



## Preparing surgeons for a seat at the health care policy table:

### *A proposal for a longitudinal health care policy curriculum during surgical training*

by **Donald W. Buck II, MD; James G. Bittner IV, MD; J. Awori Hayanga, MD, MPH; and Anatheia C. Powell, MD**

**H**ealth care reform has been a topic of heated debate for many years. Recently, this debate reached a fever pitch. On March 21, 2010, Congress passed the Patient Protection and Affordable Care Act (H.R. 3590), which will overhaul America's health care system over the next 10 years. Despite holding a critical position within the health care system, physicians often feel excluded from policy-related discussions. It is unclear whether this omission is a result of personal choice, or a direct reflection of a limited understanding of health care policy. This lack of health care policy knowledge is understandable, given that current medical education omits formal health care policy training. As a result, most trainees navigate the medical education maze with little or no exposure to the concepts of managed care, insurance coverage, medical coding, or billing until they join the workforce as staff surgeons.

#### **Educating residents in health care policy**

In this era of health care reform, it is critical for surgical trainees to understand the basic framework of health care policy and delivery. As the inconclusive, national debate reaches a crescendo, even President Barack Obama has acknowledged that meaningful health care reform can only occur with the support of physicians. He effectively

charged physicians to serve as leaders of progress toward coordinated, reasonable, outcome-driven care. A recent survey of 991 physicians from various specialties (21 percent surgeons) revealed most respondents (78 percent) agreed that physicians have a professional obligation to address health care policy issues. Most responding surgeons (70 percent) also agreed with this statement.<sup>1</sup>

In order to improve our understanding of health care policy, formal education must begin in medical school and continue throughout residency. Currently, there are only a handful of medical schools in the country that offer integrated health care policy curricula. In these centers, students learn the basics of biological and physical sciences, and take courses in managed care, insurance systems, and health care economics.<sup>2</sup> Similarly, very few hospital systems offer a dedicated health care policy component to their residency education programs. Despite the recent endorsement of the core competencies by the Accreditation Council for Graduate Medical Education (ACGME), only a small number of medical schools and residency programs have successfully implemented health care policy education as a required curricular component.<sup>2-8</sup>

While it is impossible to incorporate every aspect of health care policy, and the proposed reforms, into the current medical education system, it is

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important to discuss the concepts that are central to the foundation of the current system, fuel the reform debate, and ultimately impact our future as health care providers. One of the biggest factors driving the reform agenda involved access to care. Despite spending more on health care than any other country in the world, an estimated 46 million Americans remain uninsured, or undercovered, creating a significant financial burden on individuals, health care facilities, the economy, and health care providers.<sup>9</sup> The role of the government has also generated numerous questions, including the impact of governmental control on patient–physician privacy, practice standards, and the definition of what care is available, what care is delivered, and how it is financed. Other important concepts related to health care policy and reform include the right to health care, as well as fairness, efficiency, cost, and quality of care.

Health care policy and reform have a direct impact on every aspect of a surgical career, including practice patterns, financial foundations, and future career directions. Surgeons must coordinate patient care effectively in various health care delivery systems, consider cost-effectiveness and risk-benefit analyses of disease management, and advocate for patient safety and broad system reform. Despite potential constraints inherent to the current training paradigm, surgical trainees need to become educated in health care policy and delivery in the form of systems-based practice.

## Goals of health care policy education

The ACGME’s core competencies established the importance of learning systems-based practice. However, compliance with ACGME directives obligates training programs to overcome inherent educational challenges. Instruction in systems-based practice is hampered by the lack of robust and valid teaching and evaluation tools. Additionally, residency programs that decide to implement health care policy curricula must balance this education with duty-hours restrictions. Albeit time-consuming, a formal curricular initiative focused on the various facets of health care policy and delivery would offer trainees opportunities to understand health care policy and delivery, and to translate that understanding into effective advocacy for both patients and system reform.

