



# Joint Surgical Advocacy Conference

Grand Hyatt Washington Hotel

Washington, DC

March 22 – 24, 2009

## Program Agenda

### Sunday, March 22

- 7:00 am – 6:30 pm      Registration (*Independence A Foyer*)
- 6:00 pm – 7:30 pm      Opening Reception (*Independence A*)
- 7:30 pm                      Dinner On Your Own

### Monday, March 23

- 7:00 am – 5:00 pm      Registration (*Independence A Foyer*)
- 7:00 am – 7:30 am      Breakfast (*Independence A Foyer*)
- 7:30 am – 7:45 am      Opening Remarks (*Independence A*)
- 7:45 am – 9:15 am      Advocacy Training (*Independence A*)  
*Michael E. Dunn, President,*  
*Michael E. Dunn & Associates*
- 9:15 am – 10:30 am      Understanding Congress (*Independence A*)  
*Judy Schneider, Specialist on Congress,*  
*Congressional Research Service, Library of Congress*
- 10:30 am – 10:45 am      Break
- 10:45 am – 12:00 pm      Communications & Message Development (*Independence A*)  
*Patricia A. Clark*
- 12:00 pm – 12:15 pm      Break for Lunch
- 12:15 pm – 1:30 pm      Lunch Key Note Speaker (*Independence B, C, D, E*)  
*Paul Begala*  
*Political Analyst and Commentator, CNN*
- 1:30 pm – 1:45 pm      Break
- 1:45 pm – 2:30 pm      Views from the Obama Administration –  
The Quality Improvement Agenda (*Independence A*)  
*Carolyn M. Clancy, MD, Director*  
*Agency for Healthcare Research and Quality*

- 3:00 pm – 4:00 pm Perspectives on Health Care Reform (*Independence A*)  
*Cheryl Jaeger, Rep. Eric Cantor, R-VA*  
*Meghan Taira, Sen. Charles Schumer, D-NY*  
*Maria Ghazal, Director of Public Policy,*  
*Business Roundtable*  
*Scott Keefer, Vice President of Federal Affairs,*  
*America's Health Insurance Plans*
- 2:30 pm – 5:30 pm Individual Members of Congress (*Independence A*)  
*Representative Roy Blunt (R-MO)*  
*Representative Shelley Berkley (D-NV)*  
*Senator Tom Carper (D-DE)*  
*Representative John Shadegg (R-AZ)*  
*Senator Ben Cardin (D-MD)*  
*Representative Diana DeGette (D-CO)*  
*Representative Frank Pallone (D-NJ)*
- 5:30 pm – 5:45 pm Break
- 5:45 pm – 6:15 pm Buses Depart for Capitol Hill
- 6:00 pm – 7:30 pm Congressional Reception (*Longworth House Office Building,*  
*Committee on Ways and Means, Room 1100*)
- 7:15 pm – 7:45 pm Buses Depart for Grand Hyatt Hotel and PAC Fund-Raiser
- 7:30 pm – 9:30 pm Surgical Society Political Action Committee Fund-Raiser  
*(open to contributors to the PACs sponsoring the reception)*  
*101 Constitution Ave, NW, the Rooftop*

## **Tuesday, March 24**

- 7:00 am – 8:00 am Breakfast and Congressional Visit Planning & Issue Q & A by  
Surgical Society Staff (*Independence BCDE*)  
*(Attendees will divide into groups by state and congressional*  
*district to organize visits)*
- 8:00 am – 8:15 am Political Action Committee Raffle (*Independence BCDE*)
- 8:15 am – 8:30 am Break for Buses to Capitol Hill
- 8:30 am – 9:30 am Buses Depart for Capitol Hill
- 9:00 am – 2:30 pm Congressional Visits (*Capitol Hill*)
- 10:30 am – 2:30 pm Lunch & Congressional Visit Debriefing Room (*Rayburn*  
*House Office Building, Room B-340) (Box Lunch Provided)*
- Various Times Conference Attendee Departures

***(All times and events are subject to change)***



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### WRITING AN EFFECTIVE LETTER TO MEMBERS OF CONGRESS

When you write a thank you letter after your visit, or whenever you decide to write your legislators, this list of suggestions may be useful:

