

It matters: The case for advocacy

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It is my great pleasure to have served as president for the past year and to have led this organization into our 25th anniversary meeting. The wonderful thing about anniversaries is that they give you not only a chance to reflect on what you have accomplished in the past but also the need to reflect on the future of our organization and our profession. This reflection has led me to state the answer to the question of where we need to go next as the title. Thus, you may have the answer to the questions that I will pose today, but the case I will make is both important and sometimes difficult, so it will be worth the journey. I hope that at the end of my talk, I have carried the argument.

In preparing my talk, I had the great opportunity to interview Dr. Kim Maull, the founder of Eastern Association for the Surgery of Trauma (EAST), who was very generous with his time and told me about the history of the organization. I spoke with Dr. Carmona, our frame lecturer this year. Both of them spoke about their thoughts for the future of our profession. I was able to interview others who I do not have time to name, but they know who they are. I thank them all.

BACKGROUND

I was a medical student at the University of California, San Francisco, in my third-year surgery rotation when I met Dr. Larry Way. Unlike many educators, Dr. Way insisted that we do not go to the operating room, but instead, we sat in a classroom and learned about surgical pathophysiology. We were allowed to go to the operating room after 3:30 PM, after we had prepared our lectures and lessons and shown that we had learned the pathophysiology that was assigned to us for that day. That was very important for two reasons. First, as an acute care surgeon, I am hardly allowed to go to the operating room before 3:30 PM now. Second, Dr. Way impressed upon us the need to understand the pathophysiology of our patients. This was so that we could not only complete our future operations based on anatomical knowledge but also so that we understood the physiology of our patients. This was to ensure that the patients not only survived their operation, but the entire hospitalization as well.

In my fourth year surgical rotation at San Francisco General Hospital, I encountered Dr. William Schechter. He was a very visible force on the rotation. He was the first trauma surgeon I worked with. I remember rounding with him. He would ask all the residents to quickly find him an abnormal physical finding to show the medical students, so we could create a care plan.

During my surgery residency, I had the pleasure of training under Michael Zinner, who has remained a mentor. Gil Cryer, past president of the American Association for the Surgery of Trauma, was my trauma chief and was instrumental in my career choice.

I worked under two consultant surgeons in Nottingham, United Kingdom, in the National Healthcare System. In Britain, a consultant surgeon is known as *Mr. Dr.* is reserved for practitioners of internal medicine and/or those who have earned a PhD. Thus, I worked under the supervision of Mr. Hopkinson and Mr. Fawcett. These two gentlemen were both tremendously talented master surgeons, but more importantly, they had the courage to leave me alone in a room with an anesthetized patient and an assistant. That is really where I learned how to operate. Needless to say, it was a learning experience in both open and laparoscopic surgery.

The first faculty I served with was at the University of Rochester. I was hired by Dr. Seymour Schwartz. My partners on the trauma team were Dr. P.Q. Bessey and Dr. Patrick Lee. It was a tremendous learning experience. I also extend my appreciation to all who have worked with me while on the trauma service in Miami.

THE FUTURE OF OUR PROFESSION

This is the 25th anniversary of EAST. What are we to do about the next 25 years? How are we to plan for that? Should we break this up into five 5-year segments, or can we prognosticate 25 years all at once? It seems dangerous to prognosticate for periods in the far future without knowledge of history. Let us talk about where we are today.

Figure 1 shows the US health care spending as a percentage of the gross national product. The red line is private spending; the others are government spending on health care. The net effect is the top line. The amount that is spent on health care is unsustainable. The rate of increase in spending is similarly unsustainable. The private sector has managed to level off their spending a little bit, but our government social programs have continued to grow. Because our country lacks the resources to sustain this growth, our leaders will have to look for health care-related fiscal spending reductions. There may be some clever and selective cuts in the private sector. However, owing to political realities, cuts in the government sector health care spending will more likely be done as a blunt instrument. We, as practicing surgeons, had best be prepared both for the cuts and to defend our areas of practice (Fig. 1).

