

**SURGERY 2010: FINDING THE SILVER LINING  
ON A CLOUD OF REGULATION**

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It has been a privilege to serve as president of the Western Surgical Association this past year. I would like to thank the membership for the opportunity to serve, as I consider leadership of the Western Surgical Association to be the highest honor of my professional career. The first paper I presented at a national meeting was at the Western in Salt Lake City in 1980. Bill Remine, a late mentor and colleague, was president. I somehow survived the presentation and fortunately Allen Boyden was kind in his discussion of the paper. I was elected to membership in 1991, became active in the organization, and was elected as Recorder and held this office from 2002 to 2007. I will be forever grateful for the opportunity to serve the association; it has been a most rewarding experience.

Before I begin my formal address, I would like to first thank Don Fry for his kind introduction and then to express appreciation to a number of individuals who have been instrumental in the good fortune that I have had in my life and career. First, I would like to thank my mother, Mary B. Richter, for all the sacrifices she made as a single mom raising my sister and me. We did not have much, but the values and self discipline she instilled in me have stood me well. To her I am grateful. I love you mom. I wish to dedicate my address to her.

How did I end up at the Mayo Clinic? I went to medical school at the University of Alabama in Birmingham where I had the opportunity to work on John Kirklin's surgical service. He was a giant in cardiac surgery who had started his career at Mayo, but moved to UAB in 1967. All of the residency positions that I considered were in the Deep South, save for Mayo. It was through his influence that I applied and was delighted to be accepted. In June of 1975, my wife Ann, my son Mike Jr. and I packed up and set

out for Rochester, Minnesota with a plan to stay for 5 years. We are still at Mayo some 35 years later. There were two individuals in my intern class with whom I trained, who, along with me, joined the Department of Surgery at Mayo upon completion of our training. They are treasured friends, trusted colleagues and WSA members. Our families and extended families are very close. Many thanks to Clive Grant and Dave Nagorney, each masters in their chosen areas of interest; endocrine and HPB surgery, respectively.

During my training, I was mentored by many outstanding surgeons who each influenced the way I approach patients, operate and conduct my practice. I am an amalgamation of all the best they had to offer. Marty Adson, Bill Remine, and Jon van Heerden, all past presidents of this organization, were great influences upon me. Don McIlrath was chair of the Department of Surgery at Mayo Clinic when I was recruited. He was a gifted technical surgeon and leader who was a great supporter of me. I was hired at Mayo to be an acute care surgeon in 1980 and sent to do a trauma fellowship at Grady Hospital in Atlanta with Harlan Stone. I then joined the late Peter Mucha, Jr. and the two of us ran a trauma and emergency surgical service which was well ahead of its time. The success of this model is underscored by Mayo's Division of Trauma, Critical Care and General Surgery, now 13 surgeons strong and the burgeoning development of Acute Care Surgery as a specialty. However, my passion was upper abdominal surgery and I am indebted to Keith Kelly, who, as my chair in 1992, supported my desire to focus my practice on HPB surgery. To each of these individuals I owe a great deal of gratitude.

A special thanks to my assistants, Ms. Connie Feeder and Ms. Jacque Wilson, both of whom have supported my practice and professional activities for nearly 25 years. Thank you both for all that you do for my patients and for me.

I wish to extend appreciation to the members of my Division and Department who are in attendance today. The Western Surgical Association has been strongly supported by Mayo surgeons in the past and it remains so to this day. Thank you all for your support.

I extend my love and appreciation to my children: Mike Jr., Burke, and, Maureen. I am so pleased that they have seen fit to bring their spouses and my grandchildren for this occasion from Dallas, New York and Denver, respectively. I love you all and thank you for being here.