1. Keep your letter reasonably brief (no more than one page) and limit your subject matter to one subject.
2. Begin by thanking the Member for meeting with you and repeat your main purpose for the meeting (or state your main purpose for the letter) in the first paragraph. **If your meeting was with staff, consider directing the letter to the Member acknowledging your appreciation of the staff by name – your goal is to communicate with the Member.**
3. Explain your surgical society's position and give the Member reasons for supporting our position. Your individual perspective can make a crucial difference.
4. Be courteous, to the point, and include key information, using examples to support your position.
5. Ask for a response to a direct question, such as, "Will you cosponsor H.R. 123? Please let me know your position."
6. Never threaten or beg a Member of Congress. Always appeal to the Member on the merits of an issue.
7. Offer to serve as a resource to the Member and his or her staff on health issues.
8. Write to your member at these addresses:

The Honorable (full name)  
United States Senate  
Washington, DC 20510

The Honorable (full name)  
United States House of Representatives  
Washington, DC 20515

Dear Senator: \_\_\_\_\_

Dear Representative: \_\_\_\_\_

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# Surgery's United Agenda for Medicare Physician Payment Reform

## Surgery's Top Priorities

The surgical community stands united in the effort to bring fundamental and long-term change to the Medicare physician payment system. The House of Surgery has three top priorities for this effort:

1. **Repealing** the current sustainable growth rate (SGR) and establishing a new baseline for the physician payment system;
2. **Replacing** the current SGR with a system of multiple conversion factors; and
3. **Ensuring** that any additional payments that are made to primary care physicians are not budget neutral within the physician payment pool.

In addition to the above priorities, the surgical community has developed common positions on a number of key issues.

## Primary Care and the Medical Home

The surgical community supports the medical home demonstration project. However, it is important to wait to see the results from the demonstration project before supporting continued expansion. If the medical home model shows cost savings and value, these savings should stay within the medical home. The surgical community also believes that medical homes can be led by non-primary care physicians. The medical home should always ensure that patients have continued access to high quality surgical care. Finally, any additional payments to primary care physicians, to fund the medical home or for any other reason, should not be budget neutral within the physician payment pool.

## Quality Improvement Initiatives

Surgery understands that all segments of the health care population find a great deal of value in the collection and analysis of physician quality data and that it is important to provide patients, the public and physicians with accurate information on physician quality. The surgical community believes strongly, however, that the current Physician Quality Reporting Initiative (PQRI) is not working, and therefore needs to be drastically reworked. The program needs to provide physicians with access to their data in a timely manner and it must have a reasonable appeals process. Both the timely access and the reasonable appeals process are missing from the current program. Due to the significant problems with the current PQRI program, public reports using this information should be delayed until further evaluation and improvements occur. The surgical community also believes that physicians participating in clinical database and registry programs should continue to be eligible for PQRI bonus payments. Additionally, further federal funding to develop clinical data registries and other quality improvement tools is necessary.

Finally, in addition to moving to a program that is based on clinical outcomes, the program needs to continue to be voluntary and provide positive incentives for participation.

### **Performance Measurement and Transparency**

The surgical community believes performance measurement should be non-punitive and transparent. There needs to be meaningful and accurate clinical outcomes and processes of care data generated by physicians before performance measurement can be successful. In addition, any performance measurement system must provide data to providers on how they compare with their peers – this should be done in a confidential and non-punitive manner. Payer data should also be transparent. Finally, there should be no government mandates until a system is appropriately tested.

### **Comparative Effectiveness**

The surgical community embraces the need for comparative effectiveness research. Any comparative effectiveness research should be a tool to improve care on a per patient basis by providing information on clinical value of varying treatments and interventions. Finally, comparative effectiveness research should focus on communicating research results to patients, providers and other decision-makers, and should not be used for determining medical necessity or making coverage and payment decisions or recommendations.

