

## PRESIDENTIAL ADDRESS

From the Eastern Vascular Society

# When I grow up, I want to be successful like daddy: I just don't want to be a doctor

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I want to thank Bill Flinn for that wonderful introduction. I appreciate your efforts, Bill, and, more importantly, as my professional neighbor, your friendship and camaraderie over the years.

It's a great honor for me to stand before you as the 20th president of the Eastern Vascular Society. There is no greater reward than to be recognized and respected by one's peers. There are so many outstanding vascular surgeons in this Society who merit such recognition and who are more deserving than I to hold this office, so that I am truly humbled, and I sincerely thank you.

I wouldn't be standing here today without the help of a lot of people, too many to mention, but a few I must.

My family has always been supportive and tried to understand the professional drains on my time. I've probably spent more waking hours being a vascular surgeon than a husband and father—I am an imperfect soul. Fortunately, my kids have a wonderful mother at home, a true multitasker, who manages to keep it all together. That's important to me because I've always believed that there is nothing any of us do that is more important than to be a proper role model for our children. My kids are the stars of my universe and the light of my life, and I hope that they understand, if not today, if not tomorrow, at some point down the line that I work hard at what I do because I believe it is our moral obligation to do some good in this world, to try to make a contribution, and because I want to set that example for them.

I wasn't educated or trained at Johns Hopkins. But I've now spent more years at Hopkins than all my time in high school, college, medical school, residency, and fellowship

put together. Hopkins is a great place to be, but what makes Johns Hopkins truly special is not the tradition; it's not the buildings or the headlines. Rather, it is the people you work with there. I am so indebted to my partners and all the members of our team over the years who have supported me, challenged me, perhaps at times tolerated me, and, more often than they know it, taught me so much, and I want to say publicly how grateful I am to them, present and past.

### THE TITLE

Now, some may find the title of this address to be a little odd, so let me give you the background. When the shock of being named President-Elect wore off, I realized that this meant, among other things, that I would have to write a presidential address. I began to think about it and thought about it a lot over the ensuing months. I thought about it long and hard and really wasn't sure what to talk about. Previous presidential addresses have been about biographical topics, surgical history, vascular centers, mentoring, the malpractice crisis, turf battles, an independent board of vascular surgery, and a number of other issues relevant to the contemporary practicing vascular surgeon. I couldn't seem to decide on just the right topic.

Well, then, one night a few months ago I came home from work a little bit late and maybe a little bit tired, and my son, Mason, who was 12 at the time, looked me in the eye and spontaneously announced to the family: "When I grow up I want to be successful like daddy. I just don't want to be a doctor."

My initial reaction to this pronouncement was pleasant surprise: my son thinks I'm successful! Lord knows there are many days I don't necessarily believe that. And when I think about the 19 vascular surgeons who have preceded me as presidents of this Society, these are truly successful individuals, each of them leaders in vascular surgery whom I greatly respect and admire, from Norm Rich, our founding president and, more importantly, one of the true gentlemen in our specialty, to Dhiraj Shah, whom I introduced as president last year, the embodiment of the American dream, and the others in between. I was even more pleased to hear that my son is ambitious and wants to be successful

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Competition of interest: none.

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and make something of his life. All of us as parents can appreciate that. And as far as not wanting to be a doctor, well, that was fine since I'm not one of those parents who needs his kids to follow in his footsteps.

But then over the next few days and weeks, as I thought about what Mason said, I realized that, as they say, "out of the mouths of babes is spoken the truth." Without realizing it, Mason had captured in just a few words what I believe is the single most critical issue facing our specialty today: namely, our ability or inability to attract the best and the brightest young people in sufficient numbers into vascular surgery. History is important, and knowing the biographies of our pioneers inspires us, and the malpractice premium crisis, turf battles, and ultimate control of our specialty by regulatory boards are important topics, but none of these issues will really matter if we cannot recruit the best and brightest young people into vascular surgery as we move forward. Just pick up any issue of the *Journal of Vascular Surgery* lately, and you will see page after page after page of ads for vascular surgeons all over the country. These are not ads placed for legal purposes. They are for real jobs in outstanding private practices and some of the most prestigious academic centers in the country that aren't being easily filled. This is a critical problem, and it must be fixed, and we need to start now.