Policy makers look at figures like these concerning health care expenditures in this country. Turkey has a good life expectancy, but very little is spent on health care. The longest life expectancy in the world is actually in Japan. The United States spends the most per year per person for health care, but has a “middle of the pack” life expectancy. The \$5,000 spent per year doubles some of the other industrialized nations of Western Europe. Norway, which is one of the wealthiest countries in the world in per capita income, still does not spend as much as we do on health care. Our policy makers are asking questions about why

we spend this much per patient but our life expectancy are not necessarily as high as other Western democracies (Fig. 2).

It was not always that way. You can see that in 1970, it was a close race, but the United States has broken from the pack in the amount spent (Fig. 3).

We spend \$0.4 for hospital care and approximately \$0.28 for physicians. Only \$0.12 is spent for pharmaceuticals. It is approximately \$0.13 for health care administration. The key question is where and on whom is that money spent? The top 1% of our population, in terms of health care needs, is consuming 20% of the resources. The top 2% is spending a full one third of our health care resources. If we were able to control or eliminate costs on this top 1%, the sickest people, you would see a 20% decrease in our health care costs. Of our health care dollars, 97% are spent by 50% of the population. There is an unequal distribution of who is getting the health care. It tends to be the patients who are older, sicker, and chronically ill who are getting that health care.

Why does that affect us? I am going to show you data that most of us, acute care surgery practitioners, are intensivists. Controlling these costs is going to be our challenge.

DEMOGRAPHICS OF THE ORGANIZATION

Who are the members of EAST? There are 660,000 physicians in the United States. There are nearly 16,000 general surgeons. I am going to argue, and I may be a little off, but not dramatically off, that there are approximately 3,000 critical care or acute care surgeons in the United States, which is approximately 19% of all general surgeons and approximately 0.5% of all physicians. If you take 3,000 acute care surgeons and divide it into the US population of approximately 300 million, then a fully trained critical care or acute care surgeon represents

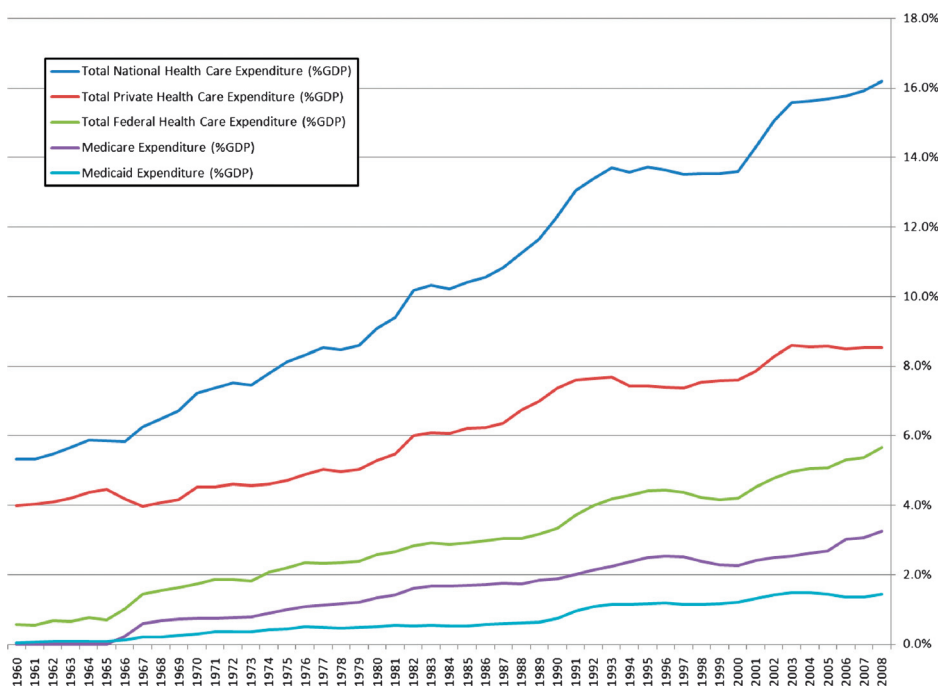


Figure 1. US health care spending as a percentage of the gross national product.