Some institutions have made the decision to broaden medical student and resident education to include health care policy and systems-based practice. In all cases, these formal curricular initiatives have generated interest among trainees, established a correlation between exposure to health care policy training and future involvement in advocacy efforts, and produced trainees more proficient in systems-based practice. For example, the Pennsylvania State University College of Medicine, Hershey, PA, instituted an elective health care policy and legislative awareness course designed to inform medical students on policy issues and provide practical experience in legislative assignments.<sup>10</sup> The authors of the course outlined components of a successful curricular initiative and concluded that medical schools should provide students with a basic understanding of the health care system, and impress upon them the importance of individual and collective advocacy.

Putting such ideas into practice, the University of New Mexico School of Medicine, Albuquerque, piloted an elective 16-credit course for medical students designed to introduce health care policy topics at an early stage in training.<sup>11</sup> The institution also extended the offering to residents, using the clinical situations of ward practice. In this novel approach, teams of residents identified systems problems affecting care during an individual rotation, collected data about problems, and proposed specific solutions. In one example, an inpatient team became frustrated by slow discharges and identified gaps in social work coverage as the root cause. All affected patients were indigent or without private insurance. Using supportive financial data, the team advocated successfully for the allocation of two additional social work positions to facilitate discharges. Although this time and labor-intensive project may be difficult to replicate on surgical services, the program serves to highlight how daily issues that arise on individual rotations can be leveraged by surgery departments, in order to provide health care policy education in real time.

In an effort to address the gap in systems-based practice, George Washington University, Washington, DC, established a three-week Residency Fellowship in Health Policy (RFHP) designed specifically for residents.<sup>7</sup> The RFHP exposes residents to health care policy issues, provides

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practical experience with health care legislation, and fosters a personal commitment to health care policy and system reform. The innovative course covers five broad content areas of health care policy (33 didactic and 14 practical sessions). Participants' exit surveys revealed a high level of overall satisfaction with the RFHP and a significant improvement in overall understanding of health care policy. Compared with pre-fellowship attitudes, more residents who completed the exit survey reported being interested in further practical experience with health care policy following residency (40 percent before RFHP versus 70 percent after RHFP,  $p < .001$ ). While the aims and achievements of the RFHP are commendable, only two (1.5 percent) surgical residents over a three-year period took advantage of the fellowship.<sup>7</sup> The authors do not cite a specific reason for so few surgical resident participants, but the unique challenges of surgical training likely play a role.

On a larger scale, Dartmouth-Hitchcock Medical Center, Lebanon, NH, instituted a two-year Leadership Preventive Medicine Residency (DHLPMR) to attract and develop residents across disciplines who desire to lead health care policy change and improve health care delivery.<sup>12</sup> Participants of DHLPMR earn a Master in Public Health degree, which includes practical experience designed to improve health care delivery for a defined population of patients. Additionally, DHLPMR trainees complete a longitudinal public health experience with a governmental public health agency. Since its inception, graduates of DHLPMR have initiated various substantive improvements to local, regional, and statewide health care delivery systems. This program allows residents a chance to effect change in an environment to which they are accountable, ultimately improving the health of a select population of patients by leading change in systems-based practice.

Surgical residents interested in the DHLPMR program may participate during dedicated research time or after residency training. Across the spectrum of surgical specialties, most training programs allow residents to take dedicated research time for one to three years during residency. During this time, surgical residents are not only conducting traditional basic science research, but are now also participating in clinical or health

systems research, and/or obtaining additional degrees, such as a Master in Public Health or Public Policy. Other examples include the Brigham and Women's Hospital Center for Surgery and Public Health, Boston, MA, which offers a two-year postdoctoral fellowship in surgical health services research, and The Robert Wood Johnson Foundation Clinical Scholars program, which offers two years of funded, protected graduate level study, and research in public health problems at one of four major U.S. academic medical centers.<sup>13,14</sup> The University of Michigan, Ann Arbor, requires that surgery residents engaged in dedicated research activities also complete an online, one-year curriculum written by MDContent and designed to educate physicians on health care administration.<sup>15</sup>

