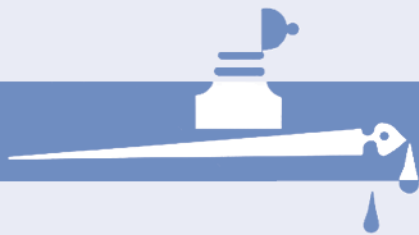


Letters



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.

Single-payor systems

In his Letter to the Editor (*Bull Am Coll Surg.* 2008;93(12):43), Sherif Emil, a fellow member of the College and of Physicians for a National Health Program (PNHP), lamented Dr. Russell’s refusal to accept a single-payor system now. Although Dr. Russell doesn’t need my assistance, I think there is common ground between the ACS and PNHP to bring about the goals and principles of both organizations—call me naive if you want to. In addition to Medicare for all, advocated by Dr. Emil, create optional luxury care, establish price controls on drugs and technology, and mandate reasonable access-time to care. (Six countries with universal care have no waiting lists.)

There are other simple reforms that would allow Americans to have longer life expectancies, better outcomes, lower complications, cost controls, and affordability comparable to other developed nations. President Obama is setting an example of civil discourse and respect for diverse opinions and ideas, all while promoting real change. We could do worse than to follow in his footsteps on the road to real reform of health care.

**Jerry Frankel, MD, FACS,
PNHP board member,
Houston, TX**

I would like to strongly support Dr. Emil’s Letter to the Editor. A single-payor national health insurance will eventually have to be enacted. To believe in “market competition” to lower health care costs is a fallacy. Patients select physicians or hospitals by other criteria than cost, and often these are also neither readily available nor can be predicted. To evaluate insurance programs is beyond the average person because of the many state-dependent clauses and rules.

Adequate insurance coverage also is only one part of the problem. An overall reduction in health care costs requires addressing not only insurance costs but also the pharmaceutical industry, as well as physician and patient attitudes and expectations.

To illustrate the point: some years ago, the Michigan Medical Society reported insurance overheads of 2.3 percent for Medicare, versus 10 percent to 26 percent for private insurers. We should mandate generic drugs. The U.S. Food and Drug Administration needs to be more thorough before allowing marketing of new medications, and their assessment should include cost-benefit analysis.

From my perspective as a retired surgeon and now longtime hospice physician, I ask the following questions: How many of us, physicians and patients alike, are dazzled by state-of-the-art technology when a simpler procedure may be just as effective? How often do we physicians propose and patients desire a desperate treatment just “because it might help for a while?” And how often do we bow to the patient’s wishes, even though we realize their futility, or feel too pressed for time, and thus take the “easy” way out? In short, decreasing health care costs requires a comprehensive approach.

Last, but not least, we have to overcome our almost paranoid

aversion to anything even remotely smacking of “socialism.” Both Great Britain and Canada have universal health care and neither of these two countries has turned communist yet. We often hear about these “poor” Canadians who cannot wait for their procedure and have to come to the U.S. and pay for it. I also have met some poor Canadians who cannot afford this, and who were pleased to have received high-standard care at home. Though some had to wait, those who became symptomatic were moved up the line. And what value can be placed on one’s peace of mind, knowing that if one ever gets ill, one will be taken care of.

I would like to close by quoting John Stuart Mill: “Laws and social arrangements should place the happiness of every individual as nearly as possible in harmony with the interest of the whole... and to establish in the mind of every individual an indissoluble association between his own happiness and the good of the whole.” It is in this sense that we should apply our commitment to beneficence, nonmaleficence, autonomy, and justice.

**Klaus Hergt, MD,
Cheboygan, MI**

Ethical issues

I was encouraged by “ACS-developed curriculum is becoming a centerpiece of training in ethics,” which was published in the March 2009 issue of the *Bulletin* (*Bull Am Coll Surg.* 2008;94(3):11–17). I agree with Ira Kodner, MD, FACS, that “Young people are hungry for the opportunity to think about the ethical values of the surgical profession.” The ethics curriculum of Dr. Kodner and Mary Klingensmith, MD, FACS, at Washington University School of Medicine in St. Louis, MO, should help fulfill this need.

However, as stated in the article, “Another challenge is to uncover

evidence that teaching ethics is a valuable use of an institution's financial and clinical resources." Medicine is both an art and a science. I would encourage a prospective, long-term, longitudinal scientific study to test if teaching ethics at the graduate level can modify behavior. Studies can, and should, be done.

**George Bohigian, MD, FACS,
St. Louis, MO**

Resident work hour restrictions

Some time ago, I was waiting on an international flight back to the U.S. The check-in representative told me that since the plane got in late the night before, that same crew would have to rest the required time, delaying the flight by two hours. I did not complain. Who wants an exhausted pilot dozing away as we crossed the ocean? Why would I complain about work requirements from the regulatory panels that address air safety? I was reminded of the resident hours situation we confront daily in academic surgical practice. Was I applying different personal safety standards to air travel than to my own practice? Have we not been repeatedly confronted by how much more safe it is to fly than to be a surgical patient? Have we not been repeatedly challenged that anesthesia has gotten so much safer, but progress in surgery so much less impressive? Then I remembered what was bothering me.