### **Innovative Payment Options**

Surgery supports the development of new innovative payment models that involve the patient, physicians and payers. Surgeons support the concept of incentive payment or shared savings programs between hospitals and physicians and encourage the removal of any legal barriers that may restrict these types of arrangements. In addition, the surgical community is supportive of pilots and demonstration projects to determine if bundling payments is an appropriate mechanism to improve the Medicare payment system. Physician payment mechanisms that move beyond the current system of payment for more services or more complex services should be explored.

### **Physician Ownership**

Physicians should have the ability to responsibly and professionally own, either individually or through a joint venture (with hospitals and/or other physicians), facilities, equipment, and services that appropriately provide high quality care for patients. Physicians should be obligated, however, to disclose this ownership information to the public.

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## Improving Medicare's Physician Reimbursement System

On January 1, 2010, Medicare payments for all physician services are scheduled to be cut by nearly 22% as a result of Medicare's flawed sustainable growth rate (SGR) formula. On top of the pending 22% cut, the SGR formula also requires annual Medicare payment reductions through 2016, for cumulative cuts of over 40% over the next six years. In July 2008, Congress passed a stop-gap measure which prevented a 10.6% reduction in Medicare physician payments, and instead provided a 0.5% increase for the remaining six months of 2008. Congress also replaced a scheduled 5.4% cut in 2009 with a 1.1% increase; however, it did not address the long-term problems with the payment formula.

The SGR formula was created to control Medicare physician spending by setting annual targets for allowable spending growth. Whenever a target is exceeded, the additional spending must be recouped in future years. This results in payment cuts for all physician services, regardless of whether utilization of a particular service actually grew beyond the limits of the SGR. Consequently, services with relatively inelastic demand and lower rates of growth, such as surgical services, are subjected to the same cuts as rapidly growing services that exceed the limits of the SGR. This is but one of the flaws with the current system. Moreover, since the late 1980s, surgical reimbursements have steadily declined and payments for many procedures are at least one-half of what they were almost 20 years ago. Additional regulatory changes over the past two years have compounded this problem by reducing payments for many surgical services.

All physicians, Members of Congress and other policymakers agree that the SGR formula should be eliminated. It is understood that if the 22% cut is implemented, it will pose particular challenges for patient access to surgical care. The challenge facing physicians, particularly surgeons, is further complicated by rising practice costs, including medical liability premiums and health information technology systems, the burdens of emergency care coverage, and a workforce growth rate that is not keeping pace with an aging population.

**Congress must act this year to halt the scheduled 22% cut and prevent future reimbursement cuts by replacing the SGR formula with a stable mechanism for updating physician reimbursement. We support system reforms that would recognize the unique nature of the different types of services physicians provide to their patients and recommend that the SGR be replaced with a system of separate physician service category targets or multiple conversion factors for use in calculating Medicare payment updates. In addition, the new system must be fundamentally fair for *all* physicians, and any additional payments that are made to primary care physicians must not be budget neutral within the physician payment pool.**

**To ensure that Medicare patients continue to have access to surgical care, Congress must do the following:**

- **Stop the 22% cut from going into effect on January 1, 2010;**
- **Increase Medicare payments in 2010 to account for the growth in the cost of providing quality health care;**
- **Repeal the current SGR formula and establish a new baseline for the physician payment system; and**
- **Replace the current SGR formula with a system of multiple conversion factors.**

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## Exploring Innovative Medicare Payment Models

Surgeons support the development of new innovative payment models that involve the patient, physicians and payers and encourage providers in different settings – physician offices, hospitals and others – to collaborate and provide patient-centered care. Exploring innovative Medicare payment models that break down the current Medicare payment “silos” should help align incentives in a way that improves quality and saves money to the overall Medicare system.