## THE PROBLEM

Just consider the vascular fellowship match process over the last decade and a half. In 1992, we had 56 ACGME-approved fellowship positions available, and there were 110 applicants: nearly a 2:1 ratio.<sup>1</sup> By 2006, the number of fellowship positions had doubled to 112, yet there were only 121 applicants, roughly 1 applicant for each available position.<sup>1</sup> This year there was an increase in the number of applicants to 145, but we still saw roughly only 1 applicant for each position.

Among the 110 applicants in 1992, 98 (90%) were graduates of American medical schools. Over the past 5 years, only 70% of our applicants were graduates of American medical schools: less than 1 for each fellowship position.<sup>1</sup> I mention this not out of xenophobic disrespect for international medical graduates, but rather because it emphasizes a fundamental failure in our recruitment process and a need for action.

A few years ago during his presidential address, Dr Tony Sidawy spoke eloquently about this subject and the need to mentor and influence young people.<sup>2</sup> There is no question that mentoring and providing role models for students and residents is important, and in fact it is critical. But my view of this issue is somewhat different. I believe we vascular surgeons have overly personalized this issue and shouldered too much guilt about this problem. You see, I believe that our difficulty in recruitment is not necessarily a vascular surgery problem per se. I don't think this is specifically a surgery problem. In fact, I believe this is a major public health problem: it is a public policy issue, and must be framed and addressed as such.

**Table I.** US physician supply and projected shortage<sup>5</sup>

Variable	1929	2000	2010	2020
Population (millions)	121	286	325	345
Physicians	144,000	772,000	887,300	964,700
Physicians/100,000	119	270	283	280
Shortage			-50,000	-200,000

The reality is that we're not just facing a potential shortage of vascular surgeons in this country in the future; we're facing a severe shortage of physicians across the board. The current demand for physicians is roughly 2.7 per 1000 population. It's estimated that in 2020 we will need 3.1 physicians per 1000 population, but we will only have 2.4 physicians per 1000 population.<sup>3,4</sup>

Over the last 20 to 30 years, all we heard was that we had an excess number of physicians, particularly specialists. Numerous public policy experts and a number of special interest groups, including the AMA, lobbied hard to restrict the number of new physicians trained in this country. In 1994, for example, the AMA predicted an excess supply of 165,000 physicians by 2000.<sup>5</sup> They were all wrong!

We produce about 25,000 new physicians each year in this country. It's now estimated that we need to train an additional 3000 to 10,000 new doctors annually to meet the needs of our growing population. Because it requires approximately 10 years to educate and train a doctor, it is estimated<sup>5</sup> that the United States will face a shortage of as many as 50,000 physicians by 2010 and 200,000 physicians by 2020 (Table I). When you consider the number of years it takes to train a surgeon, if we increased the number of general surgery residency positions by 10% per year starting today, it would require 20 years to increase the number of practicing surgeons as a whole by just 5%. This is a major health care system problem.

## INTERNATIONAL MEDICAL GRADUATES

In fact, the increasing percentage of international graduates among our vascular fellowship applicant pool is simply a reflection of contemporary health care demographics. Over the last two decades, the number of international medical school graduates entering US residencies doubled, and today they fill 27% of these positions.<sup>6</sup> The majority of international medical graduates who train in this country ultimately enter practice in the United States, and they subspecialize at a disproportionately high rate.<sup>7</sup> In fact, if it wasn't for international medical graduates, the projected physician workforce shortage would already be here. In 1963, international medical graduates comprised 10% of our physician workforce. This grew to 18% in 1970 and 24% in 1998.<sup>7</sup> Today, 14% of practicing general surgeons in the United States are international medical graduates.