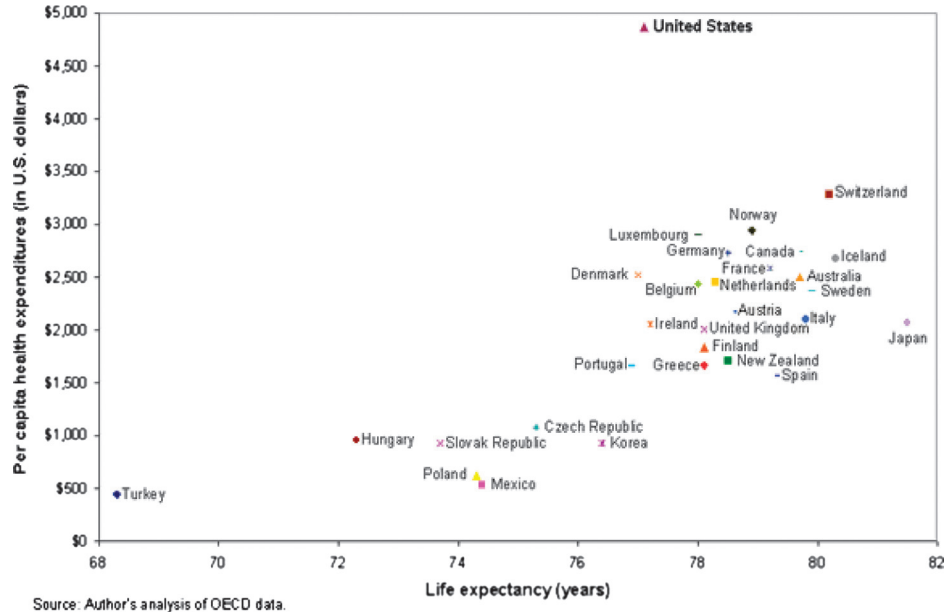


Figure 2. Health expenditures and life expectancy in 30 Organization for Economic Cooperation and Development nations.

approximately 1 in 100,000 of the population at large. We represent a very small percentage of the total population. This small percentage of the population is equivalent to the percentage of the population that are well known artists, for example. Put another way, there are not very many of us, and each of us is special enough that we should have a say in what happens to our patients and our practice environment.

Figure 4 has to do with the training positions in critical care during the past 10 years. You can be trained in critical care through a surgical program, through an anesthesia program, through an internal medicine program without a pulmonary component, through an internal medicine program with a combined pulmonary component, or through a pediatric program. Pediatric critical care takes care of a different population

than the rest of us. In terms of which specialty provides the vast majority of critical care in our country, at least of the numbers coming through the training programs, internal medicine with and without pulmonary component dwarfs the numbers that are coming through in surgery and the even smaller numbers that are coming through in anesthesiology. Based on these training positions, critical care surgeons make up approximately 7.5% of the critical care workforce. For our voice to be heard against that backdrop of a much larger number of internal medicine and pulmonary providers, we are going to have to find ways to make our voice be heard, so that what we do and the importance of what we do is protected in the future.

There are 5800 registered hospitals in the US. Of these 3000, are not for profit. About 1000 hospitals are investor owned.

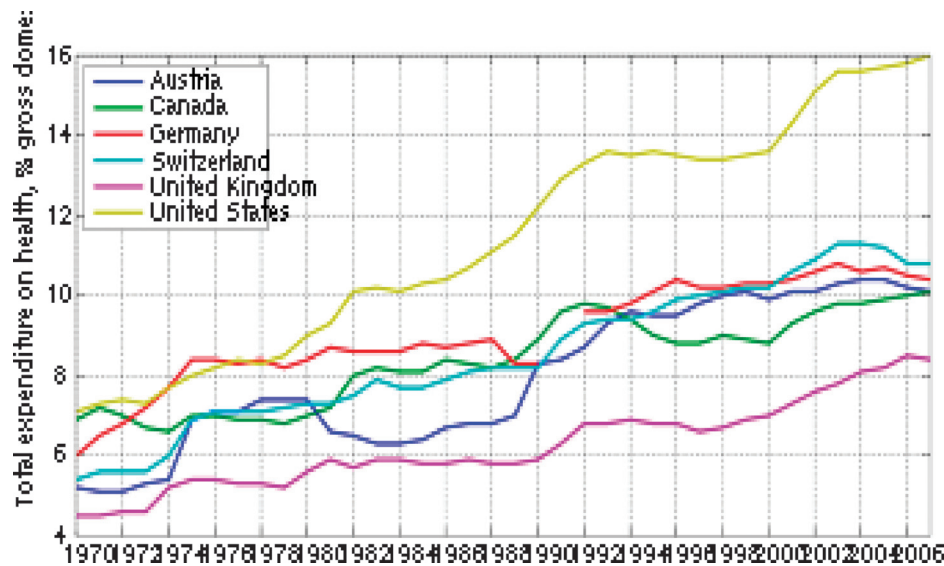


Figure 3. Health care cost rise. (1970–2007)