While many of these models are not yet fully tested and proven and therefore cannot be implemented in the near future, Congress should continue to conduct pilot studies and demonstration projects to evaluate modifications to current payment systems that encourage – rather than discourage – collaboration and accountability among health care providers across treatment settings and sites of care. **We recommend the following:**

- **Further Test and Evaluate the Medical Home** – Surgeons support the medical home demonstration project. However, it is important to wait to see the results from the demonstration project before supporting continued expansion. If the medical home model shows cost savings and value, these savings should stay within the medical home. The surgical community also believes that medical homes can be led by non-primary care physicians. The medical home should always ensure that patients have continued access to high quality surgical care. Finally, any additional payments to primary care physicians, to fund the medical home or for any other reason should not be budget neutral within the physician payment pool.
- **Examine and Assess Shared Savings Programs** – Surgeons support the concept of incentive payment or shared savings programs between hospitals and physicians, otherwise known as gainsharing, and encourage the immediate removal of any legal barriers that may restrict these types of arrangements. In addition, the surgical community is supportive of pilots and demonstration projects to determine if bundling payments around discrete episodes of care is an appropriate and viable mechanism to improve the Medicare payment system. It is critical that these service bundles are developed through transparent processes that include appropriate representation by physicians. Finally, further data evaluating accountable care organizations may be useful, but we caution that this approach may be of limited utility and not be capable of widespread implementation due to the way in which physician practices are currently structured.
- **Encourage Appropriate and Effective Care** – Surgeons believe that we need to conduct additional studies to evaluate appropriate utilization of services and to obtain and analyze data on the growth in utilization of services and quality of services by condition, type of service, region and specialty. Physician payment mechanisms that move beyond the current system of payment for more services or more complex services should therefore be explored. Methods for providing accurate, confidential and comparative information to individual physicians on how their utilization and quality compares to their peers – locally and across the country – should be adopted, provided this is conducted for the purpose of educating – not financially penalizing – physicians.



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## Improving Trauma and Emergency Care

The emergency healthcare system in America is in crisis. And while many states have made great strides in developing effective trauma care systems, significant gaps in our trauma and emergency healthcare delivery systems still exist. This was confirmed by the June 2006 Institute of Medicine's three report-series on the future of the nation's emergency care system, and by the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group's (TAG) March 2008 report to the Secretary of the Department of Health & Human Services. These reports revealed that hospital emergency departments and trauma centers across the country are severely overcrowded, emergency care is highly fractured, and critical surgical specialties are often unavailable to provide emergency and trauma care. The IOM found that a coordinated, regionalized, accountable system based on the current trauma care system model should be created. The EMTALA TAG report included numerous recommendations for enhancing the emergency medical system, including improving reimbursement for EMTALA-mandated care (which is often not reimbursed) and adopting medical liability protections. **To ensure patient access to emergency and trauma care, we recommend that Congress support:**

- **Regionalization of Emergency Care** by: (1) authorizing multi-year grants to support demonstration programs aimed at designing, implementing, and evaluating regionalized emergency care systems; and (2) providing funding for the Trauma-EMS Systems Program.
- **Improved Reimbursement for Emergency Services** by: (1) providing physicians a tax deduction equal to the amount of the Medicare fee schedule payment; (2) providing a 10% added bonus payment through Medicare to all physicians, including on-call specialists, who provide EMTALA-related care to Medicare beneficiaries; (3) allowing all Medicare participating hospitals to include stipends paid to physicians providing emergency on-call services on their cost reports; (4) providing necessary funding to trauma centers that are at serious risk of closing due to the continual increase of uncompensated and charity care costs; and (5) establishing a dedicated federal funding source for payments to providers for uncompensated emergency healthcare services.
- **Medical Liability Protections** by: (1) requiring any lawsuits against physicians who provide EMTALA-mandated care be brought under the Federal Tort Claims Act; and (2) providing immunity or limited liability for certain medical personnel involved in the evacuation or treatment of patients during a declared state of emergency.

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## Ensure Truth and Transparency in Patient Care Advertisements

Policymakers are seeking ways to provide patients with additional information about their health care providers, empowering them to make informed health care choices. Due to increased ambiguity of health care-related advertisements and marketing, recent studies confirm ongoing patient confusion when identifying the numerous types of health care providers and their relevant training. Physicians, technicians, nurses, physician assistants, and other allied health professionals all play an important and distinct role in the health care delivery system. However, America's patients deserve to be fully informed and able to easily identify their health care providers' credentials, licenses, and training when seeking treatment. **Therefore, we support legislative efforts that would strengthen patient autonomy and decision-making with accurate information about health care providers and enhance clarity in health care provider-related advertisements and marketing.**

