

Beyond the Scalpel: Advances in Minimally Invasive Surgery

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Description

A growing body of literature in vascular surgery demonstrates disparities in the type of health care that racial/ethnic minorities receive in the United States. Numerous recommendations, including those of the Institute of Medicine, have been set forth, which identify increasing the number of minority health professionals as a key strategy to eliminating health disparities. The purpose of this study is to compare the racial/ethnic distribution of the Society for Vascular Surgery (SVS) membership, the SVS leadership, vascular surgery trainees, and medical students. The results demonstrate that the racial/ethnic distribution of the SVS membership reflects a considerable lack of diversity with a paucity of diversity among the SVS leadership. An increasing rate of racial/ethnic diversity among vascular surgery trainees may indicate that the SVS will see an improvement in diversity in the future.

Quality of Health Care

In order to address disparities in the type and quality of health care that racial/ethnic minorities receive in the United States, Congress requested an Institute of Medicine (IOM) study in 1999. As part of the study, the IOM reviewed over 100 studies that assessed the quality of health care for various racial and ethnic minority groups. All of the studies were adjusted for insurance status, patient income, and other access-related factors. Many of the studies also controlled for racial differences in the severity or stage of disease progression, the presence of comorbid illnesses, where care is received (public or private hospitals and health systems), age, and sex. The meta-analysis found that, even among the better-controlled studies, the vast majority indicated that minorities are less likely than whites to receive needed services, including clinically necessary procedures. Racial and ethnic disparities in outcomes exist in a number of disease areas, including cardiovascular disease, and are found across a range of procedures. The issue of racial and ethnic disparities in outcomes is only going to become increasingly prominent in health care, given that the 2010 US Census showed that over 25% of the US population is non-white.

The Institute of Medicine recommends that increasing the number of minority health professionals be a key strategy to eliminating health disparities. The Sullivan Commission, which was formed to gather data and make recommendations about how to achieve diversity in the health professions, further

emphasizes the importance of strong leadership to attain the goal of diversity.³ In light of these recommendations, the Society for Vascular Surgery (SVS) Diversity and Inclusion Committee undertook this study of the racial/ethnic distribution of the SVS membership, the SVS leadership, vascular surgery trainees, and medical students. The purpose of this study is to characterize the racial/ethnic composition of the SVS membership and leadership and to evaluate the status of the SVS's effort to increase the number of minority vascular surgeons.

Society for Vascular Surgery

A voluntary demographic survey is conducted yearly of the SVS membership. New members as well as members who have not responded in the past are surveyed. The survey is administered electronically online through survey monkey. There are seven categories of SVS membership: Candidate, active, international, associate, affiliate, senior, and honorary. Candidate members are physicians who are currently enrolled or accepted into an accredited vascular surgery residency training program or vascular surgeons who have been in practice less than 3 years. Active members are attending physicians who have demonstrated an active interest and excellence in the field of vascular disease. International members are physicians who reside outside North America who otherwise are qualified for active membership. Associate members are nonvascular surgeon physicians, including podiatrists and scientists, who have a demonstrated active interest in the field of vascular disease. Affiliate members are nonphysicians who have a demonstrated active interest in the field of vascular disease. Senior members are SVS members who have retired from the practice of vascular surgery. Honorary members are distinguished physicians who have achieved international prominence in the vascular field. Only candidate, active, and senior members were included in the data analysis for this study. Analyses were done using respondents only as the denominator.

To examine the time-trend effects in initial JCVSD participants ($n = 44$), we identified 8224 isolated coronary artery bypass graft (CABG) procedures performed between 2004 and 2007. The impact of surgery year was examined using a multiple logistic regression model that set previously identified clinical risk factors and surgery year as fixed effects. To examine the difference in outcomes between initial participants ($n = 44$) and halfway participants ($n = 55$), we identified 3882 isolated CABG procedures performed in 2007. The differences between the 2

hospital groups were examined using a multiple logistic regression model that set clinical risk factors, hospital procedure volume, and hospital groups as fixed effects.

As the Institute of Medicine has indicated by making the concept of “patient-centered” a centerpiece of 21st century health care reform, it is critical to make benefits to patients the central focus of health care in the future. In contrast to the “patient-centered” mission statements of professional committees, containing medical costs is often the central concern in health care policy issues. However, the chief objective of health care is the provision of the best service to patients, not the reduction of medical costs. Thus, it is important to examine how to design and adjust systems to achieve that objective, including treatment fees for medical services, the organizational structure for providing health care, and other practical efforts.

In considering improvements to the quality of health care, it is necessary to define, understand, and evaluate “performance.” When constructing an index that demonstrates this “performance” in health care, it is important to make use of treatment results adjusted for the risks of individual patients. A framework must also be constructed that provides feedback in the form of accurate information that can be understood and accepted at the level of clinical practice and that can be used to improve the quality of health care. For such a framework to be constructed, a nationwide clinical database that provides an infrastructure for conducting systematic data collection and empirical analysis in collaboration with clinical practice is needed for each specialty.