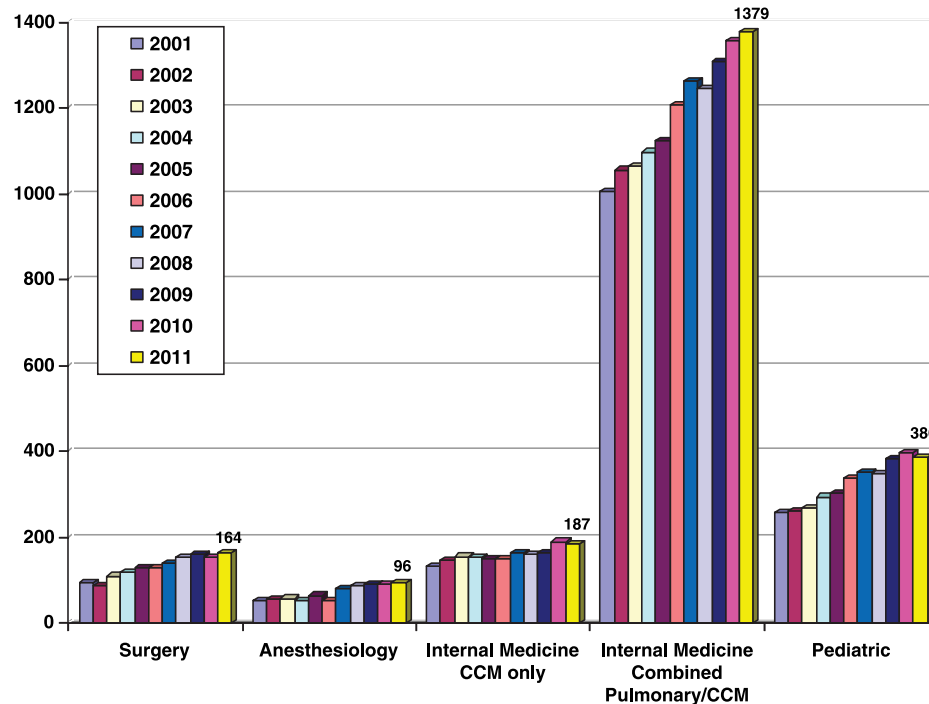


Figure 4. Training positions in critical care during 10 years.

Of the remainder, 1000 are government run. Approximately 800 hospitals are federal or institutional; some of these are attached to prisons and other federal institutions. There are approximately 350 trauma centers across the country. Most acute care surgeons are clustered in this relatively small number of hospitals with trauma centers. For us to get the acute care surgery message out, we are going to need to address the issues of these 5,000 hospitals through what we have experienced in our 350 trauma centers.

Why is it important that we as acute care surgeons define ourselves as we go forward in the future? First, we need to differentiate ourselves from other areas of practice, for example, surgeons who practice only minimally invasive surgery or, for example, our pulmonary colleagues who practice critical care. We need to let the greater medical community and the nation as a whole know that what we do is different from what other medical and surgical specialists do. We need to allow the development of specific service lines and to allow comparison of institutions with acute care surgery programs. We need to generate and measure quality outcomes. If we cannot define our specialty, if we cannot make it clear to the greater public what acute care surgery is, if we cannot define our areas of expertise and state the advantages of having these services available to the hospital, others will define it for us. This is one of the great challenges for acute care surgery.