In the preceding examples, academic and policy institutions recognized the value of health care policy training and supported implementation of large-scale curricular initiatives. Unfortunately, these programs can present logistical difficulties and pose financial challenges for many surgical programs and residents. However, a large-scale initiative is not required to achieve the benefits of health care policy training. Individual residency programs in family medicine, internal medicine, pediatrics, urology, and radiology have established successful health care policy training initiatives.<sup>11,16,17</sup> For example, the Mallinckrodt Institute of Radiology, St. Louis, MO, developed a five-week didactic curriculum relevant to health care policy and radiology practice.<sup>18</sup> Prior to initiation of the curriculum, all radiology residents described their baseline knowledge of health care policy as "weak." Following the course, interest in curriculum topics and perception of their importance and relevance to radiology practice increased among those residents who participated. In addition, almost half of participants (42 percent, 13 of 31) felt motivated to pursue further health care policy education, and 61 percent (19 of 31) developed interest in administrative issues and in radiology organizations.

Although educators recognize the need for teaching health care policy and advocacy in residency training, few well-developed surgical residency curricula exist. Even so, leaders in surgical education, practice management, and public health should consider combining their efforts to

design and implement a standardized, validated, resident-focused curriculum with both didactic and experiential components. A complete health care policy and advocacy curriculum could address at least five of the six ACGME core competencies, including patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Perhaps more importantly, such a definitive curriculum could supply residents with the tools they need to both navigate the health care system and to advocate on behalf of their patients and profession.

### Proposal for a longitudinal health care policy curriculum

A longitudinal curriculum—delivered over a rotating period of time during residency training—provides advantages over the stand-alone options described above. First, it takes advantage of protected resident education time already carved out in many residency schedules to meet ACGME requirements. Second, a longitudinal curriculum does not require residents to utilize elective or dedicated research time, which is in short supply in the emerging era of combined training. Third, a curriculum designed by the individual department could be tailored to the specific needs of the residents and take advantage of both intra-departmental support and resources from the larger hospital and medical school infrastructure. Fourth, a curriculum rotating over a period of one or more years can repeat topics for reinforcement as well as change material/lecturers to highlight new areas and/or new approaches. Finally, this approach can centralize disparate topics previously taught independently, such as practice management (for example, coding and reimbursement), electronic health records (EHRs), advocacy and leadership skills, and so on, into one

program that meets core competencies and resident needs in a cohesive and meaningful manner. We propose the development of a longitudinal curriculum, both didactic and experiential, that incorporates elements of the approaches men-

Figure 1

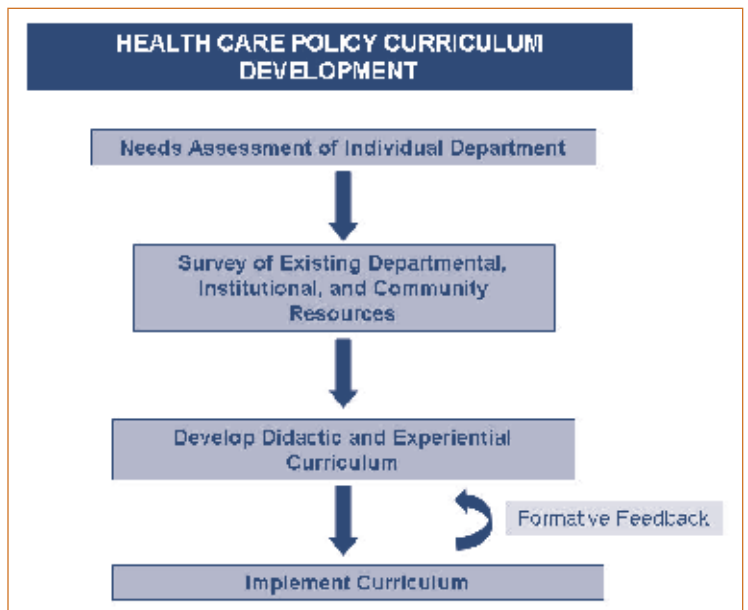
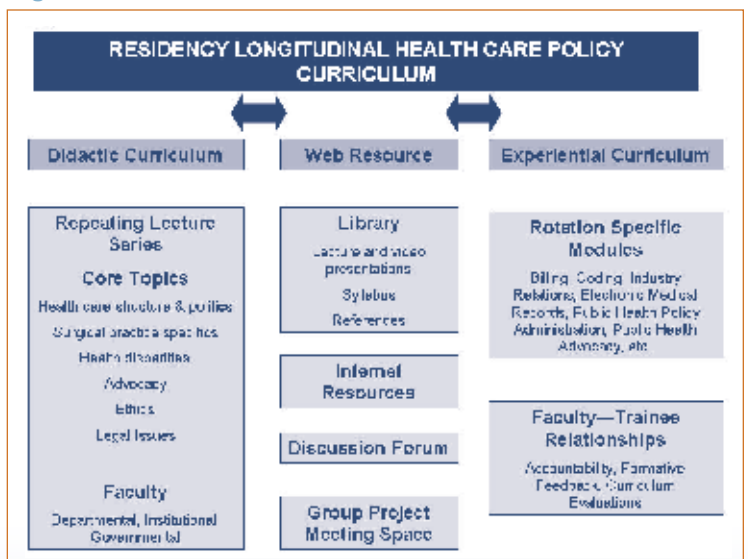