In addition to providing necessary health care services to our citizens, international graduates have played a major leadership role in academic medicine and, in particular, in academic surgery. International medical graduates comprise 10% of academic general surgery faculty positions in

**Table II.** Number of international medical graduates in American academic surgery departments<sup>8</sup>

General surgery	99	Orthopedics/sports medicine	19
Cardiovascular/thoracic	75	Otolaryngology	12
Transplant surgery	46	Colorectal surgery	10
Surgical oncology	43	Hand surgery	6
Plastic surgery	37	Endocrine surgery	5
Vascular surgery	36	Burn surgery	4
Neurosurgery	35	Surgical endoscopy	4
Urology	34	Laparoscopy	3
Research	32	Oral surgery	1
Pediatric surgery	29	Nutrition	1
Trauma/critical care	29		

the United States, 89% of our medical school surgery departments have at least one international medical graduate on their faculty, and vascular surgery is well represented (Table II). Numerous international graduates have served or currently serve as department chairs of surgery.<sup>8</sup>

While international medical graduates have clearly contributed very positively to our health care system in general, there is an embarrassing flip side to this coin. In an increasingly global economy, America is engaging in a significant “brain drain.” The majority of these international graduates come to us from relatively lower-income countries around the world, so that we are weakening what are already disadvantaged health care systems in many source countries. We are robbing these countries of their human capital and their financial investment in the education of these physicians, and this is not right!<sup>9</sup>

In the Philippines, for example, which is an important source of physicians and nurses in America, 1000 private hospitals have closed during the past 5 years because of a shortage of health care providers.<sup>10</sup> In fact, many Philippine physicians are actually retraining as nurses for higher-paying jobs in Western countries!<sup>11</sup> What this says loud and clear is that the Philippines have undervalued physicians. Perhaps we in America are also undervaluing physicians’ services and thus are facing difficulty in attracting young people into medicine. Maybe we should learn from the Philippine example.

## DEMOGRAPHIC CONSIDERATIONS

There is no group of patients more threatened in the future than those with cardiovascular disease. The elderly are the fastest-growing segment of our population, and the numbers are staggering. By the year 2020, the number of individuals over the age of 65 will increase by 50%, and by 2050 that group will grow by 135%.<sup>12</sup> In other words, those over the age of 65 will comprise 17% of our population in 2020 and 20% in 2050. The greatest growth will be in the oldest elderly—those over the age of 75.<sup>12</sup>

Furthermore, the elderly population of tomorrow will be better educated, with double the college degree rate and one half the high school dropout rate of the current elderly patient population.<sup>12</sup> They will be the most medically informed and medically sophisticated elderly patient population in history and will expect and deserve the highest

quality of life in their retirement years. Claudication may not be an acceptable lifestyle!

Currently, physicians devote 32% of their time caring for those aged 65 and older. Without an increase in consumption, which seems unlikely, we will spend 39% of our time caring for this demographic group by 2020. Government estimates predict a 30% increase in inpatient days, a 20% increase in outpatient visits, a 17% increase in emergency department visits, and a 40% increase in nursing home residents over the next 15 years.<sup>3</sup>

In 1992, just under 600,000 peripheral vascular operations were performed in the United States.<sup>13</sup> It is estimated that in 2020 there will be anywhere from 1.0 million to 1.8 million vascular operations performed in this country.<sup>2,13</sup> This means that we will need roughly 4500 trained vascular surgeons. This would require graduating 160 vascular fellows annually.<sup>2</sup> We currently graduate 112. We don’t even get 160 applicants!

## PROFESSIONAL DISSATISFACTION

Compounding this challenge is the aging of our physician workforce. Currently, about 18% of practicing physicians are between the ages of 55 and 64. Although we don’t have specific data for vascular surgeons, 22% of general surgeons are between the ages of 55 and 64. What is particularly disconcerting is that the retirement age for physicians has precipitously declined in recent years. Fifteen years ago, the mean age of retiring physicians in America was 71. Today the mean age at retirement is 59, and it is 57 for surgeons.<sup>14</sup> This likely reflects, at least in part, an increasing level of professional dissatisfaction. When one considers the financial investment that society makes in the education and training of physicians, roughly \$110,000 per resident in this country,<sup>5</sup> this premature exit from the practice of medicine of our most experienced practitioners represents a huge economic loss for society. This is a public policy issue! Furthermore, in recent surveys, 30% to 40% of physicians in private practice said they would not choose to enter medicine if they had to make the choice over again.<sup>15-18</sup> Our government must maintain the solvency of Medicare with strategies other than just annually reducing reimbursement; we must achieve meaningful malpractice premium reform, and we need to limit the growing burden of regulatory paperwork. Appropriately financially rewarding physicians and improving the quality of our professional lives to stop this premature exodus from practice represents a solid return on investment for society. It’s basic, good economics, and it will help us recruit the next generation of vascular surgeons.