Are we to become simply nocturnal surgeons? The Discovery Channel had a documentary approximately 10 years ago. It was called "After Midnight." It concerned those people that had work hours between midnight and 6:00 AM. It focused on bakers, the people that run the printing presses, and the people that provide security at the airport. The reason that the Discovery Channel was in a trauma center was that they were

looking at the people that worked the night shift. The program intended to focus on the nurses, but the trauma surgeons were also working during the night hours as part of their 30-hour shifts so we were involved as well. There is certainly a pressing need to provide coverage at night, but no other surgical service was found in the hospital at those hours. The challenge is for us to be seen as more than just those who cover the night shift. The alternative to the "nocturnal surgeon model" for acute care surgery is to define a unique surgical specialty that is of distinct value to health care systems. This is what we are going to have to advocate. We are going to have to advocate that we are more than just the nocturnal surgery service.

A recent patient experience illustrates our problem in defining the benefits of acute care surgery. I had a transfer patient not too long ago. He was a gentleman just older than 50 years. He came from an island that had a hospital but no intensive care unit (ICU). This gentleman had an incarcerated inguinal-scrotal hernia. He had a hernia repair on the small island. Postoperatively, he developed Fournier's gangrene, necrotizing fasciitis, and septic shock. He came on a Sunday afternoon. The gentleman was hypotensive and breathing 40 times a minute. We intubated and resuscitated him. The attending anesthesiologist who was on duty that day was only four months out of training. I sat with her and convinced her that we could get this patient to and through the operating room on that Sunday afternoon. I took the patient to the operating room for serial debridements. I brought him back to the ICU. I continued the resuscitation. He was in acute alcohol withdrawal. I got him through that. I reconstructed his abdominal wall. He was skin grafted. I sent him home in 23 days, awake and alert, walking back to his spouse and 3-year-old child in the islands. He was a very grateful patient.

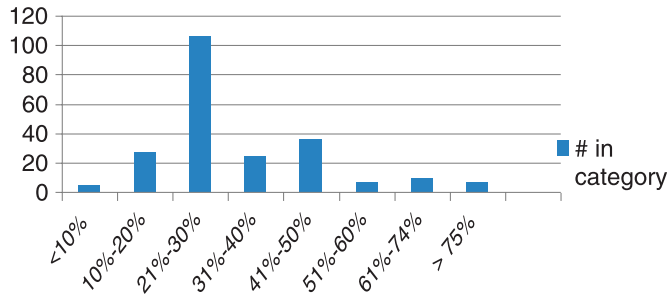


Figure 5. Percentage of time in ICU.

Afterward, the case was reviewed. First, the patient had Blue Cross. We were paid for our care. Second, the family was grateful to our institution. Our satisfaction scores were good.

Lastly, the list of Current Procedural Terminology (CPT) codes was reviewed. The question that was asked was, “Does our minimally invasive surgery fellow not have privileges to do every operation that was done on this patient? Why could a fellow not have done this?” Let me assure you that these questions are being asked in your hospital also. This is our acute care surgery challenge. It does not matter in terms of billing and collections whether the most experienced surgeon or the surgeon who is 1 day out of training is doing the operation. The charge is the same whether you are the most experienced or the least experienced.

I had a chance not too long ago to look at the history of seat belts. I am talking to trauma and acute care surgeons. I do not have to tell you the value of seat belts. Seat belts cut the risk of severe injury in half and the risk of death in half. Seat belts are good medicine. You click the latch; maybe, it wrinkles your clothes, and maybe, it does not. Seat belts save lives. Despite these advantages, seat belts were slow to be used by the population at large for what I think are the same reasons that surgeons are slow to realize the importance of advocacy.

The first seat belt was designed 200 years ago for carriages. Seat belts were used extensively in early aviation; the first seat belt for a car was placed in a Volvo in 1959. Robert McNamara, who eventually became Secretary of Defense for Kennedy, was the Chairman of Ford Motor Company. Ford Motor was the first American manufacturer to routinely put seat belts in American cars. There was a story, told by General Motors executives, that Bob McNamara was trying to sell safety, to which General Motors replied that Bob McNamara may be selling safety, but General Motors was selling cars. From the 1960s to the 1980s, seat belts never really went over with the American public.

It was not until 1983 that the first seat belt law was passed. At that time, the average seat belt use in the United States was 14%. That is one in seven persons who used this restraint device. It is not until relatively recently that seat belt use approached 90% use. The high percentage use is not because we know that seat belts are good for us. It is because we are afraid of the ticket we are going to get if we do not wear the seat belts.

