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Measures to Resolve the Shortfall of General Surgeons

MEASURES TO RESOLVE THE SHORTFALL OF GENERAL SURGEONS

Training, recruiting, and retaining general surgeons, tricky issues that are problematic for hospitals across the United States. Furthermore, this impacts the entire field of surgery from students interested in surgery to the most established surgeons in practice. What can we do to resolve these issues?

You are listening to ReachMD, The Channel for Medical Professionals. Welcome to The Clinician's Roundtable. I am your host, Dr. Mark Nolan Hill, Professor of Surgery and Practicing General Surgeon. Our guest is Dr. Dana Christian Lynge, Associate Professor of Surgery at University of Washington School of medicine and practicing general surgeon. Dr. Lynge is the legal author of research published in the Archives of Surgery on the national shortage of general surgeons.

DR. MARK NOLAN HILL:

Welcome, Dr. Lynge.

DR. DANA CHRISTIAN LYNGE:

Thank you for having me.

DR. MARK NOLAN HILL:

We are discussing measures to resolve the shortfall of general surgeons. Dr. Lynge, it used to be stated that if you had to have one doctor on a deserted island, you would have a general surgeon and you recall in years passed that we would do everything from every intra-abdominal case to breast surgery to thyroid/parotid surgery, aneurysmectomy, radical neck dissections, just everything. I remember in my residency we used to do most of the non-obstetric hysterectomies that were done and ran the anterior and posterior colporrhaphy clinics. Now, clearly where we doing those type of surgical procedures poorly for this to happen or why did this change?

DR. DANA CHRISTIAN LYNGE:

A big question and even I am not sure that I am fully qualified to answer, but if you look at trends in practically every area of human

endeavor, particularly over the last century with explosion of knowledge in every area, increasing sub-specialization is becoming the norm. When Harvey Cushing basically started this specialty of neurosurgery, he was a general surgeon I believe and hand surgery grew out of general surgery and so it's not necessary that general surgeons were doing a poor job. It's just the nature of the beast that humans as they get to be more focus on smaller and smaller areas and learn more and more and more about it, and also I think one of that trends in modern life is the demand for "experts" in one area of endeavor or another. You know, in their own literature as you know there is a lot of debate about volumes and the association between outcome and volumes and whether certain cases should be referred to high volume "centers of excellence" and whether they will get better outcomes and whether that's due to the surgeon doing more or due to the institution taking care of more of them and which kind of procedures that should be. So, better or for worse, the general surgery has become increasingly fragmented by different subspecialties emerging from it and then laying claim to part of the turf. Of course, that's mainly an urban phenomenon whereas in the small rural areas, the general surgeon is still the main surgical practitioner and does the full gamut of what used to be called general surgery up to and including some gynecology, orthopedics, even urology, and ENT. Although, recent graduates of general surgery programs in most cases unless they have gone to specific programs which provide that training like Cooperstown or Oregon Health Sciences all have started out on their own won't have the training to do obstetrics/gynecology or orthopedic procedures.

DR. MARK NOLAN HILL:

I am sure some of our listeners are wondering what's the liability issue of someone who is a general surgeon, let's say doing some gynecologic surgery, orthopedic surgery, etc.

DR. DANA CHRISTIAN LYNGE:

Yeah, I actually don't know the answer to that. Good question and one that I have wondered about. I have in the course of going to say <_____> at Cooperstown spoken to general surgeons probably mostly in their late 50s or in their 60s, who were trained to do this and who told me that you know when the obstetrician left town or before they had obstetricians, they would do C-sections and hysterectomies. You know, whether they had to take out extra insurance to do that, if they justify because of their case numbers and training, I don't know if they had a bad outcome and an aggressive malpractice, attorney got them in court and said "We know what justifications you have for carrying out this kind of surgery would they be in trouble." That's not an answer I can give you unfortunately. I do think that nationwide in this country because the elder generations of omni-surgeons, who were trained and comfortable in doing these subspecialty procedures is dying out or leaving practice and because the younger generation is not trained and probably because of perceived or real litigation issues, general surgeons aren't doing as wide gamut of procedures as they used to in rural areas.

DR. MARK NOLAN HILL:

If you have just joined us, you are listening to the Clinician's Roundtable on ReachMD XM. I am your host, Dr. Mark Nolan Hill and our guest is Dr. Dana Christian Lynge, Associate Professor of Surgery at the University of Washington School of Medicine and a Practicing General Surgeon. We are discussing measures to resolve the shortfall of general surgeons.

Dr. Lynge, it used to be standard for all plastic surgeons, cardiothoracic surgeons, and other specialties to have a full residency program in general surgery before they went on to their sub-specialization. Now, many of the residency programs are changing where they are not boarded in general surgery and the number of years spent in general surgery is decreased. How do you think that this change in philosophy influences the problem we are talking about now?

DR. DANA CHRISTIAN LYNGE:

I actually think and again I am not a program director, so I am not department chairman, I am not really that sophisticated to respond on this question, but I actually think that it may work to the advantage of general surgery residency training.