While much of this information comes from the private sector, professional dissatisfaction appears to be a particular problem in academic medicine today. In the largest study of its kind, published earlier this year, a 136-item validated quality-of-life and professional-satisfaction questionnaire was sent to more than 3000 faculty members at 4 medical schools in the United States. The respondents were equally divided among all academic ranks, and all disciplines were

represented; 131 (7.5%) were surgeons. A remarkable 54% response rate was achieved.<sup>19</sup> The results were unsettling:

- 20% reported symptoms consistent with depression
- 18% reported mild to severe anxiety
- 24% of younger faculty and 45% of older faculty reported drinking alcohol daily to several times per week
- 35% reported significant work interferences with family life
- 30% reported being more “edgy” than in the past
- 29% withdrew emotionally from family and friends several times a month
- 23% reported getting adequate amounts of sleep

Furthermore, only 37% reported that their job expectations were being realized! Among the 15 specialties responding to the survey, surgeons reported the most depressive symptoms, the highest level of anxiety, the least job satisfaction, and the most work strain.<sup>19</sup> Today’s students are interfacing with a surgical faculty who have less time to teach, feel pressured, and are anxious and dissatisfied with their jobs. Many of us are hardly ideal role models.

In a landmark book, *Time to Heal*,<sup>20</sup> Kenneth Ludmerer comprehensively describes the evolution of the American medical education system from the turn of the century and chronicles the threat to traditional medical education due to decreasing government and private financial support and reduced reimbursement, with increasing pressure on faculty today to generate clinical income and research support. The results of this survey quantitate the threat he describes in this 1999 book. So, while we must take responsibility for the message we communicate about our careers, we cannot solve this challenge alone. How many of us have heard our deans or faculty retention committees pontificate about the value of scholarship, the importance of teaching, and, recently, focus on the quality of life for faculty? Today, American hospitals are reporting record profits. Vascular surgeons contribute significantly to those margins, and this will grow with the increasing performance of percutaneous procedures.<sup>21,22</sup> It’s time for our deans and hospital presidents to work with us to develop creative solutions for these challenges, perhaps including better profit sharing.

In fact, dissatisfaction with a medical career is not new and is largely cyclical.<sup>23,24</sup> *The Social Transformation of American Medicine*<sup>23</sup> cites a paper published in 1869 in which one doctor referred to medicine as “the most despised of all professions for educated men.” At the turn of the century, Veresaeu,<sup>24</sup> in *The Memoirs of a Physician*, wrote of medicine that “there are times when the powers to continue such a life are entirely exhausted and you are seized with such depression that only one thought remains—to turn your back on all and flee.”<sup>25</sup> In fact, it seems that every generation of physicians has had anxiety about the profession.<sup>17</sup>

Furthermore, today, professional anxiety or dissatisfaction is hardly unique to medicine. Recent studies have identified an unprecedented level of unhappiness and career dissatisfaction among lawyers and teachers, for exam-

**Table III.** First-year medical students<sup>28</sup>

Country	First-year enrollment	Population	Ratio
United Kingdom	5970	61.0 million	1/10,218
Australia	1460	19.3 million	1/13,200
Canada	2096	31.5 million	1/15,029
United States	17,120	290 million	1/16,939

ple.<sup>26,27</sup> Frankly, I can understand why lawyers may feel unfulfilled, and I can see how teachers may be frustrated, and I can accept that internists, dermatologists, and general surgeons may be dissatisfied. But vascular surgery is different! What differentiates vascular surgery from the law, from teaching, and, indeed, from many other medical specialties is that we are not a profession in its senescence or twilight. Vascular surgery is in its adolescence. It is one of the most vibrant, evolving, innovative, and exciting medical specialties in contemporary practice. We are not going to flee; we’re just beginning, and we need to communicate that message to our young people.