Lastly, and most importantly, I wish to thank my wife Ann. She is the reason that I am standing before you today. When we met I was set on a career in chemical engineering. She came from a medical family; her dad was an orthopedic surgeon at Baylor in Houston. Unfortunately, I never met him as he died when Ann was only 8 years of age. But it was through her that I had my first contact with surgeons. Their passion for their work, energy and enthusiasm were infectious. They were great role models and I wanted to be like them. When I completed my degree in chemical engineering, I applied to medical school. E Stanley Crawford, a Baylor surgeon, wrote a letter that I am sure helped me to get acceptance into medical school and since Ann's dad was deceased, he walked Ann down the aisle at our wedding in Houston so many years ago. There are many in this audience who know Ann and how remarkable a person she is. Whatever success I have achieved in my life is in no small measure due to her love and support.

As I considered the various topics for my presidential address, I found the task to be very daunting. I, as others have done, read numerous presidential addresses for enlightenment and pondered this chore since my election as your president in November of 2009. Indeed, this has consumed my thoughts this past year and increased my admiration for those who have so successfully delivered on this charge. The most memorable addresses are those that are both timely and inspirational. While there are a number of topics that might serve to inspire, the passage of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010 is so important to our patients, to our profession, and to our economy that I felt it incumbent upon me to address it.

In 1993 when the Clinton Health Security Act was being hotly debated, Jack Pickleman, then president of the Central Surgical Association and a past president of the Western Surgical Association, delivered his presidential address entitled “A Letter to the President.” His address was both galvanizing and hilarious, and thus memorable. I am neither a health policy wonk nor a wit. While I will not be so naive to think that I can make this topic inspirational, I will endeavor to make this complex bill understandable. I will review the history of how we got to where we are, why there is a crisis health care in the US today, provide an overview of PPACA, and highlight those aspects of this legislation that have the potential to have a positive impact both for our patients and for us as surgeons.

### **The History of Health Care Reform in the United States**

Health care reform has been on the agenda of our leaders for nearly a century. In 1912, Teddy Roosevelt said, “It is abnormal for any industry to throw back upon the

community the human wreckage due to its wear and tear, and the hazards of sickness...should be provided through insurance.” President Franklin Roosevelt attempted to attach a national health care provision to the Social Security Act of 1935, however was unsuccessful.<sup>1</sup> In 1945, President Harry Truman pushed for a federally-funded national health insurance program, but was thwarted by the post-war political climate and a strong private insurance lobby. Indeed, by 1951, more that 50% of patients admitted to hospitals had private medical insurance. Thereafter, efforts were directed at providing coverage for the elderly. In 1961, John Kennedy endorsed creation of a Medicare bill to cover hospital costs for the elderly. After Kennedy’s assassination, Lyndon Johnson was successful in getting the Medicare bill introduced into law in 1965. Part A (hospital coverage) is provided premium free, Part B is a voluntary program of supplementary insurance for which eligible individuals pay a premium for physician fees and outpatient coverage. In 1997, Part C Medicare Advantage was added (currently 10 million seniors are enrolled in Part C) and in 2003, Part D, a prescription drug benefit plan, was introduced. Medicare now covers 38 million elderly individuals, the disabled and those with end-stage renal disease, and is one of the most popular social programs in history.<sup>2</sup>

Continued efforts at health care reform have occurred in the US since the institution of Medicare in the 1960’s. In an effort to rein in hospital costs, Medicare introduced a prospective payment system for hospitals under Part A of Medicare based upon diagnostic related groups (DRG’s) in 1983. This resulted in a fixed payment to hospitals based upon DRG rather than actual cost of providing care.<sup>1</sup> In 1986, Ronald Reagan signed the Consolidated Omnibus Reconciliation Act (COBRA) which stipulated

that insurance eligibility would continue for 18 months following separation from employment. The premium was the responsibility of the employee and lack of premium payment resulted in immediate policy termination. In 1992, the relative value unit (RVU) was introduced to determine physician fees under Part B of Medicare.

