Building and Maintaining a Successful Surgery Program in Rural Minnesota

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For decades, it has been axiomatic that rural health care systems are crucial factors not only in the health of the populations that they serve but also in the viability of America's rural communities. Medical care, as it is delivered in rural America, is becoming increasingly problematic as national health care delivery models continue to evolve. Increasing reimbursement pressures and changing practitioner lifestyle expectations had a variety of negative effects on the health of rural communities and the populations they serve. The results of those pressures have consistently and repeatedly been manifested across the country by rural hospital closings[1] and a declining level of surgical care available. These two factors are interrelated, given the importance of surgical services to the revenue stream of any hospital.

Our involvement with rural surgery programs—our own, at two rural critical access hospitals (CAHs); our regional rural surgery service consulting work; statewide conferences; and national venues, such as the semiannual Rural Surgery Symposium sponsored by the Mithoefer Center for Rural Surgery[2]—has led us to the conclusion that the basic model for rural surgery practice in America is in serious

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jeopardy as reimbursement and provider models evolve. The conventional rural surgery model of providing hernia/gallbladder surgery, basic trauma, cesarean sections, and basic gynecologic and orthopedic surgery is going to have limited and decreasing sustainability in the coming years. This has been troubling as we see these things representing the basic thrust of this country's nascent rural surgery postgraduate training programs. They must be a vital component of such training, but by themselves, they represent rural surgical programs that are ultimately doomed to failure as a broad-based solution to the surgical needs of the rural populations and the viability of the health care institutions that those programs need to serve. These conventional programs may serve to meet current local needs, but they emphasize breadth of services rather than depth, and, without the background or resources available to provide modern, advanced surgical services, their ability to grow and compete is impaired. Their growth becomes dependent entirely on the growth of their local populations rather than providing a viable alternative to larger nearby institutions.

Our experience has been that a rural surgery program does have to be broadly based in the service it provides but to sustain its growth, it must be surgeon directed and centered on modern surgical practice. In today's surgical world, that means flexible endoscopy, minimally invasive surgery (MIS), and advanced laparoscopic techniques. As those techniques continue to evolve, all surgical practices—rural and urban—must evolve with them or risk being left behind. If they are left behind, they will die, no matter how many hernia/gallbladder operations or cesarean sections are performed. In that regard, the importance of flexible endoscopy, including screening programs (colon and Barrett's esophagus), and flexible endosurgery cannot be overemphasized. In addition to providing direct revenue, these procedures serve as springboards to the identification of a wide variety of gastrointestinal disease, wherein surgical treatment represents an appropriate solution and those operations are preserved for the local system. This in turn requires that a surgery department be capable of addressing them using modern surgical techniques. It does little good for a system if a local surgeon-endoscopist identifies intractable gastroesophageal reflux disease yet is unable to perform a laparoscopic Nissen fundoplication or identifies a colon cancer but cannot offer a laparoscopic colon resection. A scenario even more problematic for a local system is one where all flexible endoscopy is referred to remote gastroenterologists. Patients are generally more likely to get their operation, if indeed such an operation is deemed necessary by a gastroenterologist, within that medical specialist's own referral system.

COMPONENTS OF A SUCCESSFUL RURAL SURGERY PROGRAM

There are many components to a successful surgery program, rural or urban, and the extent to which these components are identified and implemented is directly related to the extent of that success. These components go beyond doing competent surgery and extend into areas of education and leadership. Educational programs for the public enhance information, visibility, and community pride as the programs generate awareness of various disease topics and what advanced surgical options are available to them locally. Educational seminars are no less important for a surgery program's local referral primary care base, for largely the same reasons. The extent to which such educational opportunities can be extended to regional primary health care providers has the added benefit of expanding a program's referral base, just as regional informational patient education seminars can expand a surgical patient base beyond the local area.