Surgery, Academia, & Administration:
An Interview with Dr. Stanley W. Ashley
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Stanley W. Ashley, MD is a graduate of Oberlin College. He continued his education in New York City at Cornell University Medical College. He then completed his residency in general surgery at Washington University in St. Louis. In this time, he also completed three years of basic science research focused on gastrointestinal physiology.

He carried on as faculty at Washington University in St. Louis until moving to the University of California, Los Angeles for seven years where he served as program director of the general surgery residency. His academic and administrative work continued when he moved to Brigham and Women's Hospital in 1997. Dr. Ashley served as program director of the general surgery residency for over 10 years and was vice chair of the Department of Surgery. In 2011, he assumed the role of chief medical officer at Brigham and Women's Hospital, and currently remains at this post.

In this interview, Dr. Ashley reflects upon his wealth of experience within academia and administration, providing students with thought-provoking and timely advice. Dr. Ashley urges those interested in surgery to strive for excellence while pursuing an arena of personal passion. He reflects upon his experience in implementing Massachusetts health care reform and provides projections for future physicians working within these transformed systems.
MDE: How did you come to pursue medicine, and from there, surgery? What or who influenced you?

SWA: Well, my dad was a doctor, and it was something in the back of my mind all along. Like many children of physicians, I resisted it for a while. But, it was something I thought about as an ideal blend of an intellectual pursuit with the capacity of helping others, while still leaving me with wide open options for what I might do. I think being a physician is one of these things that you feel like, it’s an essential enough function that you’ll always have a job and you’ll always be able to help people.

In medical school, I struggled with multiple specialties as a third year student and ended up deciding that the fit was best with surgery. I liked surgical problems. I liked being able to resolve something — or sometimes not — but surgical problems don’t go on for ever. There are some pros and cons to that in terms of the relationship with patients, but it felt like a good medium in terms of what I wanted.

MDE: What was medical school and residency like for you?

SWA: I enjoyed them both. I was in New York City for medical school. It was overwhelming to begin with. I was intimidated. I had never lived in a big city before and there were all of these incredibly smart people. But it went ok and I enjoyed it.

And then residency was also an interesting time. I trained in Washington University in St. Louis. I had actually thought I would end up a small town general surgeon and I went into a training program where you had to do research. I started in a basic science laboratory after the second year and ended up deciding that I wanted research to be part of my career and that academics was where I was headed. In total, I did three years of basic science research. It was mostly gastric physiology, acute ulceration of the stomach, and stress ulceration. Diseases that have since pretty much gone away but at that point were very much a part of surgery.

MDE: You were program director of the general surgery residency at the Brigham for over 10 years and before that about 4 years at UCLA. You reflect upon the Brigham’s program in “The Making of a Surgeon” (2012). What are the driving tenants of these programs under your leadership?

SWA: Both of the programs were geared towards producing leaders in whatever field of surgery our graduates ended up pursuing. The majority of our graduates ended up in academic positions. Both programs had research as a component of the training. We were really trying to produce people that were both excellent clinicians, providing the best care, but also surgeons that were able to go wherever they went and assume a leadership role in their program, hospital, or fellowship.

MDE: What qualities would you advise students to seek out when pursuing
a strong surgical residency program?

SWA: I think you can go to too small a program, in which case you won't get enough diversity in your experience. Too small in terms of the hospital and community. It is important to have a wide range of surgical experience, and usually that means rotations at multiple hospitals.

I think looking at what the graduates do in terms of what you want to do is wise. If you are headed towards academics, I would suggest that a program that is producing people that end up in academic jobs is the way to go. And likewise, if you are headed for a community position, a program that produces many community surgeons is ideal.

There are many programs today that produce predominately sub-specialists, they don't produce general surgeons anymore. That is very much true on the coast as opposed to the middle of the country, where there still is a possibility of being a general surgeon.

There are probably fifty good training programs in surgery, so some of it is just how the program feels on visits and whether the fit is right — whether you like the chairman, program director, faculty, and residents. You get a sense for a program just by meeting and talking with these different players.

MDE: What would you encourage students to focus on if interested in pursuing a residency in general surgery?

SWA: There is a certain bar of performance — but there is no magic formula to getting into a good surgery residency. There tends to be a component to the application which is comprised of the program director and residents’ initial impressions once you have reached that bar that ends up having an impact on selection.

I don’t think it’s imperative that students do research to go to one of the best programs, but it certainly helps. Some unique experience or a passion for something — a fire in the student’s belly — for some part of surgery. I don’t think it is imperative that you do a rotation at your top hospital either.

MDE: After serving as program director of the general surgery residency for a number of years, you transitioned into the administrative role of chief medical officer. What prompted the change?

SWA: I was looking for something new. I looked at a lot of chair of surgery positions. Then this position became available, my children were at a stage
in their lives where it would have been hard to move them for another chair of surgery job, and this seemed like an interesting fit for where I was in my career.