Another run at health care reform was made by the Clinton administration in 1993 with the Health Security Act. The Clinton plan called for universal health care through private insurer competition, employer and individual mandates, but also heavy government oversight and regulation. With a Republican majority in the House and Senate in 1994, the bill was not approved. In response to the Clinton plan, the Republicans, led by Senators John Chafee and Robert Dole, proffered an alternative which served as the basis for the universal health care plan passed by Governor Mitt Romney in 2006. According to Joe Klein of Time of Magazine, the PPACA signed by Obama on March 23, 2010 was “a mongrel; its roots in the Republican plan of 1993 and in Massachusetts”.<sup>3</sup>

### **The Health Care Crisis**

The United States is the most affluent country in world, with a robust system of employer-provided health benefits—fully 98% of companies with 200 or more employees provide such offerings. The elderly are covered by Medicare and the poor are covered by the Medicaid program jointly funded by federal and state governments. Wherein lays the problem? In 1980, health care spending in the US was \$1,000 per capita and totaled 8% of gross domestic product (GDP). Since then, health care costs have spiraled out of control. In 2007, health care spending in the US was \$7,290 per

capita, 16% of GDP (see Figure 1a&b), and totaled 2 trillion dollars (i.e. \$2,000,000,000,000). The cost of health care and medical insurance continues to increase, pricing many out of the market; 50 million by choice or by circumstance are uninsured in the US. Of seven industrialized countries analyzed, the Commonwealth Fund ranks the US dead last in dimensions of performance: quality, efficiency, access, equity and healthy lives.<sup>4</sup> In this survey, the Netherlands ranked first in the dimensions of performance with health care spending of \$3,837 or 9% of GDP (Figure 2). Moreover, in the US the status quo is not sustainable. If current trends persist, we will be spending some 38% of GDP on health care by 2075.<sup>5</sup> In 2007, 62% of all bankruptcies in the US resulted from the financial implications of an episode of illness.<sup>6</sup> In 2009, the budget deficit was a whopping 9.9% of GDP, the highest since WWII, and more than four times the recent historical average of 2.4%. With an ever increasing expenditure of federal spending on health care, the government will have no choice but to cut programs and services or raise taxes.

Before addressing the Patient Protection and Affordable Care Act (PPACA), examination of the Massachusetts experience is instructive. The Massachusetts plan was implemented July 1, 2006, and was successful in reducing the uninsured in the state to 2.6%. Eighty-seven percent of the expansion was achieved by January 2008, one year after insurance exchanges became available. There was no undermining of the employer-based health benefits. With institution of the plan, utilization increased but at the expense of access. The number of internists accepting new patients decreased and wait times for primary care appointments increased.<sup>8</sup> From fiscal year 2007 to 2010, Massachusetts state health care spending increased from \$133 million to \$880 million. The increased



spending has prompted the governor of Massachusetts to consider price controls both on insurers and hospitals. These observations regarding spiraling costs in Massachusetts may have relevance to the financial impact of the nationwide implementation of PPACA.

### **The Patient Protection and Affordable Care Act**

In preparation for this address, I sought a complete version of the legislation. To this end, I was directed to [www. Healthreform.gov](http://www.Healthreform.gov) and learned that the bill was 2, 800 pages in length and that a pdf(portable document format) file of the certified full-text version totaled 4.27 megabytes. If printed, the hard copy version would measure one foot front to back. While the legislation is complex, implementation will require interpretation and rule writing by the DHHS Secretary, Kathleen Sebelius, and her staff. According to the *Kansas City Star*, “The massive health law says the ‘secretary shall’ make roughly 1,300 decisions on provisions in the law, everything from the smallest detail to defining what constitutes ‘essential’ health care. She’s charged with leading teams of government regulators who will add an expected 30,000 to 50,000 pages of regulations to the 2,800-page law”.<sup>8</sup> In the remainder of my address, I will touch on the high points of the bill and attempt to explore where opportunity lies or, in other words, where the silver lining shimmers on this cloud of regulation.