### THE MEDICAL EDUCATION CHALLENGE

There is another fundamental systems problem affecting our physician shortage. We have an insufficient number of medical schools in this country. Medical school education has not kept up with the growth of our population. During the past two decades, our population has increased 23%, while medical school enrollment has grown only 7%. As a result, the number of medical students per 100,000 population has decreased by 13% (International Medical Workforce Conference, unpublished data, 2002). In the United States, we educate fewer medical students per capita than many other leading industrial countries (Table III) (Association of American Medical Colleges, unpublished data, 2002). The Florida State University College of Medicine opened its doors in 2002 as our 126th medical school and the first new medical school in 20 years. The Association of American Medical Colleges now estimates that we should increase the number of American medical students by 15%.<sup>28</sup> A study by the Robert Wood Johnson Foundation estimated that we need an additional 25 medical schools in this country to alleviate projected future physician shortages.<sup>29</sup> There are enormous benefits to local communities that have a medical school. They bring in faculty who provide care to the local citizens. Economically, the average medical school contributes roughly 8000 new jobs and \$1 billion annually to the local economy.<sup>30</sup> At the present time, there is a bill pending in Congress to provide \$1.5 billion to expand significantly the number of positions in American veterinary medicine schools. We need a comparable investment in our medical schools. Don’t our elderly deserve as much care as their pets?

Acceptance into medical school is still a highly competitive process, with only half of all applicants being accepted. I believe that this highly selective process dissuades many qualified students, and potentially great doctors, from even

applying. In fact, in the recent past we have seen a significant reduction in medical school applications.<sup>17</sup>

I also believe that many students are dissuaded from becoming doctors, and especially surgeons, because of the length of the education and training process. This year we achieved approval of the Primary Certificate in Vascular Surgery, which will reduce by a year or two the residency training period. We need to do the same thing with medical school education. Where in the constitution does it say that medical school must be 4 years in duration? Maybe this made sense when most graduates were general practitioners and needed to know everything about everything. But we are in a different world today. We are educating and training specialists and subspecialists, and 3 years should be enough time to educate these bright young people and prepare them for postgraduate training. Furthermore, does every medical student need to spend 4 years in college before entering medical school? We've had a small number of 6-year programs in the past. I believe that we as a profession, and as a society, need to move decisively to increase the opportunity for qualified students to enter medical school and shorten the period of medical education and training.

Furthermore, the government continues to cap spending on graduate medical education, which represents only 3% of Medicare spending.<sup>5</sup> We need more medical school graduates and more residency positions for them.

### LIFESTYLE CONSIDERATIONS

Unfortunately, in vascular surgery we have fallen behind other specialties in filling the training slots we currently have.<sup>31,32</sup> In a recent analysis of medical school graduates from 1996 through 2002, it was noted that after controlling for income, work hours, and years of training, "controllable lifestyle" explained more than 40% of the career choices of these individuals.<sup>33</sup> Controllable-lifestyle or "lifestyle friendly" specialties are defined as those that allow more personal time free of practice requirements for family and leisure activities and control of total weekly hours devoted to professional activities.<sup>33-35</sup>

Although many have assumed that this is largely a gender issue, it is not. While the proportion of women choosing a specialty with a controllable lifestyle increased from 18% in 1996 to 36% in 2003, the proportion of men choosing a controllable lifestyle increased from 28% in 1996 to 45% in 2003.<sup>34</sup> Controllable lifestyle is more of an issue for men than for women.