Figure 2



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tioned here and suggestions from the ACGME, in order to provide more comprehensive and relevant health care policy education than what is currently available. The first steps to developing this curriculum are a needs assessment—with input from departmental administration, faculty, and residents—and a survey of existing resources. These assessments allow the curriculum to be relevant to the individual department and avoid duplication of effort (see Figure 1, page 24).

The centerpiece of such a curriculum, given the large volume of sometimes unfamiliar information that residents must assimilate, is a repeating series of one-hour lectures covering core areas (see Figure 2, page 24). These lectures may be drawn from core areas such as health care structure and politics, surgical practice specifics, health disparities, advocacy, ethics, and legal issues.<sup>7,18</sup> In order to capitalize on existing resources, lecturers and reading material may be culled from the surgery department and from partnerships with the hospital administration, schools of medicine and public health, and organizations such as the American College of Surgeons. Utilizing existing Web resources for residents can extend the course to cover the inherent scheduling uncertainties of surgical departments. A Web-based library may be made available on a departmental or school intranet with syllabi, PowerPoint files and/or video files of lectures, files of relevant papers, links to Web sites and e-books, and a discussion forum.

Each rotation may provide part of the experiential curriculum. The faculty of each department and rotation may be surveyed to understand available systems resources and practice models such as private practice, academic, public or Veterans Affairs hospital, use of EHRs, data collection for quality improvement or outcome research projects, technology-rich departments (such as minimally invasive or robotic divisions), and other resources.

Based on rotation-specific resources, each rotation can develop its own “mini” policy education curriculum. For example, in real-time, a public hospital rotation could discuss health care access issues, while a private, minimally invasive rotation could address working with product vendors. And individual faculty members could mentor residents as they rotate through the specific practice setting. These discussions have particular

relevance in the outpatient clinic setting. Instead of simply focusing on the clinical needs of the patient, residents could discuss the billing method of the surgeon or practice during the outpatient experience.


Developing and implementing both didactic and experiential components of a formal health care policy curriculum will require departmental commitment and an upfront investment of time and labor. The developed curriculum will require ongoing evaluation, as health care policy continues to evolve and departmental needs change. The fruits of this labor, however, may be a more comprehensive and relevant policy education for surgical residents. This education is becoming essential for surgeons to fully understand health care practice and to continue to be advocates for our patients. Decisions are made by those who show up, and we must ensure that the surgeons

***Dr. Buck** is a plastic surgery resident at Northwestern University, Chicago, IL. He is the RAS member of the ACS Advisory Council for Plastic and Maxillofacial Surgery. He is also a member of the RAS-ACS Executive, Education, and Communications Committees.*



***Dr. Bittner** is a general surgery resident at the Medical College of Georgia School of Medicine, Augusta, GA. He is Vice-Chair of the RAS-ACS Education Committee.*



of today and tomorrow are not only present at the health care policy table, but prepared as clinicians, leaders, and advocates. 