The goal of the bill is to insure the 50 million Americans who have no health insurance, decrease overall health care expenditures, and improve outcomes. The plan is incremental and will be phased in over the time interval 2010 to 2019 (Figure 3). Lifetime and single-year caps on benefits will be eliminated. Preexisting conditions will no longer preclude coverage. State-run insurance exchanges will increase competition

and decrease premiums. Enrollment of the uninsured will not begin until 2014. The Congressional Budget Office (CBO) estimates that the legislation may decrease health care expenditures by \$100 billion per year, a trillion dollars over 10 years. Economists agree that everyone must be covered if we are to bring the rate of health care spending under control. The decrease in the growth rate of health care spending has been coined as “bending the cost curve”. This will be accomplished by modifications in reimbursement, incentives for quality and efficiency, integration of care, population health management and preventive services. This is what the Health Care Advisory Board calls the “Reform Paradox”: giving more care to more people and paying less for it.<sup>7</sup>

The PPACA is expected to decrease the deficit by \$124 billion over the next decade. It will be funded by a combination of increased revenues and decreased expenses. Increased revenue will be in the form of taxes: industry taxes, passive income tax, hospital payroll insurance tax and “Cadillac” tax. One of the most important sources of funding will be a tax on “Cadillac” health plans (\$10,200 for singles, \$27,500 for family; subject to a 40% excise tax); those with no co-pays and minimal out-of-pocket spending. This tax would not be implemented until 2018. There will be fines on individuals who do not purchase insurance (individual mandate) and employers who do not provide health benefits (employer mandate). The cost of newly-enrolled Medicaid patients, some 16 million, will be borne by the individual states. Decreased expenses will be achieved by a Medicare fee for service rate cuts, Medicare advantage scale back, disproportionate share hospital rate cut, elimination of fraud and abuse, readmission penalty (pay for performance), Independent Payment Advisory Board (IPAB) and Medicare shared savings (Accountable Care Organizations). This multi-pronged effort to

decrease health care costs has been termed the “spaghetti approach” by Jonathan Gruber, an MIT health economist.<sup>9</sup> He states, “Throw everything against the wall and see what sticks.” Whether the legislation will achieve the planned reduction in the deficit remains to be seen.

In a 2009 statement on health care reform, the American College of Surgeons (ACS) espoused four key principles: promotion of quality and safety, access to surgical care, medical liability reform, and reduction in health care costs.<sup>10</sup> The ACS did not support the bill because it was felt to fall short of supporting these four principles. In particular, several provisions were thought to have a negative effect on surgical patients and the surgeon’s ability to provide quality, efficient health care. These were: creation of the Independent Payment Advisory Board (IPAB), failure to repeal the sustainable growth rate (SGR) formula and lack of meaningful liability reform. The first two warrant further explanation.

The IPAB will consist of 15 members who are experts in health finance payment, economics, actuarial science, health facility and health plan management. Each will serve 6-year terms. There will also be three members from the Department of Health and Human Services. The IPAB must keep Medicare spending within GDP growth plus 1% beyond 2018. The CBO estimates a \$28 billion reduction through 2019. By rule, the board cannot ration care, raise cost to beneficiaries, restrict benefits or modify eligibility criteria.. Thus, the only option available to the board is to reduce payments to providers. Appointment is full time at a salary of \$165,300 and it is anticipated that recruiting highly qualified candidates for the board may be difficult. According to Timothy Jost, J.D. of the Washington and Lee University School of Law, “If the IPAB is to be truly effective it

must consider not just cuts in provider payments but also changes in how providers are paid, or perhaps even consumer incentives”.<sup>11</sup>

The Balanced Budget Act (BBA) of 1997, which went into effect in 1998, established the SGR that sets yearly spending targets for physician services under Medicare. The SGR links the annual growth of Medicare fees to growth of real GDP, Medicare caseloads and practice costs. However, it ignores the increasing volume and complexity of medical services which is the main reason health care spending outpaces income growth. For the first few years, the SGR produced payment increases for the physician’s fee schedule: 2.3% in 1998 and 1999, 5.5% in 2000 and 5% in 2001.<sup>12</sup> Upticks came to a halt in 2002 when a cut of 5% was implemented. According to the formula, the more the volume and complexity of services grows in one year, the more physician fees must be cut the next year. Congress suspended application of the SGR formula on June 1, 2010 and raised fees 2.2% effective for 6 months. Thus, implied fee cuts can be large and grow if cuts are deferred. On December 1, 2010, the implied fee cut will be 23% followed by further reductions of 6.5% and 2.9% in 2011 and 2012, respectively. According to Henry J Aaron, Ph.D.<sup>13</sup> of Brookings Institution, “Because budget projections are based on the assumption that SGR fee cuts will be implemented, abandoning these cuts is scored by the CBO as a spending increase. The need to hold down the cost of reform led Congress to strip the SGR changes from the reform bill”.