Nevertheless, gender is one of the most important issues we must address in vascular surgery. Currently about 60% of college graduates, and roughly 50% of medical school graduates, in this country are women, up from about one third just a decade ago.<sup>14,36,37</sup> It has been estimated that in 20 years 60% to 70% of all medical school graduates in this country will be female. While some have assumed that women disproportionately enter primary fields, such as pediatrics, that is not entirely accurate. Only about 28% of women are practicing primary care medicine. Women clearly are entering specialties and subspecialties. They're

just not becoming general surgeons and not becoming vascular surgeons.<sup>36,37</sup>

The first vascular certificate was awarded in 1982, and the first woman to be board-certified was 1 year later, in 1983. However, it wasn't until 2001 that more than 10% of vascular certificates went to women, and even today more than 85% go to men.<sup>38</sup> Regrettably, we're losing ground. Female applicants to vascular fellowships have markedly decreased over the last 3 years (Table IV). This year, only 10% of our applicants were women.<sup>39</sup> We need to redouble our efforts to recruit women into vascular surgery and end this gender gap.

### THE "GREATEST GENERATION"

Gender is not the only cultural challenge we face as we move forward. In our society today, we view the elderly, our vascular patients, as a burden. This is clearly a 20th century phenomenon. Thomas Cole,<sup>40</sup> in a 1992 book entitled *The Journey of Life: A Cultural History of Aging in America*, points out that in earlier ages, when death struck more randomly, people did not focus so much on birth to death in a linear view of life. In earlier agrarian economies, the young, the middle aged, and the old all played productive roles in society. Life was viewed as a Lion King circle-of-life phenomenon. But in the Victorian age, and clearly in the 20th century, we have abandoned this view and adopted this linear view of life.<sup>40</sup>

Our patients are the greatest generation<sup>41</sup> They are our parents and grandparents, our aunts and uncles, and our neighbors. We need to do much more than just read about the greatest generation and talk about the greatest generation: we need to encourage our young people to serve them. Our greatest generation is our greatest asset, and they deserve our gratitude and our greatest medical care. In fact, as we mentor and teach young people and as we try to influence them to consider a career in vascular surgery, we need to emphasize not only our innovative, evolving, and exciting new technology, but also, more importantly, our collective moral obligation to the greatest generation. I believe they will respond.

### VASCULAR SURGERY: POISED FOR SUCCESS

In fact, I happen to be optimistic about the future of our specialty because I've always believed that difficult times—times of challenge—represent moments of enormous opportunity for those with vision, for those with passion, and for those who understand the challenges and are willing to lead. And if vascular surgeons are anything, we are leaders! We led in the passage of the SAAAVE act that is going to save thousands of lives. We've led by establishing the Primary Certificate, which will shorten residency training. And we're leading in innovative educational strategies, such as the use of simulators in endovascular training.

I'm optimistic about our future in part because I believe lifestyle considerations can be a tremendous strategic advantage for vascular surgery as our specialty continues to evolve and innovate.<sup>37</sup> There is not another specialty that



**Fig 1.** Abdominal computed tomographic scan. Note the ruptured abdominal aortic aneurysm.

will allow more diverse and individualized professional career profiles than vascular surgery. Vascular surgeons can do open and endovascular procedures, or either. They can concentrate on venous disease, dialysis access, and inpatient or outpatient care. Today, the evolution our specialty should be incredibly attractive to young people with a desire for a lifestyle-friendly career. We need to refine our message and communicate it effectively, and we need to start now.

However, we must recognize that young people today are incredibly sophisticated, savvy, and well informed. As we mentor and teach young people and as we try to influence them to consider a career in vascular surgery, we need to be absolutely straight with them. There are a variety of career tracks one can pursue in vascular surgery, but the fact is many of us work really hard in our profession, and we will continue to work hard in the future, and there is nothing wrong with that. We work hard because we love what we do, and there is nothing wrong with that. We work hard because what we do is important and rewarding, and there is nothing wrong with that. We work hard because we feel blessed to have been given the privilege to serve our greatest generation, and there is nothing wrong with that. We work hard because our patients depend on us, trust us, and appreciate us in ways that words cannot describe, and there is nothing wrong with that.