This speaks to human behavior. Common sense should justify the use of seat belts, yet for 23 years, we as a population in this country did not use them frequently. Why is it that we

do not do things that we know are good for us, both us as surgeons and in our greater society, until we see negative consequences? Perhaps, human behavior requires negative consequences before changes in behavior are seen. Thus, I will pose that as an answer as to why surgeons as a group are not participating in large numbers advocacy.

SURVEY OF MEMBERSHIP

I did a survey in preparation for this talk. More than 300 of you answered that survey. Thank you very much. At the end of the survey, people had a chance to write comments. One person wrote and said, “I hope that EAST does not become an advocacy organization.” We cannot become an “advocacy only” organization. We are a 501(c)(3) nonprofit organization. We can certainly become an organization that trains you how to think and how to think decisively. We can teach skills. We cannot tell you what to think. Dr. Cotton and his Advocacy and Outreach Committee have created resources, both here at the meeting and on our Web page to help with this. We need to advocate for ourselves at the local, regional, and federal levels. To do that, we must bring to our institutions and to our lawmakers ideas about why we are special and the value that we bring to the hospital.

Let me talk about who our EAST members are and how we can serve them. The age of EAST members, not surprisingly, is relatively young. Surgeons are in their early 30s before finishing training. Most of the EAST members are between 40 years and 49 years, but we have a good number of senior members as well. Almost a quarter of our members are female.

There was sort of a trick question that I placed on the survey. The question was “What is your primary area of practice?” Remember acute care surgery includes emergency general surgery, surgical critical care, and trauma. Almost half of our members identify themselves as acute care surgeons, but a substantial proportion see themselves as performing trauma only. There are those that do emergency general surgery and a small number that identify themselves as surgical intensivists or surgical critical care providers.

What is our practice environment? For our EAST members, it is mostly academic, although there are substantial proportions that are hospital system employed.

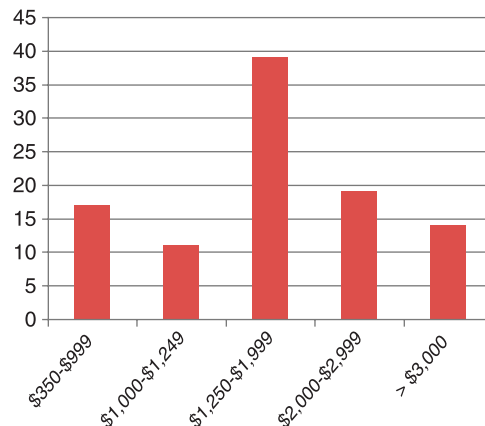


Figure 6. On-call compensation.

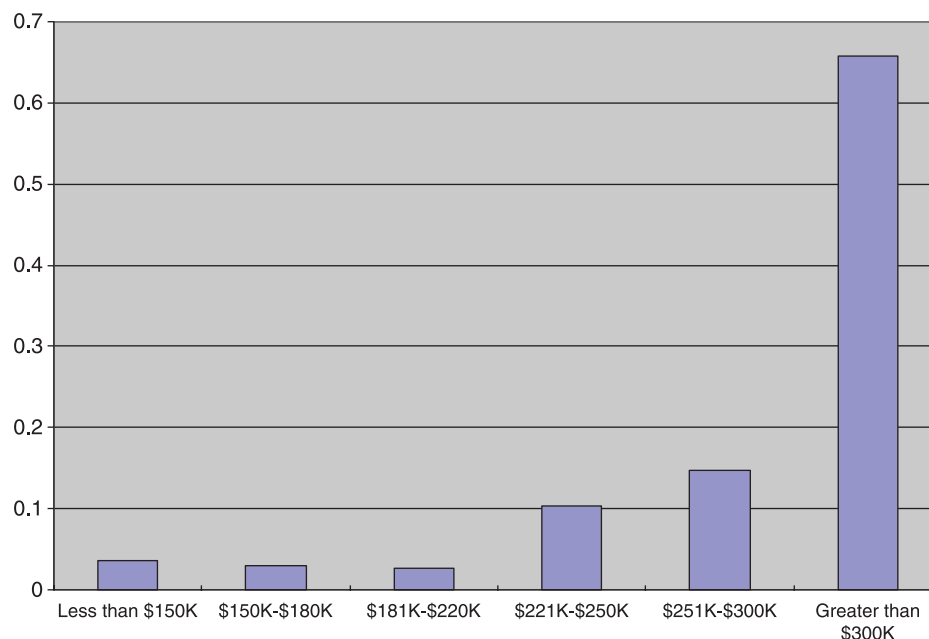


Figure 7. Income distribution.

