

# The practice of general surgery today requires growth and adaptability

by Paul H. Lin, MD, FACS

I have rarely reflected on the changes that have occurred in my general surgery practice in Spokane, WA, over the past 15 years. Frankly, we didn't seem to be doing anything extraordinary. Then I met Thomas R. Russell, MD, FACS, ACS Executive Director, last fall at the annual banquet for the Henry Harkins Surgical Society, and I mentioned that my small general surgery group practice had recently merged with two other surgical practices, resulting in the formation of a 13-member group. Dr. Russell seemed intrigued by what we had done and asked me to elaborate on some of the changes in surgical practice that I have witnessed in the course of my surgical career. Some of these observations may be useful to other general surgeons who are trying to sustain their practices during this time of transition in our specialty.

### *The early years*

I finished my surgical training in 1992 at the University of Washington and decided to go into private practice, joining a group of four other general surgeons in Spokane. The few surgeons in town who had completed specialty fellowships after completing general surgery residencies were vascular surgeons.

Given these circumstances, within the first week of practice, I had the opportunity to perform a redo thyroidectomy, an abdominal-perineal resection, and an axillary-bifemoral bypass for a mycotic aortic aneurysm. Surgeons in our small group were expected to competently provide the whole spectrum of general surgery services. Some of the surgeons in my group also performed vascular surgery, J-pouches, Whipples, and advanced laparoscopic procedures. In terms of physical resources, we had our own stereotactic breast biopsy machine. I thought I had hit the clinical goldmine.

### *Changing environment*

In the past 15 years, numerous general surgeons with fellowship training have migrated to Spokane. We now have two colorectal surgeons, three surgical oncologists, two laparoscopic surgeons, and two full-time breast surgeons (one of whom is fellowship trained) in the area. As a result, I handle fewer breast and colon cases and no longer offer vascular services. Instead, I have learned to do advanced laparoscopic procedures.

Another transformation occurred three years ago, when the merger mentioned previously took place. Five of the 13 surgeons in our expanded practice are fellowship trained. We share call, so everyone does some "general surgery." We allow surgeons to carve out niches in their practice, but we have a generous revenue-sharing plan to prevent turf battles. We share patients liberally and frequently use surgeon availability as a basis for assigning post-call cases.

The formation of our large group and our on-call policies came at an opportune time, given the trauma and emergency call crisis plaguing so many cities. Although the number of surgeons in this area is adequate for our patient base, the four area hospitals all want 24/7 coverage of their emergency department (ED). In addition, Spokane has a level II trauma service that the two large downtown hospitals share. This situation really stretched the call pool quite thin.

### *Hospitalist program*

To address this situation, last fall we started a surgical hospitalist program with the four hospitals in town. Because these institutions are components of two hospital systems, when participants in the hospitalist program take call, we cover two EDs, provide trauma services, and do inpatient consults. We do not schedule office visits or elective procedures during these times. This arrangement ensures that two surgeons

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always are available to take call. In return, they receive a stipend from the institutions for each day of on-call duty.

The surgical hospitalist program has proven to be a win-win situation for the surgeons, the hospitals, and our patients. Providing ED coverage has always interfered with surgeons' ability to maintain an active elective caseload. Under this arrangement, we no longer have to cancel patients if a trauma case rolls in, nor do we have to wait until the end of the day to do an appendectomy. This arrangement has taken a perceived liability and turned it into a lifestyle-improving revenue source. Furthermore, patients are able to undergo urgent operations in a timely manner, and the operating room schedule is more efficient. Patients also have greater access to subspecialists, such as surgical oncologists, who no longer are required to take emergency call.

Making this system work takes a critical mass of surgeons as well as ED volume. Hospitals are more likely to consider having practicing surgeons in the community serve their patients palatable than trying to hire their own surgeon-hospitalist staff. And, despite all the grumbling from general surgeons about the hassles associated with taking ED call, the fact of the matter is that 20 percent to 25 percent of our patients come to us through the ED.

### *Conclusion*

In retrospect, it seems that the changes that have occurred in my practice specifically over the past 15 years really are reflective of the changes that have been taking place in general surgery as a whole. Like other general surgeons, I no longer provide what once was considered the full scope of general surgery services. I now play the role of surgical hospitalist four to five days each month. Nonetheless, my lifestyle is better than ever, although I do miss being a general surgeon in the broadest sense of the term.

These trade-offs are the compromises that practicing general surgeons now face. Likewise, forward-thinking residents must now decide whether to specialize and practice in an urban environment, to be an acute care surgeon with a limited scope of practice, or to be a general surgeon in the broadest sense and practice in a

rural location. Perhaps the greatest irony is that soon general surgeons who want to practice the way their predecessors did 60 years ago will be the ones who need to complete a fellowship.

Although change is often a disconcerting and sometimes difficult process, the members of our group practice believe that the modifications we've made have allowed us to continue to serve our patients well and establish a viable and positive practice for ourselves.

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