#### OUR PATIENTS: WHAT IT'S ALL ABOUT

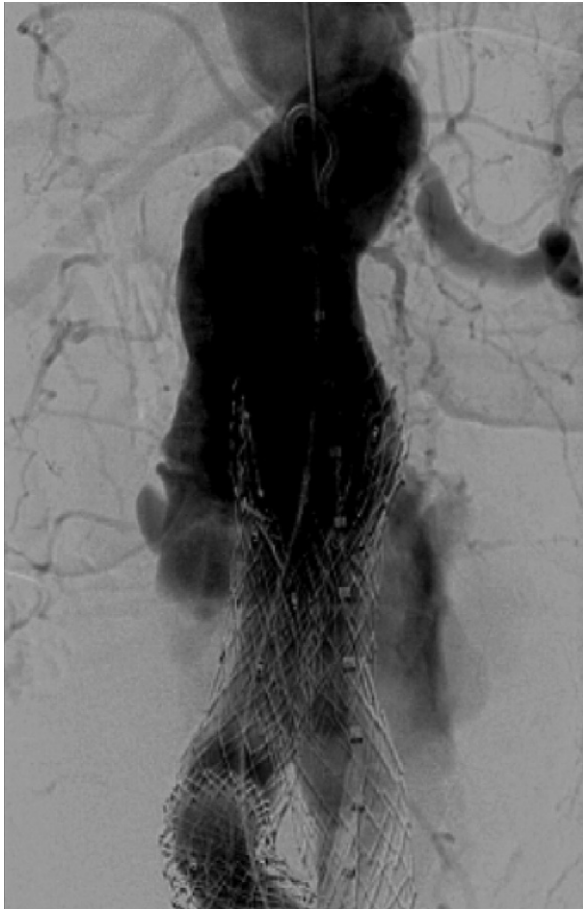
I want to introduce you to one member of the greatest generation, Henrietta, who is 86 years old. She's an average citizen who spent much of her adult life working in a factory making burlap bags. She lives alone now with her dog in a row house in East Baltimore, leading a simple and very sedentary life. She was 84 when I met her 2 years ago. She had a number of significant



**Fig 2.** Completion arteriogram after aortic stent-graft repair of the ruptured abdominal aortic aneurysm.

health problems, including severe coronary artery disease, atrial fibrillation, congestive heart failure, hypertension, and hyperlipidemia. She had presented to our emergency department with several hours of severe abdominal pain. This is her computed tomographic scan (Fig 1). As you can see, she has a ruptured abdominal aortic aneurysm. On the basis of her extensive comorbidity and advanced age, I thought it was not likely she would survive an emergency open repair. But Henrietta is alive today. She's alive and well today because of modern vascular surgery. She's alive today because a brilliant vascular surgeon in Buenos Aires, Juan Parodi, dreamed and believed you could perform aortic aneurysm repair from the groin. He worked hard and made it happen. She's alive today because other vascular surgeons worked really hard and refined and perfected this revolutionary technique of endovascular aneurysm repair. She's alive today because industry believed in this technology and in our specialty. She's alive today because older traditional vascular surgeons were willing to open their minds and accept this change and work with their younger colleagues to learn from them and perform these procedures with them, as we did in this case. We worked really hard for a few hours, and there was nothing wrong with that (Fig 2).

Henrietta is alive today because, unlike all other specialists who treat peripheral vascular disease, vascular sur-



**Fig 3.** Arteriogram demonstrating type I endoleak due to endograft migration.

**Table IV.** Fellowship applicants: Gender<sup>40</sup>

Gender	2004	2005	2006
Women	21%	18%	10%
Men	79%	82%	90%

geons don't treat lesions—we treat patients, and we get to know our patients, and we develop long-term relationships with our patients, and we follow our patients. So when Henrietta again developed severe abdominal pain a few months ago, she knew whom to call and where to come, and her impressive graft migration and type I endoleak were quite apparent (Fig 3). She underwent further endovascular repair and is alive and well today. Henrietta, an average and decent person, part of the greatest generation, is alive and well today because the greatest generation deserves the greatest care, because what vascular surgeons do is important and innovative, and because we love what we do and our patients love us for it, and there is nothing wrong with that. In fact, there is an awful lot of good about that. There

is a lot of good in what all of us do every day in our practice of vascular surgery, and we should never forget that! That is what we need to communicate to our young people. Thank you.<sup>35</sup>

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