How many nights of call per month do you take? Most of the surgeons cover between one and five, but there are some persons taking six to ten. I am hoping that someone misunderstood my question because there are respondents who answered that they take more than 20 nights on call. I do not know if they are actually living in the hospital or if they just never get home.

How many do minimally invasive surgery? Of our group, 87% performs minimally invasive surgery. To my surprise, approximately 60% to 70% perform advanced minimally invasive surgery, with an average of five to six cases a month.

How many cover the ICU? Ninety-two percent. Almost all of us are intensivists. What percentage of the time are we spending in the ICU? It is a normal distribution. There are some who apparently are spending a lot of time in the ICU and probably do not have much time to operate. Most of us are spending approximately 20% to 33% of our time working in the ICU. We are very much a society of intensivists. Acute care surgeons are intensivists who operate. We understand the deranged physiology of the sickest patient in the hospital. We are well trained, busy intensivists who also operate with a skill set equal to that of surgeons who do not care to think about patients with critical illness and deranged physiology (Fig. 5).

I had some financial information questions as well. On-call duty was part of the contract for 83%. Only approximately a third has a financial bonus for taking extra call. On-call compensation ranged from a low of approximately \$350 to \$5,000. At the upper end of the scale were those who included not just the on call pay but the collections from private billing as well. Because of this some of the reported incomes were quite high. For most of the respondents, a night on call is worth somewhere between \$1,200 and \$2,000 (Fig. 6).

This is our self-reported incomes. Two thirds of us are making more than \$300,000 a year. I was surprised by this, but we are doing very well. As Rich Carmona said to me, you cannot

go to a congressperson who works day and night and makes half of what you do and claim that you are not doing well enough financially. When we advocate for ourselves, it must be about patient safety, training, and a safe environment to operate on our patients. When we advocate for our profession, we must speak on the issues of patient safety, resident training and providing a safe hospital environment. Because we are a group of financially fortunate individuals, we must not speak solely or even at all about our remuneration. To do so, would be to lose the impact of the other points that we must convey. (Fig. 7).

ADVOCACY

There are four stages of advocacy. First, we can vote for the right candidate. You show up and vote. I am sure all of us do that. Next, we can support the campaign of a candidate that shares our views. Not a lot of us are doing this. Third, we can share expert opinion on pending legislation. Who knows more about what we do than we do? We need to be available to the legislators that are writing these bills that affect us directly to tell them what the world really looks at ground level. Lastly, someone has to write the legislation that is proposed by our representatives. Who is better to write it than those of us who directly live it? We need to be writing the first drafts of legislation that directly affects our patients, our work environment, and us.

The survey asked, "Do you know the name of your congressperson?" Three quarters said yes. Of our highly educated physician membership, one quarter had no idea who their congressperson was. We have to do better than that. The survey asked, "Have you met your congressperson?" Only 22% of us have met our congressperson. We are "1 in 100,000" type of people. Our congresspersons need to know who we are. Maybe they do not need to know you by name, but they need to

know your face. When you are in Washington, DC, make an appointment with your representative. Maybe, the first time you will get to see a staff member. Maybe, the second time you will get to see the congressperson. Senators are harder to see. However, all who represent us in Washington need to know us and know what we do.

We asked if the respondent contributed to a political campaign in 2008 or 2010. In both cases, the answer was that 16% contributed. Eighty-four percent did not contribute. What about the American College of Surgeons Political Action Committee (ACS PAC)? Of the people that took this survey, two thirds had not contributed to the ACS PAC. If you agree with 80% of what the ACS PAC does, give them some money. Then write Dr. John Armstrong, Chair of the ACS PAC, and tell him about the 20% you do not agree with. Of the 60,000 eligible members who could contribute to the ACS PAC in 2010, only 4% contributed. However, when they sent out a membership survey, 30% of the respondents thought that they are members of the ACS PAC. If you are earning greater than \$300,000 a year, putting aside \$1,000 each year is one third of 1% of your gross income. This would allow us, in every 2-year election cycle, to contribute a full \$2000 to the election campaign of your choice.