## References

1. Antiel RM, Curlin FA, James KM, Tilbert JC. Physicians' beliefs and U.S. health care reform—a national survey. *N Engl J Med*. 2009;361(14):e23.
2. Cox M, Pacala JT, Vercellotti GM, Shea JA. Health care economics, financing, organization, and delivery. *Fam Med*. 2004; 36(1): Suppl:S20-30.
3. Accreditation Council for Graduate Medical Education (ACGME). Common program requirements: General competencies. February 2007. Available at: <http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf>. Accessed February 15, 2010.
4. Gomez AG, Grimm CT, Yee EF, Skootsky SA. Preparing residents for managed care practice using an experience-based curriculum. *Acad Med*. 1997; 72(11):959-965.
5. Callahan M, Fein O, Stocker M. Educating residents about managed care: A partnership between an academic medical center and a managed care organization. *Acad Med*. 2000;75(5):487-493.
6. Mirowitz SA. Development and assessment of a radiology core curriculum in health care policy and practice. *Acad Radiol*. 2000;7(7):540-550.
7. Greysen SR, Wassermann T, Payne P, Mullan F. Teaching health care policy to residents—three-year experience with a multi-specialty curriculum. *J Gen Intern Med*. 2009;24(12):1322-1326.
8. Wichman CL, Netzel PJ, Menaker R. Preparing psychiatric residents for the “real world”: A practice management curriculum. *Acad Psychiatry*. 2009;33(2):131-134.
9. Borman KR, Edgar J. Poth Memorial Lecture: Lessons learned inside the beltway: One surgeon's encounters with health care policy. *Am J Surg*. 2009;198(6):736-741.
10. Quraishi SA, Orkin FK, Weitekamp MR, Khalid AY, Sassani JW. The health care policy and legislative awareness initiative at the Pennsylvania State University College of Medicine: Theory meets practice. *Acad Med*. 2005;80(5):443-447.
11. Jacobsohn V, DeArman M, Moran P, Cross J, Dietz D, Allen R, Bachofer S, Dow-Velarde L, Kaufman A. Changing hospital policy from the wards: An introduction to health policy education. *Acad Med*. 2008;83(4):352-356.
12. Foster T, Regan-Smith M, Murray C, Dysinder W, Homa K, Johnson LM, Batalden PB. Residency education, preventive medicine, and population health care improvement: The Dartmouth-Hitchcock leadership preventive medicine approach. *Acad Med*. 2008;83(4):390-398.
13. Center for Surgery and Public Health, Brigham and Women's Hospital. Available at: <http://www.brighamandwomens.org/CenterforSurgeryandPublicHealth/EduOpp.aspx>. Accessed February 15, 2010.
14. Clinical Scholars Program. Robert Wood Johnson Foundation. Available at: <http://rwjfsp.unc.edu/scholars/howtoapply/index.html>. Accessed February 15, 2010.
15. MDContent.com. Available at: <http://www.mdcontent.com>. Accessed February 27, 2010.
16. Shortt SED, Hodgetts PG. A curriculum for the times: An experiment in teaching health policy to residents in family medicine. *Can Med Assoc J*. 1997;157(11):1567-1569.
17. Leveridge M, Beiko D, Wilson JWL, Siemens R. Health advocacy training in urology: A Canadian survey on attitudes and experience in residency. *Can Urol Assoc J*. 2007;1(4):363-369.
18. Mirowitz SA. Development and assessment of a radiology core curriculum in health care policy and practice. *Acad Radiol*. 2000;7(7):540-550.

**Dr. Hayanga** is administrative chief surgical resident, University of Michigan. Ann Arbor. He is Chair of the RAS-ACS Education Committee.



**Dr. Powell** is a general surgery resident at New York University, New York, NY. She is Vice-Chair of the RAS-ACS Communications Committee and a member of the Advisory Council of Operation Giving Back.