I read with great interest and then read again the Position Statement on Further Work Hour Restrictions from the Resident and Associate Society of the American College of Surgeons, which was published in the January 2009 *Bulletin* (pages 19-21). I greatly respect the authors and admire the thought and effort that went into the report presented to the Institute of Medicine Consensus Committee in March 2008. Obviously,

in retrospect, the presentation had little impact on the recommendations of the Institute. It might be useful to query why the position of the College had so little effect.

It seems the concerns of the surgical education community relative to work hour restrictions have centered on how we get things done as we are now doing them with fewer resident hours to apply, and how we get surgeons trained in effectively less contact time. Our first reaction is that the regulation is not needed. Then we get specific about the impact of such foolishness. The horrifying response always seems to involve hiring more residents or physician extenders. Otherwise, safety is compromised. Of course, any prediction that something will cost more money in health care today means it just cannot be done. Then again, we might be forced to extend resident training years to assure the public that their surgeons have had adequate experience. Given the tally of resident debt and the need to pay them so poorly for yet more years, this extension is most unlikely to happen. I would like to address these issues separately.

The majority of the approximate 5,000 hospitals in the U.S. have no residents and deliver the majority of surgical care to the public. The outcome of surgical care may not be meeting the accelerated path of safety of other industries, but we know and the public knows that the quality of surgical care in the U.S. is better than ever, getting better all the time, and is the source of great confidence and pride for the public and the surgical practice community. It is not clear that patient safety cannot be ensured in settings without perpetual and dense resident coverage. How is it possible to provide surgical care even when there are no residents? Apparently in those settings without teaching, there is a strong professional rela-

tionship between nurse providers and surgeons to guarantee collaborative care, information exchange, and continuity of care. Patient safety and quality in the main are exemplary with absolutely no need for resident involvement. The large majority of residents trained in academic health centers go on to staff these hospital settings and seem to do very well.

Should we not start with a viable and realistic care model and then look for the best ways to include trainees into this safe, collaborative, continuous setting of surgical care? That model would involve the successful example in community practice modified to meet the needs of education. Rather than considering the work of residents as an isolated quantum, it would seem better in the current challenge to regulate hours that we look more at work redesign rather than cries of desperation and looming collapse of the academic programs. In other examples, when labor became too expensive, labor-saving measures were found to keep the industrial operation in play. History is also instructive in medicine itself. Predictions were dire that phlebotomists, electrocardiograph technicians, laboratory staff, and steadily increasing paraprofessional assistants might make medical students less than prepared.

There were grave predictions 30 years ago that the requirement of attending surgeons to actually be present in the operating room would make it impossible to ever train an independent surgeon again. The surgeons graduating from these circumstances are, in fact, superb. Furthermore, the basic notion of supervision has been greatly eroded in favor of personal responsibility of the attending surgeon to be the prime patient contact and advocate insinuating residents and students into care in ways that are neutral to outcome. We are in the midst of a massive work rede-

sign already. Perhaps adding the work hour requirements to the list is not too much of a burden and might lead to a very happy solution.

Can we really not train someone to be a surgeon in five years working 80 hours or even 60 hours a week? I submit that we can. In order to do so means that residents need to be on high utilization services working on the cases we expect them to master and not on services with insufficient volume and excessive work unrelated to the educational task. Residents should be working with faculty who are trained to pass on surgical skills and knowledge with facility in the context of ongoing patient care. That faculty should be rewarded for educational outcomes as well as paying patient volume. Residents should be comfortable in the operating room because they are well versed beforehand in the skills needed by exercises in simulation. There is no way to waste time with ill-prepared faculty, ill-prepared residents, and exorbitant waits for the opportunity to work in the actual surgical setting in a way that is constructive toward prompt and effective competence. Residents should not be burdened with administrative

tasks or anything that resembles personal service to attending physicians. They should know exactly what they are expected to do and their days and nights should be organized to advance toward those expectations.

Administrators must realize that our residents are not discharge coordinators and the hospital information system must meet the needs of residents and not vice versa. The information system must capture the reality of patient status, past care, and treatment plan in a way that is understandable immediately to the oncoming team. Continuity of care is needed more than ever; that continuity is electronic and not word of mouth from fallible memory.

It is fortunate that the electronic display of air traffic is sufficient to assure air safety without the air traffic controllers staying around 80 hours a week. There is, frankly, no doubt that we can train residents to graduate as effective, competent, and compassionate surgeons in five years. There is no doubt this training can be done in a work environment that is recognizable to the community surgical setting to which most of our residents are destined. And there can be no doubt that those

surgeons will be effective in the surgical settings they eventually will populate. Finally, there can be no doubt this can be done meeting the expectations of our public during and after training.

I am so impressed by the work of my colleagues on the position statement. I know how hard we all work to ensure safety and quality education of the next iteration of surgeons for our communities. However, perhaps we are missing some obvious approaches in a time when we are confronting so many changes in our practices. There seems little value in just balking and forecasting doom. Let us just get busy to redesign our programs, using examples from far and wide. Those examples in industry, human performance science, private medicine, and other countries are abundant. Surely we must adapt them remembering our national medical objectives and responsibilities. But there is no reason to declare that it cannot be done. That message of despair is surely not one that the College really wants to send. We can do it and we will.

**Ronald Merrell, MD, FACS,
Richmond, VA**