While not part of PPACA, federal support for conversion to electronic health records (EHR) is provided as part to the 2009 American Recovery and Reinvestment Act, also know as the “stimulus package”. Cash payments for those eligible providers who demonstrate “meaningful use” of certified EHR technology will begin in 2011. One of

the core requirements calls for use of computer-provided order entry (CPOE) for the ordering of at least one medication for more than 30% of patients with at least one medication on their medication list.<sup>14</sup> Eligible providers must also report data on three core quality measures in 2011 and 2012: blood pressure, tobacco status and adult weight screening and followup. Penalties in the form of reduction in Medicare payments for those who do not use certified technology will begin in 2015. As of 2009, only 2 % of acute care hospitals used EHR. Implementation of EHR will be difficult due to cost, training, privacy issues and system intercommunication. Cost will be problematic for the 78% of physicians who practice in groups of fewer than eight.<sup>15</sup>

While PPACA is comprehensive and broad in scope, there are a number of things that it does not do. As noted above, it does not repeal the SGR and tort reform was not addressed. Fortunately, there are no reductions in federal medical education payments and while under consideration early on, the Medicare eligible age was not reduced to 55 years.

### **Finding the Silver Lining**

So where is the silver lining on this dark cloud of regulation? First, through the efforts of the American College of Surgeons, PPACA authorizes funding for select trauma centers, trauma service availability, regionalization of emergency care and reauthorizes the Trauma EMS program. The ACS was also successful in ensuring provisions that address the surgical workforce crisis: 1) an incentive payment program for major surgical procedures performed by general surgeons practicing in a Health Professional Shortage Area, 2) establishment of a pediatric specialty (including pediatric

surgeons) loan repayment program, 3) redistribution of unused GME residency slots by increasing the GME positions in states with the lowest physician-to-patient ratios. Sixty-five per cent of unused slots would be redistributed, of which 75% must be used for primary care or general surgery.<sup>16</sup>

Under health care reform, hospitals that demonstrate quality will benefit financially. According to Price Waterhouse Cooper's Health Research Institute<sup>17</sup>, PPACA can be expected to impact hospitals in three main areas. The first is hospital readmissions. In 2012, Medicare will penalize those hospitals with readmission rates in excess of those expected on a risk-adjusted basis. The readmissions are for acute myocardial infarction, heart failure, and pneumonia. Secondly, in 2013, value-based purchasing (VBP) will be instituted. Payments will be made based upon efficiency, patient satisfaction and quality of care. Thirdly, penalties for hospital-acquired conditions (HACs) will begin in 2015 affecting those falling in the bottom quartile when compared to national data. It will be in the hospital's best interest to work toward continuous quality improvement and stay out of the bottom quartile. Surgeons have led the way in the pursuit of quality. The National Surgical Quality Improvement Program (NSQIP) is a national effort to improve surgical care and cut costs. In a just released study of 118 hospitals, each experienced a reduction ranging from 262-524 complications per year. This study showed that NSQIP can improve both the quality and cost of patient care. According to the ACS, if Congress were to fund NSQIP in every hospital, health care costs would be reduced \$175 to \$347 billion over 10 years.<sup>10</sup>

The stimulus package of 2009 includes \$1.5 billion for comparative-effectiveness research (CER). This has been defined by the federal government as "research

comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat, and monitor health conditions in ‘real world’ settings.” The law specifically prohibits comparative-effectiveness research from being used to decide which services Medicare will pay for and how much it will reimburse. Comparative-effectiveness research is not new to surgeons. We have been participating in this type of research throughout our careers and should help lead our respective institutions in this arena going forward.

