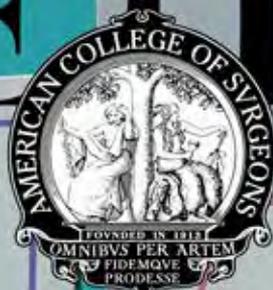


BULLETIN

AMERICAN COLLEGE OF SURGEONS



July 2003
Volume 88, Number 7

More Surgeons Say They'll Stop Practicing



Doctors shrug:
Why physicians are walking out

**COLLEGE
REDOUBLES
LIABILITY
REFORM
EFFORTS**



The doctor won't see you now

BULLETIN

AMERICAN COLLEGE OF SURGEONS



JULY 2003
Volume 88, Number 7

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About the cover...

Surgeons and other physicians are front-page news these days due to the groundswell of political activism that has arisen in response to the growing malpractice crisis. In his column this month on page 3, Thomas R. Russell, MD, FACS, ACS Executive Director, discusses the problem and the College's response. Additionally, F. Dean Griffen, MD, FACS, sounds a cry for surgeons to take the lead in addressing in this problem in his article on page 41.

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From my perspective

The current lack of available professional liability insurance coverage and the escalating premiums for the plans that are offered has created a huge crisis for surgeons and other physicians in this country. Granted, this problem has arisen before, but the current situation presents new and significant challenges for the medical and surgical communities. The question at hand for the College is, what can we do to hasten the correction and positive resolution of this issue?

Status of the situation

According to recent estimates from the American Medical Association, physicians and surgeons in approximately 18 states are having difficulty obtaining affordable professional liability insurance, and another 26 states are experiencing worsening conditions that may become more acute. Many of the geographical differences in the severity of the crisis are rooted in state laws that prohibit the implementation of various salutary efforts that have been successful in other areas of the country.

Additionally, some surgical and medical specialties are clearly at much higher risk. These specialties include general surgery, thoracic surgery, neurosurgery, vascular surgery, obstetrics, radiology, and emergency medicine.

A lot of finger-pointing has occurred with regard to the cause of the problem. Some people ascribe it to the insurance carriers, others to the trial attorneys, and still others to health care providers. Who gets blamed depends upon the point of view of the accuser's constituency. Yet, some experts claim that the current situation is simply the natural by-product of the insurance cycle, which fluctuates every 10 to 15 years and creates a "hard market."

Indeed, a number of factors may have contributed to this imbroglio. One undeniable fact, how-



“ We are going to counter the professional liability insurance crisis in a manner that is more forceful and proactive than any effort we have ever before employed. ”

ever, is that in certain cases, jury awards have been out of control. High damage awards are perhaps attributable to two factors: (1) the public's unrealistic level of expectation with regard to outcomes; and (2) the inherent difficulty of sorting out the fundamental differences between a maloccurrence versus malpractice. Many medical practitioners can understand why the public finds differentiating between these two types of events difficult. However, physicians remain very dissatisfied with the way the issues play out in courtrooms, and rightly so.

College rallies

What is the American College of Surgeons doing to meet its obligation to respond to this cri-

sis on behalf of our Fellowship and the many surgeons who are not members of this organization? Let me make it clear that we are going to counter the professional liability insurance crisis in a manner that is more forceful and proactive than any effort we have ever before employed. We will be devoting not only time and effort, but also significant financial resources, to this cause. During their June meeting, the Board of Regents earmarked \$3 million to fund a major effort to offset the current situation and enact some sort of federal and state reform.

In addition, College staff has been active in and now chairs the Health Coalition on Liability and Access (HCLA), which is composed of more than 80 organizations. HCLA has been actively leading the fight in Washington to convince Congress to pass medical liability reform. Although the House of Representatives has passed medical liability reform numerous times, achieving consensus in the Senate has continued to be huge hurdle that we have been unable to overcome.

Nonetheless, leadership in this sort of confederation is important because this problem of professional liability and its current ramifications is too big for one organization to manage alone. It must be addressed by a united front that represents the physicians and surgeons of this country and that can contest the well-organized and well-financed competing forces lobbying on this issue. Surgeons in high-risk specialties, in particular, must have a clear and forceful voice in HCLA, which is robust enough to lead the charge for all of medicine. We need to be vocal and offer solutions that are more than short-term fixes to this long-term problem. We must pool the College's resources with those of other groups and work to create an environment in which reform legislation may be enacted. We need to create a coalition of medicine

because we must be united and willing to work together on this important initiative.