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## Enhancing Quality Improvement Initiatives

Surgeons understand that all segments of the health care population find a great deal of value in the collection and analysis of physician quality data and that it is important to provide patients, the public and physicians with accurate information on physician quality. To demonstrate our commitment to provide the highest quality surgical care to patients, our organizations are actively engaged in developing evidence-based and clinically relevant quality measures and establishing clinical data registries. To be successful, however, surgeons believe that performance measurement should be non-punitive and transparent. Furthermore, meaningful and accurate clinical outcomes and processes of care data must be generated by physicians. Finally, any performance measurement system must provide data to providers on how they compare with their peers, and this should be done in a confidential and non-punitive manner. Unfortunately, while Congress has taken the first steps towards implementing informed quality improvement programs, the current Medicare Physician Quality Reporting Initiative (PQRI) is not working and needs to be drastically reworked. **We therefore make the following recommendations:**

- **The PQRI program needs to provide physicians with access to their data in a timely manner and it must have a reasonable appeals process.**
- **Due to the significant problems with the current PQRI program, public reports using this information should be delayed until its validity has first been verified.**
- **Physicians participating in clinical database and registry programs should continue to be eligible for PQRI bonus payments.**
- **Quality reporting should continue to be voluntary and Congress should provide positive incentives for participation.**
- **Congress must recognize the increased systems cost to report quality measures and collect clinical data and should provide physicians with adequate funding to implement quality reporting requirements.**

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## Investing in Healthcare Research

Surgeons are committed to advancing the public health by fighting diseases, developing treatments, and finding cures through continued medical research. Institutions, such as the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ), are leading the way to help improve our nation's health and save lives. Surgeons also embrace the need for well-designed *clinical* comparative effectiveness research (CER), which can be a valuable tool to "learn what works in healthcare" and support good clinical decision making. CER must focus on communicating research results to patients and physicians, and should not be used for making centralized coverage and payment decisions.

In order to make the discoveries today that will heal tomorrow's patients, medical research needs to be fully funded. The recently passed American Recovery and Reinvestment Act (P.L. 111-005) makes a significant commitment to this vital research by appropriating \$10 billion for NIH and \$1.1 billion for CER and represents an unprecedented opportunity to improve the quality of care for all Americans.

**Going forward, we urge Congress to:**

- **Provide sustained and adequate funding for the NIH (and its twenty-seven Institutes and Centers) and clinical CER initiatives;**
- **Ensure that comparative effectiveness research is conducted in a fully open, transparent and accountable process that gives surgeons a significant voice in determining CER funding priorities and study design and processes.**



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### Ensuring Children's Access to Reconstructive Surgery

According to the March of Dimes, 3% of babies born annually (120,000) suffer from birth defects. Of that 120,000, approximately 40,000 children require reconstructive surgery. Examples of these deformities include cleft lip, cleft palate, skin lesions, vascular anomalies, malformations of the ear, hand, or foot, and other more profound craniofacial deformities. Although surgeons are able to correct many of these problems, often, insurance companies deny or delay access to care by labeling the procedures "cosmetic" or "non-functional" in nature. According to one report, nearly 54% of plastic surgeons had pediatric patients who have been denied insurance coverage, or have experienced significant and deleterious obstacles in obtaining approval for coverage of surgical procedures. A statutory requirement for insurance coverage of children's deformities is therefore necessary to prevent insurance companies from denying medically necessary reconstructive care.

The **Children's Access to Reconstructive Evaluation & Surgery (CARES) Act (H.R. 1339)** has been re-introduced in the 111<sup>th</sup> Congress by Reps. Carolyn McCarthy (D-NY), Patrick Tiberi (R-OH), and Bart Gordon (D-TN). This bi-partisan legislation requires insurance companies to provide coverage for the treatment of a minor child's congenital or developmental deformity or disorder due to trauma, infection, tumor, or disease. According to CBO, the CARES Act is expected to have a negligible impact on revenue. **To ensure children's access to medically necessary reconstructive surgery Members of Congress are urged to co-sponsor H.R. 1339, the CARES Act, and the Senate companion bill soon to be re-introduced by Senator Landrieu (D-LA).**