Another silver lining is that an additional 32 million individuals by 2019 will be insured. Many of these are in the young adult age groups, many of whom have previously chosen not to purchase health insurance. Generation X (born between 1965 and 1981) and Generation Y (born early 1980’s to 2000) will lead the way to health care change. According to a survey by Deloitte Center for Health Solutions,<sup>18</sup> Gen X and Gen Y expect the health care system to do a lot of things it is not doing now. They want to see their health records, to know if their doctor is competent and they want to know what it will cost up front. They want information, understandable prices and connectivity through technologies. By embracing the emphasis on information technology, measuring quality and outcomes, and exploring bundled payments, we will be better able to meet the needs and expectations of Gen X and GenY.

The looming shortage of general surgeons presents both challenges and opportunities. It has been estimated the US faces a shortage of 1300 general surgeons as early as this year.<sup>19</sup> The US Census Bureau predicts that by 2050 the number of US residents over 65 will double to 88.5 million and the 85 and older population is expected to triple to 19 million.<sup>20</sup> Even if utilization rates remain constant, the overall amount of

surgical work will increase 14 to 47% between 2010 and 2020.<sup>21</sup> Add to these estimates the 32 million who will become insured by virtue of PPACA, access to surgical care may be compromised. These factors may well posture us to make a strong case to roll back the 1997 Balanced Budget Act caps on funding for graduate medical education.

Sheldon<sup>22</sup> has suggested that a system of surgical care analogous to trauma systems may help to address the surgeon shortage. He suggests a wheel and hub concept with the academic medical center as the hub as a potential solution.<sup>22</sup> The growth and development of Acute Care Surgery as a subspecialty may well help to provide access for patients with traumatic and acute surgical conditions.<sup>23,24</sup> Moreover, an opportunity exists to explore innovative use of mid level providers to make surgeons more efficient providers of surgical care, thereby increasing access.

While not part of the PPACA, the work-hour rules instituted by the Accreditation Council for Graduate Medical Education (ACGME) in 2003 represent another set of regulations to which the surgical community has had to adapt. This has not been easy now seven years after implementation. Many senior surgeons lament that accountability and continuity of care has been compromised. Some have expressed their frustration by marginalizing trainees in the clinical arena. But times have changed and there is no going back. The surgeon of the future will have to function within collaborative models of care, be fully versed in systems-based practice, be excellent communicators and know how to negotiate shift changes and handoffs. A surgical generation has been trained under these guidelines and many more are to follow. After all, the surgeons we are training today are the leaders of tomorrow and will pattern their practice upon how they received their training. I agree with Dr. James Whiting<sup>25</sup> who wrote in an editorial, "It is



time to think creatively and to establish models of surgical responsibility and ownership appropriate for today's more collaborative medical environment and to utilize the strengths of our current generation of surgical trainees. It is time to grow up and stop whining. The dinosaurs went extinct, and our surgical heritage deserves to evolve.”

So what does the future hold? According to the *Washington Post*, “Fifty years from now, it is likely that almost all doctors will be members of teams that include case managers, social workers, dietitians, telephone counselors, data crunchers, guideline instructors, performance evaluators and external reviewers. They will be parts of organizations (which either employ them or contract with them) that are responsible for patients in and out of the hospital, in sickness and in health, over decades. The records of what they do for a patient—and what every doctor does—will be in electronic form, accessible from any computer. Software will gently remind them what to consider as they treat, and try to prevent diseases. How the patients fare will be measured and publicized, and used in part to judge the practitioners' performance. At the same time, health care organizations, aided by the government, will make an effort to let caregivers know the ‘best practices’ they are expected to follow”.<sup>26</sup>

