plaintiffs' attorneys will make an already bad situation more costly, increase premiums, and make an already stressful surgeon's environment more stressful and less safe psychologically. And focusing on the patient's care will become more difficult.

The real solution is, first, to train surgeons how to communicate well to their patients and to show true compassion and care—as good rapport breeds fewer lawsuits—and

second, to pass caps on noneconomic loss and have the loser pay the legal costs. These two pieces of litigation would literally stop frivolous lawsuits better than a transparency system.

**Donald Dennis, MD, FACS
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Surgical workforce shortage

I want to extend my compliments to Richard A. Cooper, MD, regarding his lecture on "The coming era of too few physicians," which was originally presented at the 2007 Clinical Congress and published in the March *Bulletin* (pages 11–18). This article should serve as a clarion call to all those concerned about the health care of our next generation. I know that I have been stimulated to submit a resolution to the Tennessee Medical Association, which emphasizes the responsibility of today's physicians to tomorrow's patients on this subject. If we do not act, then the dire consequences for our "complacency—indeed, active inertia" should rightly be left at our doorsteps. Thank you for a well-researched and enlightening piece.

**Mark A. Brzezienski, MD, MS,
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I am often behind in my reading, so it was with some irony that I was able to compare the October 2007 *Bulletin* with the [March issue]. On the one hand, we have the most outspoken and eloquent description of the impending crisis of physician shortage this country has ever experienced ("The coming era of too few physicians"). On the other hand, there is an article that espouses the benefits of volunteering to teach anatomy (Seyfer AE, Welling D, Fox JP. The value of surgeons teaching anatomy to first-year medical students. 2007;92(10):8-14).

Sorry, but there is a paradox

here. If you need to increase the number of surgeons, you need teachers. If you want truly devoted teachers, they may volunteer, but volunteering without pay means that the commitment to teaching can be interrupted too easily. After all, it is not fixed in the workday of the surgeon, and it can be displaced by clinical needs, that is, emergencies.

Teachers should be fully supported and paid. If we are to ramp up the number of students and teachers, we need educational support as never before envisioned. Teachers should receive compensation for this work, and they should receive full administrative support, both at the undergraduate level in anatomy classes and for residency education.

The old model of the volunteer teacher is at odds with the reality that the best talent and most experienced surgeons are busy, busy, busy, taking care of the burgeoning tasks facing general (and vascular, my specialty) surgeons. It is time to change the paradigm.

**Jeffrey L. Kaufman, MD, FACS
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Locum tenens

As a general surgeon now doing locum tenens work, I read with interest and agreement the articles by Ronald M. Tolls ("The practice of locum tenens: Views of a senior surgeon," pages 8–10) and Stuart A. Reynolds ("The practice of locum tenens: Commentary," pages 11–12) in the May *Bulletin*. I would like to comment on two issues. Degradation of technical skill so aptly discussed by Dr. Reynolds can be minimized or avoided by doing long-term assignments of several months or recurring one to two weeks at the same hospital, where not only on-call coverage is provided, but the locum tenens surgeon also has regular clinic duties and schedules elective cases referred to him. This sort of longer-term

commitment is more likely to result in the sort of familiarity with staff and referring physicians that leads to a more normal practice of surgery and larger caseload. A second issue deals with credentialing by the locum tenens agencies and is an area where the surgeon needs to be careful and persistent. Ultimately the client hospital credentials the locum tenens surgeon for work at its facility. However, some of the companies do their own credentialing (beyond their risk-management strategies), which, in the case of one company I have dealt with, was poorly done and without any input whatsoever by any surgeon. The initial result was that this company would “credential” me to deal with a patient’s splenic injury because that was what general surgeons do, but it would not “credential” me to repair the same patient’s facial laceration because I was not a plastic surgeon! But we finally got that absurdity resolved.

Locum tenens physicians I have met have all been sincere in providing excellent patient care under sometimes difficult circumstances. Developing oversight of the locum tenens industry would be helpful.

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Teaching medical students

The article “Teaching surgery to medical students: Perspectives from our mentees” (July 2008, pages 48–53) provides surgeons with important insights that should be considered a challenge. I suspect many of us had similar thoughts years ago when we were in the same position—when we were expected to do as we were told. I have several observations that may be useful for students and others.

When I was trying to decide on a specialty, it seemed to me that people who enjoy working with their hands should enter a surgical field (or a procedurally oriented

medical field). Medical students put off by the demands of a surgical career may not realize that performing surgery is usually fun and rewarding. Simply “confessing” that pleasure, while mentioning that people who dislike working with their hands should enter a medical specialty, may inspire undecided students to look again at surgery.

As an ethicist, I understand Jun Matsui’s moral distress at inflicting unnecessary pain and participating in a system that makes students part of the problem when surgery does not live up to its ideals. Unfortunately, medical ethics rarely deals with organizational issues, especially involving power structures, instead focusing on broader problems such as organ transplantation and end-of-life issues. I would hope that the ACS can address Ms. Matsui’s very appropriate concerns.

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Laparoscopy in third-world countries

It is all very well for Dr. Ross Segan to make a name for himself in being the first to introduce laparoscopic surgery to Afghanistan (“The best and worst week

of my life: A surgeon at war.” *Bull Am Coll Surg.* 2008;93(4):15–21). We all know the advantages of this procedure, but it does need much skill and training and involves expensive equipment. In the 1980s, before laparoscopic cholecystectomy became routine, I used the small-incision open approach to cholecystectomy. A 2” transverse subcostal incision was used (though one registrar used only a 1” incision!).

The advantages are similar to the laparoscopic approach—when an intercostal block is performed at the end of the operation, powerful analgesics are rarely required and the patient is usually able to go home the next day. The time taken is much shorter and, in the event of anatomical, pathological, or surgical difficulties, it is simple to enlarge the wound without so much “loss of face.”

It might be simpler and safer to train local surgeons in third-world countries to use the small-incision open approach to abdominal surgery than risk the complications that bedeviled the laparoscopic operation in its early days.

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Trauma meetings calendar

The following continuing medical education courses in trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

- **Advances in Trauma**, December 12–13, Kansas City, MO.
- **Trauma, Critical Care, & Acute Care Surgery–2009**, April 6–8, 2009, Las Vegas, NV.
- **Trauma, Critical Care,**

& Acute Care Surgery 2009–Point/Counterpoint XXVIII, June 8–10, 2009, Atlantic City, NJ.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at <http://www.facs.org/trauma/cme/traumtgs.html>, or contact the Trauma Office at 312/202-5342.