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REPLY: SURGEONS AND HEALTH POLICY— CLAIMING OUR SEAT AT THE TABLE

Reply to the Editor:

In a recent issue of the *Journal*, Mennander and colleagues¹ provide an insightful summary of cardiothoracic (CT) surgical training in the Nordic countries. Although not the focus of their manuscript, the discussion of universal health coverage is certainly unique compared with the current status quo in the United States; a point nicely expounded on in a recent editorial by Vervoort and colleagues.²

Under our current market-based system, it is clear that millions of patients are left without access to health coverage and without the potential financial safety net offered in single-payer systems. While procedural, medication, and follow-up costs continue to rise, the likelihood of patients needing CT surgical care that is financially prohibitive or injurious will continue to grow, while clearly any sentient surgeon or physician understands why such circumstances should not drive health care decision making. As inequities in the social determinants of health are increasingly studied, one point appears increasingly clear—that universal health coverage offers high-quality care without financial hardship for those most in need.

What may be simultaneously frustrating is that our current system for physician reimbursement is sorely inaccurate without apparent systematic rhyme or reason, with CT surgeons being the most underreimbursed specialty, according to a recent examination of the Medicare Fee Schedule by Chan and colleagues.³ Financially, it appears the current system within which we operate is broken from both the perspective of patients and their surgeons. But what can the CT surgical community do about this?

On an individual level, the simplest step is prudence with regard to cost containment, whether that be avoiding unnecessary testing, expensive equipment with little added value intraoperatively, and use of best practices shown to decrease lengths of stay for our patients. More broadly, it is time for surgeons to claim their seat at the table for future deliberations and policy changes. It is clear that previous policymakers have missed the mark, and who better than us to advocate for our patients, communities, and the health care system within which we work every day? Institutional and hospital-system involvement represent critical

grassroots-level leadership opportunities for meaningful change, whereas the Society of Thoracic Surgeons and American Association for Thoracic Surgery Workforce on Health Policy, Reform, and Advocacy as well as the American College of Surgeons Health Policy and Advocacy Group are both national-level groups offering myriad opportunities for involvement to make our collective voices heard. There is no better time than now, and who better to advocate for their patients than their surgeons?

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REPLY FROM THE AUTHOR: CHERRY PICKING OR CHOOSING FOR BETTER AND WORSE

Reply to the Editor:

On behalf of my co-authors and myself, we gratefully acknowledge the insightful comments on universal health coverage by Vervoort and Swain¹ and very much thank them for their interest toward our manuscript.² The *Journal* offered us an exceptional opportunity to discuss cardiothoracic specialization in the Nordic countries, and we sincerely understand that our manuscript is only part of a whole series of educational aspects.

Nordic cardiothoracic surgeons believe in the efficiency of the tax-based, single-payer model characteristic to the Nordic countries. The strong tradition of equity of the citizens is present in medical decision-making. It is impossible to exchange money for a desired treatment, which is decided on medical indication only, eg, an aortic valve stenosis cannot be treated by transcatheter means if the method is considered medically questionable to the individual patient. The Nordic consultants are collectively responsible