THE NEXT 25 YEARS

Most importantly, we need to define our specialty. We need to define the specialty of acute care surgery, and specifically state how that is different from what other surgical specialists do. Many acute care training programs are doing different things with the second year of the training. Some of the most impressive things I have heard are rotations on the interventional radiology service. We need to continue to push to make our specialty look different from other surgical specialties. A number of talented individuals have tried to get us our own CPT codes. This is not going to happen during the next year, and it is not going to happen in 10 years, but it might happen in 25. Eventually, we are going to need our own CPT codes, so that on the occasion an accountant or administrator asks what is unique about what we do, it is going to be explained by unique CPT codes. I think it is realistic to hope that by the 50th anniversary meeting of EAST, we will have our own CPT codes. This effort may be difficult and contentious, but it is something we are just going to have to do. We need to begin to advocate for ourselves, for our patients, for our profession, for our trainees, and for our future. We need to advocate locally, within our own hospitals, regionally, at the county and state level, and at a national level. Our group of highly trained trauma surgeons who represent a "1 in 100,000" kind of talent is not grassroots. That is what we call grass-top, but you have still got to get in the game.

Let me tell you a bit about the kind of patient that only a trauma and acute care surgeon can care for. An 18-year-old patient, in a case of mistaken identity, was assaulted by two professionally trained hit men. This young man was not a criminal. He had never been convicted or, to my knowledge, committed a crime. He lived in the Haitian-American com-

munity in Miami. He was mistaken as a drug dealer. Two men were sent to his home to kill him and take his drugs. In the time that it took to bring the door down, the young man was able to jump into the closet of his bedroom to hide. Fortunately for the victim, this event occurred during the peak of the hot Miami summer.

The two men came into his room. They saw the victim in the closet. This young man was holding the closet door as hard as he could, so one of the assassins had to put his gun down and pull the door open while the other one shot at the victim at close range. In the ensuing fight over the closet door, it got so hot that the hit men took off their ski masks. They left the victim when they thought he was dead. This young victim was shot 14 times in the chest, abdomen, and upper leg.

The patient was brought to the trauma center with a very low blood pressure. We raced him back to the operating room. We placed bilateral chest tubes, we opened him and performed a 3-hour long resuscitative operation. I literally operated on every intra-abdominal organ. We used a combination of cell saver and blood bank blood. Every injury that could be stapled was stapled in a damage control fashion as fast as we could go.

When I was done, I took him up to the ICU, where one of my colleagues continued the resuscitative effort. As his blood pressure came up by the next morning, it became apparent that he had an arteriovenous fistula between the femoral artery and the femoral vein. My colleague and EAST member Peter Lopez took him back to the operating room and was kind enough to fix that injury for me the next day. That young man left the hospital 28 days later. He walked out neurologically intact to go and lead the rest of his life. I did not see him for months, until I was called to testify at the trial of the two hit men. They had taken their masks off thinking that this young man was not going to live. He was able to identify them to the police. They were arrested, tried, and convicted, and both are serving two life sentences plus 20 years.

The fact of the matter is that what we do matters very much. It mattered very much for this young man that there were people there, not only myself but also others, who could take somebody shot 14 times at point-blank range by two professional killers and save his life. It is important for that young man who is not a criminal, who never committed a criminal act, who will go on to live a long life.

What we do is important. It is important that we have future surgeons who are trained to that kind of advanced surgical care. That is why we have to get out and advocate for our profession and our patients. We need to explain to the country at large what it is that we do and why we are different from other medical and surgical specialties. In the future, we need to educate our residents, fellows, and young surgeons how to provide that kind of effort. That is why it matters, and that is why we have to get in the advocacy game.

Thank you very much. It has been my pleasure to serve. I look forward to the next 25 years.

DISCLOSURE

The author declares no conflict of interest.