### Preserving Patient-Centered Healthcare

Physician-owned ancillary services, including diagnostic imaging, specialty hospitals and ambulatory surgery centers (ASCs) result in demonstrated improvements to the nation's healthcare system. The ability to provide diagnostic imaging for patients in an office setting significantly improves the quality and efficiency of care delivered, is convenient for patients and increases patient satisfaction. Similarly, the benefits of physician-owned specialty hospitals result in cost-effective care; lower infection, complication and mortality rates; shorter hospital stays; and a marked increase in patient satisfaction. Patients who seek care at physician-owned ASCs also reap these same benefits, receiving high-quality, cost-effective, and patient-centered healthcare.

Cuts in payment rates for ASCs and diagnostic imaging, and prohibitions on physician-owned hospitals threaten the viability of these beneficial patient-centered healthcare arrangements. **Congress should preserve the right of physicians to refer patients to ancillary services (including diagnostic imaging equipment, specialty hospitals and ASCs) that they own and operate, and Medicare payment rates must be adequate to ensure that patients have continued access to these critical patient-centered healthcare services.**

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# Improving the Surgical Workforce and Preserving Quality Resident Training

The future supply of surgeons is woefully inadequate to provide the care that our citizens will require, and one recent study determined that by the year 2025, the nation will face a shortage of 41,000 surgeons. Training a healthcare workforce to successfully serve the needs of the nation requires stable, long-term, predictable funding given the length of time required to educate and train surgeons. Unlike training for primary care physicians, which only takes 3 years, it takes up to 8 years for some surgical specialties to complete their medical residency training. Lifting the cap on Medicare-funded residency positions, as established by the Balanced Budget Act of 1997, must be done as soon as possible so that more U.S. medical students can begin the rigorous surgical residency training process to help stave off the surgical workforce crisis.

Any changes to surgical residency training programs should also be viewed in light of these workforce challenges. Surgeons believe that further mandatory reductions in resident duty hours could produce a generation of surgeons who will not be as skilled or committed as their predecessors and will fall short of public expectations. In addition, adherence to strict duty hours could lead to medical errors attributable to more frequent patient handoffs, fragmentation and loss of continuity of care. To counter this, surgical residencies will be forced to lengthen their programs. This would create an additional deterrent to medical students considering surgery as a career, many of whom are already daunted by the prospect of five to eight years of surgical training and the overwhelming educational debt burden this creates. Concerns about resident fatigue must therefore be balanced with the need to adequately train surgical residents and ensure quality patient care.

**To ensure an adequately trained surgical workforce, we recommend:**

- **Preserving Medicare funding for GME and eliminating the residency funding caps;**
- **Fully funding residency programs through at least the initial board eligibility;**
- **The Accreditation Council for Graduate Medical Education (ACGME) is effectively addressing issues related to resident training and fatigue and legislation or federal regulation is therefore unnecessary.**

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## Alleviating the Medical Liability Crisis

Medical liability insurance premiums have risen steadily over recent decades, at times increasing an average of 15% a year, and some states and specialties have seen even more dramatic increases. Although medical liability premiums have stabilized over the past year or two, premiums remain prohibitively expensive for many physicians. For example, according to the *Medical Liability Monitor*, in 2008 rates for some OB-GYNs in Florida were approximately \$215,000; in Illinois they were \$178,000 and were \$194,000 in New York. In contrast, in Texas, premiums have steadily decreased since the passage of reform legislation and now in some parts of that state OB-GYNs pay as little as \$26,000. Surgeons support legislation which provides common sense, proven, comprehensive medical liability reform and are open to testing alternative reforms.

**To alleviate the medical liability crisis and ensure patient access to surgical services, Congress should pass Federal legislation:**

- **Modeled after the laws in California or Texas, which includes reasonable limits on non-economic damages;**
- **Providing medical liability protections for physicians who follow established evidence-based practice guidelines;**
- **Studying alternatives to civil litigation, including: early disclosure and compensation offer; the administrative determination of compensation model; and health courts.**