Health care reform is the law of the land and we in the medical profession will have to adapt. Since the law is both complex and associated with great ambiguity, implementation will depend greatly upon interpretation by the DHHS as it sets upon the task of “rule writing” Will reform be successful? Remember there were three main goals inherent in the legislation: decrease the number of uninsured, improve performance in the dimensions of care and decrease overall health care expenditures. Health care reform will accomplish the first with the addition of 32 million insured by 2014. Improved

overall health for the US population is yet to be determined. With regard to the last goal, it just does not make common sense that we can provide more care to more people for less money. What impact will the results of the November 2, 2010 mid-term elections have on implementation of the plan? According to CNN: “ ‘repeal Obamacare’ might be the battle cry that swept the Republications into control of the House, but making good on the promise will be tough.” With control of the House of Representatives, Republicans will have the power to call hearings and impede funding of the federal health law. However, with a two-thirds majority vote required to override veto by the President, and Democratic majority in the Senate, repeal is unlikely.

So as surgeons, what do we have to look forward to as we face this looming cloud of regulation? I have been fortunate to spend my entire career at Mayo Clinic, a forward-thinking, physician-led, now national health care enterprise. Whenever faced with a dilemma or a challenge, we have always asked the question, “What is in the best interest of the patient?” In adherence to this principle, my surgical world has changed as my parent institution has both led and adapted to the changing health care landscape. Preoperative briefings, surgical pauses, never events, best practices, root cause analyses, resident work-hour restrictions, standard surgical orders, electronic medical record, computer provider order entry, team approach to care , patients satisfaction and the list goes on. I am proud to say that in the Division of Gastroenterologic and General Surgery that I chair, some 40% of our 16 surgeons are women. So in this new world now punctuated by health care reform, is the future still bright for a career in surgery? You bet it is. “The top 10 reasons why general surgery is a great career” presented by then president Richard Thirlby<sup>27</sup> to this Association in 2006 remain valid to this day with one

exception (Table 1). In this new world that we are in, the culture of surgery needs to change. Surgeons need to be collaborators, communicators, team players and team leaders both in and out of the operating room. We need to find the time to participate in the committee structure of our home institutions and to advocate to our political leaders in order that we as surgeons have a voice in shaping both institutional, state and national health care policy. This we owe to our patients, to our profession and to the young people that will follow in our footsteps.

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**Table 1****Top 10 Reasons Why General Surgery is a Great Career**

|  |
|--|
| Reasons  |
| 1. I love to cut.  |
| 2. Patients will change your life.   |
| 3. You will change patients' lives.  |
| 4. There's a spirituality if you want it.                                      |
| 5. You will have "heroes", you will be a hero.                                 |
| 6. Surgeons have panache: the surgical personality and the culture of surgery. |
| 7. Your mother will be proud of you.   |
| 8. The pay is not bad.   |
| 9. Job security.   |
| 10. Training is fun (you'll never forget it) and training never stops.         |

Source: Thirlby RC. The top 10 reasons why general surgery is a great career.

Presidential Address, Western Surgical Association. Archives of Surgery 142, 423-429.

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## Legends

**Figure 1:** International comparison of spending on health 1980-2007. (a) Average spending on health per capita (US PPP = purchasing power parity). (b) Total expenditures on health as a percent of GDP (Gross Domestic Product). Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris OECD, Nov 2009).

Source: Davis K, Schoen C, Stremikis K. Mirror, mirror on the wall: how the performance of the U.S. health care system compares internationally, 2010 update [Internet]. New York: The Commonwealth Fund; 2010 June 23 [Accessed June 23, 2010]. Available from <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx>

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**Figure 2:** Overall ranking of 7 industrialized countries based upon dimensions of care: quality, access, efficiency, equity, longevity, and health expenditures per capita 2007.

Source: Davis K, Schoen C, Stremikis K. Mirror, mirror on the wall: how the performance of the U.S. health care system compares internationally, 2010 update [Internet]. New York: The Commonwealth Fund; 2010 June 23 [Accessed June 23, 2010]. Available from <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx>

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**Figure 3:** Timeline for implementation of the Patient Protection and Affordable Care Act (PPACA) 2010-2018.

Source: The Reform Paradox. The Advisory Board Company 2010. Washington, DC.

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