**MDE:** What does your role of chief medical officer entail?

**SWA:** There are some defined parts of it. For example credentialing, risk compliance, the medical library — these things sit under my office. But then there is also the general role of being the senior physician in hospital administration.

It is kind of a funny position. I am a little bit between hospital administration and the docs. I advocate in both directions. When the hospital wants physicians to do something, it often goes through me and sometimes those are things they don’t want to do. And likewise, when the physicians want something different than what the hospital would like them to do, that goes through me. So I end up with both sides not always completely happy with me. But that is something you can do at the end of your career and not worry too much about.

It is kind of a time when it feels like every day there is something new we are asking physicians to do. And I can help sort of mediate that. I can say no when a new advance doesn’t make any sense and sometimes people listen and sometimes they don’t. I kind of went into this saying that every time I added something to people’s plates, I would take something else off. I haven’t completely succeeded in that, but am trying.

And with this position, you help people. A lot of it is professionalism. Docs with problems at work or problems outside work, alcohol, things like that. How do I help people get through those kind of issues?

And then a large part of the role is, for example, if there is an initiative around length of stay, I work with nursing and care coordination to find out a way to solve those issues. am the physician representative in that setting.

**MDE:** How often are you in the OR now that you are chief medical officer?

**SWA:** I still have an OR day a week and I probably get there every other week or maybe every 2 weeks. It is considerably less. I miss it sometimes. For me, the OR is a nice place to get away from the noise, the emails, and the phone calls. But it has been a fine transition. I have felt that I need to keep my surgical skills in tact, of course.

**MDE:** How has the Affordable Care Act altered hospital administration at the Brigham?

**SWA:** Massachusetts was a little bit ahead here. We had RomneyCare, which is, to an extent, what Obamacare was modeled after. That has been about a 10 year process and what it clearly did was improve access for
people that had trouble paying before. I think that as a surgeon, I noticed it primarily in that I never had patients that we had to hold off on doing a procedure because they hadn’t cleared some insurance hurdle or they hadn’t gotten the free care designation that they needed to get their procedure paid for. What it did in Massachusetts was rapidly fill primary care offices so access became longer for everybody as a whole and it filled our emergency rooms because people could now afford to come in for care. And so, with this, healthcare costs increased dramatically. Massachusetts costs rose faster than anywhere else in the country. Earlier than an awful lot of places, we were facing things coming down the pike around how we would pay for healthcare and that meant changes in what our payers were doing. This translated to both higher patient co-pays and tiering. Insurance companies said, if the patient needed to go to the more expensive academic medical center, they were going to have to pay more out of pocket than if they went to the community hospital.

Then the state got into it and we now have a regulatory board that looks at how fast our costs are rising compared to a group that they think is comparable with us. If we are rising faster than either that group or the state GDP, then we are supposed to face penalties. That really hasn’t happened yet. But we are sort of more into that part of things now, thinking about government regulation. In addition, we have an increasing number of contracts where the risk is shifted to us. All of this has started a whole lot of new thinking.

One mode of thinking is to invest in nurse practitioners for our primary patients. They contact the high risk primary patients on a daily basis, keep them out of the hospital, and think about alternative ways to help with their care. It has been an investment by both the hospitals and the docs hiring nurse practitioners. One of my roles has been to kind of sell the docs on why it makes sense for an orthopedic surgeon to give up some dollars to pay nurse practitioners to keep people out of the hospital.

**MDE:** What changes do you anticipate the Affordable Care Act will make to the field of surgery?

**SWA:** I don’t think anybody has a crystal ball on that. I think it is still going to be great to be a physician. The basic things we do aren’t going to go away and we are headed in the right direction. We are trying to fix some things that have been a problem for a long time. Having said that, it is a different job than it was when I trained and the changes will take time to settle in properly.

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The Medical Student Press Review of Systems

MDE: Favorite part of medical school?

SA: I think the third year. Clinical rotations were definitely the best. You feel like you spend a lot of time getting ready for that and it is great.

MDE: Least favorite part of medical school?

SA: You know the first year you are so nervous for things and it’s so exciting to be in medical school. But then you finish the first year and you get a little time off and you come back again and you are just back in the classroom so much of the time. I think it’s gotten better, they are more integrative with curriculum now than at that point. The second year of medical school was very hard.

MDE: Who has been the most influential mentor in your medical career?

SA: The chair of surgery at Washington University in St. Louis, Dr. Samuel A. Wells, really had a big impact of my view of academic surgery — what was the right way to do things and what was the wrong way. I still call him up and ask for advice.

MDE: What medical specialty other than you own would you like to attempt?

SA: Well, I am sort of attempting other specialties now. We just had a period with no newborn medicine chair, so I acted as the chair. Now I didn’t do anything clinical, but I got to learn a lot. There are pros and cons to different specialties. I think there are tons that would make me very happy.

MDE: What profession other than your own would you like to attempt?

SA: I love teaching... but maybe a rock climber or a ski instructor.