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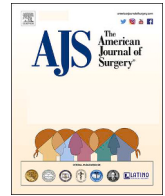
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My Thoughts / My Surgical Practice

Redefining academic surgery and recognizing the value of community practice

There is a natural tendency to label, categorize, and differentiate people. This inclination is evident in surgery as well, where one of the first demographic questions we encounter—whether in surveys about disease management or applications for membership in surgical societies—is whether we identify as an academic surgeon or a community practice surgeon. Traditionally, academic surgery is bound to large academic institutions and university medical centers. Many have defined the academic surgeon as one who is a clinician, educator, and researcher.^{1,2} It is clear academic surgery requires a large team of surgeons who have varied interests and expertise across missions in order to accomplish the goals and work at hand. Community practice surgeons, on the other hand, are less well-defined and, while some have described them to be surgeons practicing outside of tenure-tracked academic medicine,¹ a better description might be a surgeon who prioritizes high-quality clinical care delivery over scholarly pursuits. At the same time, there are ample numbers of surgeons practicing at academic institutions who have mostly clinical responsibilities, and likewise there are many surgeons practicing in community settings who are engaged in teaching and research. Historically, community practice was synonymous with private practice, however in the current era of healthcare corporatization, even this distinction has become more unclear as many community practice surgeons are now employed or in multi-specialty groups. Here we propose the expansion of the definition of academic surgery and suggest that community practice surgeons can most certainly be contributing academic surgeons.

Rosengart et al. described seven attributes of academic surgeons to include: critical problem identification, expertise, innovation, observation, improvement, dissemination, and education.² These are in fact features of all surgeons striving to improve our craft and the outcomes of our patients. While the surgeon-scientist is a unique and less common modification of the academic surgeon, described as one who writes grants for salary support and carries out bench research,³ the more common academic surgeon can be found in all practice settings. The guiding principle of academic pursuits naturally requires one to be intimately aware of clinical problems that require continuous improvement in care and outcomes—one who understands the impact of disease on both patient and community and first and foremost an expert clinician.

Innovative solutions have often been developed in community settings for conditions like hernia recurrence and cancer metastasis, utilizing flexible endoscopy and laparoscopic techniques. Laparoscopic cholecystectomy, for example, was developed and initiated by Dr. Erich Mühe, a community surgeon in Böblingen, Germany.⁴ The first surgeon to popularize laparoscopic cholecystectomy in the United States was Dr. Eddie Joe Reddick in the late 1980s. Dr. Reddick, along with Dr. Douglas

Olsen, refined and widely promoted this technique at Baptist Hospital in Nashville, and their work, including publications and presentations, helped drive the rapid adoption of laparoscopic cholecystectomy across the U.S., revolutionizing minimally invasive surgery.

Once a novel technique such as laparoscopy is developed, its safety and efficacy are typically validated through clinical trials, and surgeons in community settings can play a pivotal role. These trials may be funded by grants, industry sponsors, or cooperative groups, and community practices can be a great source for patient enrollment. There is an increasing interest in expanding trial enrollment to more community settings to assure a more diverse, enriched, and equitable trial enrollment.⁵ Benefits of utilizing community sites for clinical trial enrollment also include faster trial initiation and enrollment, while industry-sponsored trials are especially suited to community settings where streamlined activation is possible.

Education and training is a main feature of academic medicine, and much of surgical training also occurs in community hospitals. Of the 353 accredited general surgery training programs in the United States, 221 (62.6 %) are either community-based or community-based/university affiliated programs.⁶ In today's healthcare landscape, where many community sites have been folded into larger academic health care institutions, it is customary to have trainees rotate at various community sites for some or even all of their training. Likewise, traditional community surgeons, once integrated into the academic institution and with surgical privileges at the main site, may choose to bring cases to academic centers where they again find themselves in a teaching role with trainees of all levels.

Meanwhile, healthcare corporatization is now commonplace, pushing all surgeons—academic or not—to focus on clinical productivity, creating barriers and sometimes disincentives to academic and scholarly activities. Much focus has been placed on what academic centers need to do to promote continued scientific advancement in surgery despite this trend.^{3,7} With the continued integration of community and private practices into academic umbrellas, opportunity for community-based research integration emerges that will benefit research endeavors and the community it serves more broadly. Bringing academic-minded surgeons into these community settings could create a tremendous potential for research opportunities and patient pools that may not have been previously included within the confines of the primary institution's location.

Moreover, academic pursuits have been broadened in scope to include administrative activity and program building—both activities quite common in community settings. In university settings, we might denote this type of successful work with titles involving “vice chairs” or “deans” while in community settings, this achievement is often depicted

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with titles of “medical directors” and “chief medical officers”. In each setting, these pursuits acknowledge the academic pursuit of improving and disseminating certain standards of care and clinical integration.

Additional avenues for academic activity include society involvement and volunteerism. Surgical societies such as the American College of Surgeons and the Association of Women Surgeons (AWS) are important venues for professional growth, education, networking, and dissemination of practice guidelines and updates. Depending on the society, community practice surgeons can make up a significant portion, if not a majority, of the membership.¹ In 2024–2025 AWS active membership, for example, 213 (30.7 %) of 693 members reported that they are in a type of community practice setting (ie hospital-employed or group practice) while 399 (57.6 %) describe themselves as having an academic practice. Societies offer opportunities for committee membership and leadership and are an excellent avenue for surgeons without access to larger institutions to achieve their academic goals.

Another frontier of academia is global health research and international volunteerism. While structured global health initiatives are more common within large academic institutions where there may be more institutional and grant funding, more salary protection, and more cross-coverage availability, a substantial number of community practice surgeons participate in short-term missions in global surgery.⁸ It is foreseeable that with more integration of community practice surgeons into larger health care models, opportunities to participate in global health care activities could expand in the future.

While the academic quest can be achieved on many fronts in different practice settings, it is important to also consider how, why, and when practice choices are made. Most obviously, there are far more fellowship-trained surgeons than there are academic positions, thus while most community-based surgeons have a general surgical practice of broad scope, there are many specialized, fellowship-trained surgeons in the community. For some, there may be competing factors such as family, spouse, children, weather, and geographic location that drive choice of practice setting during various phases of one's career and life. Desire for mentorship or work-life balance may also influence choice of practice setting. It is likely that many surgeons practicing in community settings still have research interests and are engaged in academic pursuits who may not desire academic positions.

At our institution, we have embraced community expansion and the incorporation of our community surgeons into our academic department.⁹ Patients prefer care closer to home for routine clinic visits and surgical care, with ready access to higher-level care at the main academic center when needed. These sites allow for expansion of education and surgical resident training. Our community locations have also become active sites of clinical trial enrollment, bringing some of our most valued cancer trials to our community practices. Meanwhile, our community surgeons are engaged in academic pursuits enabled by this expansion. As we build on our community relationships and improve access through this community surgery program, the department is creating a framework for quality and an integrated health system focused on patient-centered care.

In summary, in the current health care landscape, academia and community need not be separate descriptive terms, but recognizing a more collaborative, mutually beneficial space could allow for progress, innovation, sustainability, and collegiality. If we continue to insist on surgeon categorization, rather than limiting surgeons to describe themselves as academic or community-practice, we could start asking what kind of academic pursuits surgeons are engaged in. With this approach we would come to learn much more about our hard-working community practice surgeon innovators and educators.

CRediT authorship contribution statement

Nimmi S. Kapoor: Writing – review & editing, Writing – original draft, Data curation, Conceptualization. **O. Joe Hines:** Writing – review & editing, Writing – original draft.

Declaration of interests

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