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Commentary: Nobody roots for Goliath

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In the spectrum from mechanistic hypothesis to clinical interrogation and application, surgeons are the indispensable effector arms on academic investigative teams. Surgeons are also the economic engines of all medical schools and hospitals. In the accompanying article, Ikonomidis¹ acknowledges the economic and cultural pressures for surgeons to remain in the operating room. He then uses his personal experience to propose a beautifully delineated series of solutions to revitalize the surgeon–scientist pool.

In 1989, a Medicare fee schedule was enacted based on physician work, practice expenses (including mandatory training), and malpractice costs and digested into resource-based relative value units for thousands of specific services. The American Medical Association's Specialty Society Relative Value Scale Committee subsequently further refined the service-specific relative value units. Historically, because cardiac surgeons must train more extensively, work longer hours, take more challenging risks, and absorb greater practice expenses, we have been compensated favorably by the Specialty Society Relative Value Scale Update Committee.

In my experience, when I have floated the idea of academic protected time for surgeons to deans and hospital administrators, I have discovered that they know that we are the fiscal engines of the school and the hospital. Their goal is to keep us in the operating room. Following a short skirmish about protected time, the discussion devolves into the magnitude of their tax on our department. I find myself arguing that petty larceny is tolerable while grand larceny is not.

Now, as we parade about our hospitals, everyone knows that we work hard and our discipline mandates that we accept

Goliath speaking with the Dean.

CENTRAL MESSAGE

I have not encountered successful academic surgical programs in the absence of charismatic surgical leaders (like Dr Ikonomidis or Gene Moore in Denver). And Goliath should not anticipate much help.

ego-challenging risks. We are also perceived as displaying a level of obligate self-assuredness that may border on arrogance. This buys us a little sympathy when we complain about protected time, our compensation, and the width of our parking space. This is where Goliath comes in. Like Goliath, cardiothoracic surgeons are often misconstrued as Philistines wielding "... a spear shaft... with an iron point weighing 600 shekels" (first book of Samuel 17:7) by our administrative and noninterventional colleagues.

In the fourth paragraph of his article, Dr Ikonomidis presents a beautifully delineated series of ideas in which junior faculty are guaranteed protected time that is not based on clinical productivity. After 35 years as a department chair and decades on National Institutes of Health (NIH) study sections, I am hopeful that these ideas could work in some departments; however, I have consistently failed in their application myself. Tolstoy famously observed in *Anna Karenina*: "All happy families (academic surgical departments) resemble each other; every unhappy family is unhappy in its own way."² Our NIH-funded program project grant and accompanying T-32 training grants have survived for 3 decades. Again, in my view, the paramount driver is senior academic surgical mentor(s) (like Dr Ikonomidis in North Carolina and Gene Moore in Denver) who live the commitment that young surgeons who can assimilate the rigorous discipline of basic science will evolve into more competent

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surgeons whose lives will become more gratifying, rewarding, and fun. Surgeons are uniquely situated to test the mechanisms postulated by our basic science friends. The basic folks need us. When a grant's mechanistically based first specific aim is then tested clinically in the fourth specific aim, the NIH will leap at the opportunity to fund us.

So, in my view:

1. The administration of the funding must be coordinated within the department of surgery.
2. Multiproject applications that symbiotically synergize more easily recruit participants and are more readily fundable.
3. Actively recruit basic scientists who can provide techniques that permit and promote mechanistically-based clinical hypotheses.
4. Weekly meetings, preferably at 6 AM on Mondays (urgent cardiology consults infrequently occur on Mondays—they all come on Fridays) encourage rapid progress. 6 AM is rough for the basic guys, but as soon
- as they appreciate the level of productivity, they come on board.
5. Junior faculty may have multiple mentors.
6. When a hypothesis/study is proposed, any volunteer may accept first authorship. The first author must do all the writing (surgeons hate to write). The first author can ask co-authors to do anything—except write.
7. Never begin data collection on a project until the sequence of authors has been established.
8. The senior (last) author's responsibility is to solve systems problems. Abstracts must be edited within 24 hours, manuscripts within a week.
9. Salary support (all) provided by grants is added to the investigator's salary with no departmental taxation.

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2. Anna Karénina. Translated by Nathan Haskell Dole. New York: Thomas Y. Crowell & Co; 1887. London: Walter Scott Publishing Company Ltd, 1889.