DR. MARK NOLAN HILL:

How's that?

DR. DANA CHRISTIAN LYNGE:

Well, in our program for instance, plastic surgery, some people go all the way through and then decide they want to go into Plastic Surgery, but increasingly the majority of people, who go through plastic surgery residency do 3 years of general surgery, then go into Plastics. It has been proposed and I think will happen soon that in both vascular and cardiac surgery, they will have similar options and that they would still do 3 years of preliminary training, a lot of which will be general surgery with some other areas of focus, for vascular surgeons and interventional radiology, for cardiac surgeons, cardiology, and then immediately go into their subspecialty training. So, like integrated plastic surgery programs they won't be board certified general surgeons. So, that has some interesting implications – one is you'll have fewer graduating general surgery chiefs because you won't have people going through 5 or 5 to 7, depending on your program, four years of general surgery before going on will be required. So, that will create some interesting manpower issues for programs. Two, though those chiefs who do come through should have greater number of major general surgery index cases, say major GI cases because instead of having 7 chiefs in general surgery you will only have 5. So, those should have the opportunity to actually get higher numbers of the interesting major cases in their chief here than they would have before. That's just a thought and there might be some other implications. The other thought is, you know issue is, is it really necessary to have a plastic surgeon, a vascular surgeon, or a cardiac surgeon, who is board certified in general surgery and has spent the chief year doing Whipple's and hepatic resections and major colon resections. Do they really need that? I guess everybody have their own thoughts on that. I think probably in most cases, they don't, because in most cases, they are probably not going to need that kind of sophisticated general surgery as part of their training and you know, there will be exceptions to those cases. Some plastic and reconstructive surgeons will probably do more intra-abdominal work or stuff that it might behoove them to do full 5 years of general surgery and some thoracic-oncologic surgeons who still use a good deal of the foregut as part of their surgeries and may behoove them to do a 5 full years of general surgery. So, I think by and large, those integrated systems were cardiovascular, thoracic, and plastics just do 3 years and aren't fully quite general surgeon. You know, that's happening, like it or not.

DR. MARK NOLAN HILL:

Now, what are your thoughts about the trauma surgeons doing the acute surgical cases and doing a role such as the surgical hospitals, as you have mentioned this before? What are your thoughts about this?

DR. DANA CHRISTIAN LYNGE:

Well, I have read a little bit about that program and one of my colleagues here at the University of Washington, Jerry Jurkovich at Harborview is one of major promulgators of that Acute Care Surgeon Program. When I talked to him about it, he said you know his idea is not to produce a surgical hospitalist per se, it's more to produce basically somebody, who can do trauma and all sort of general surgical emergencies instead of a larger urban hospital with high a volume of trauma, general surgery emergencies, and critical care and these will be boarded in critical care as well, I think in most cases.

DR. MARK NOLAN HILL:

Now, we have talked about the difficulty in emergency rooms getting general surgeons to take call, get there in the middle of the night for acute appendix, acute perforated diverticulitis, and things like that. Do general surgeons want to be less busy or do they want to be more busy or do all they want is elective procedure?

DR. DANA CHRISTIAN LYNGE:

I think it depends on the person. You know, some people want a narrower focused area of surgical endeavor; some want a more controllable lifestyle than perhaps traditional general surgery affords, some may want to be more busy, some may want to be less. I mean, you know, if you are talking about people coming out of medical school, I think they also because, probably because of the amount of death they had compared to when we went through. They also have an eye on what's going to produce maximum bank for bucks given a certain length of training, going more into debt and when they get out, how much are they going to earn in order to pay off this massive debt load. So, there is a whole variety of factors, and I am sure they must think of the fact that at least from what I read for a lot of general surgeons in this country, unfortunately they are working harder and making the same or may be less because of remuneration policies of the government and the insurance companies.

DR. MARK NOLAN HILL:

Is the remuneration significantly less for general surgery than it is for other specialties nationwide?

DR. DANA CHRISTIAN LYNGE:

Gosh, you would have to talk to somebody from the AAMC about that. General surgeons still make a good living. I think the perception of people though is that you probably can earn more and have a more controllable lifestyle if you are in some of the other surgical sub-specialties, that appears to be the perception of, you know, people finishing medical school, but you know you could find data on what the average cardiovascular, plastic surgeon made in it, I am superficially acquainted with that and they do make more than general surgeons and you know, I wouldn't be grudged on that, but you know I think the perception is that you know general surgeons work pretty hard for their money in terms of call, etc.

DR. MARK NOLAN HILL:

I want to thank our guest, Dr. Dana Christian Lynge. We have been discussing measures to resolve the shortfall of general surgeons.

I am Dr. Mark Nolan Hill and you have been listening to The Clinician's Roundtable on ReachMD, The Channel for Medical Professionals. Be sure to visit our website at www.reachmd.com featuring on-demand pod casts of our entire library and thank you for listening.

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