I will keep the Fellowship updated on our progress regarding this effort and, as always, welcome your feedback and ideas.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

❖ **Raymond Lanzafame, MD, FACS**, a general surgeon from Rochester, NY, was recently appointed to a four-year term as a Special Government Employee of the Food & Drug Administration's Center for Devices & Radiological Health (CDRH). Dr. Lanzafame will serve as a consultant to the General and Plastic Surgery Devices Panel, and as a consultant to other panels of the Medical Devices Advisory Committee and to the CDRH.

❖ In May, six ACS state chapters—Brooklyn/Long Island, Northern California, Massachusetts, New Jersey, North Carolina, and Tennessee—participated in the College's **Capitol Hill Visit Program**. Hosted by the Washington, DC, Office, the program provides Fellows with the opportunity to meet with their legislators on Capitol Hill and advocate for federal issues that affect their practices and patients. Specifically, chapter members urged their legislators to pass legislation that would bring about medical liability reform, stop the Medicare physician payment cuts, and fund trauma systems.

❖ **A special meeting for retired and soon-to-be retired Fellows of the College** will be held in conjunction with this year's Clinical Congress in Chicago. Scheduled for Tuesday, October 21, from 1:45 until 3:00 pm, the meeting will be hosted by Robert E. Berry, MD, FACS, and will focus on specific issues of interest to senior Fellows. A panel of senior Fellows will explore whether the College might consider providing services specifically tailored to meet the needs and interests of its senior members. Check the *Bulletin* for additional information in coming months. If you have a specific issue you would like the panel to address, please contact Dr. Berry via e-mail at valber@att.net.

❖ Are you or your staff encountering problems with coding and payment for surgical procedures you perform? Call the **ACS Coding Hotline** (1-800/227-7911). Hotline consultants can help your practice choose the right procedure and diagnosis codes so you can prepare and submit clean claims for more prompt reimbursement. ACS Fellows are entitled to 10 complimentary consultations per year.

❖ As part of its Member Benefit package, the College has developed the **ACS PDA Center**, which offers a large selection of hardware, software, accessories, and services. Included in the center are a large selection of leading medical PDA software products from Lippincott, Williams & Wilkins, F.A. Davis, PocketMedicine, and Merck. Also available are handheld devices from all of the major manufacturers, including Palm, Handspring, Sony, Compaq, and Hewlett-Packard. A 5 percent discount is available for all hardware and software products for members of the College. To browse the products available through the center and to place a secure online order, visit <http://facs.pdaorder.com/welcome.xml> or call 1-800/462-0388.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

Medicare reforms address physician concerns

In long sessions completed on June 26, both the Senate and House passed Medicare reform legislation before leaving for the traditional July 4 recess. The House passed H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003, by a narrow vote of 216-215. Most notably for surgeons, the House bill provides for Medicare physician payment updates of at least 1.5 percent in 2004 and 2005. Under current law, it is estimated that physician reimbursement will be reduced by an estimated 4.2 percent in 2004, with further negative updates occurring in subsequent years.

In contrast, the Senate overwhelmingly passed its own version of Medicare reform legislation, S. 1, by a margin of 76-21. For surgeons and other physicians, the legislation is not quite as helpful. S. 1 does not include a provision for a positive update for physicians. However, Sens. Jon Kyl (R-AZ) and Arlen Specter (R-PA) both offered resolutions regarding the Medicare payment problem, which were included in the final bill. These resolutions urge Congress to fix the problem to prevent additional cuts in physician payments. While these resolutions do not have the force of law, they will strengthen the negotiating position for physicians when House and Senate conferees meet to resolve differences between the two bills.

Surgeons should urge their elected officials to support provisions in the Medicare package that would avert scheduled cuts and ensure a positive update for 2004 and 2005 by using the College's Legislative Action Center at <http://capwiz.com/facs/home/>. For more information, contact ahp@facs.org.

National Trauma Awareness Month events held

The month of May marked the fifteenth anniversary of National Trauma Awareness Month. To help call public attention to trauma as a persistent public health concern, the College hosted two events in Washington, DC.

On May 21, the ACS Committee on Trauma (COT) sponsored a briefing for the Washington representatives of state governors. The event highlighted draft findings of a soon-to-be released government study showing the states' baseline-level of disaster preparedness and trauma care system capabilities six months after the September 11, 2001, terrorist attacks. The program, hosted by Kurt Newman, MD, FACS, vice-chief of pediatric surgery at Children's National Medical Center, defined the elements of a comprehensive trauma care system and detailed the activities of the Health Resources Services Administration's (HRSA's) National Trauma-EMS Systems Program. HRSA officials believe their study will provide a snapshot of the states' response capabilities immediately following September 11.

One week later, the College sponsored a special briefing at the National Press Club to educate the media and the public about the current state of trauma system development across the country. In addition, COT leadership showcased select findings from the second annual report of the College's National Trauma Data Bank™ (NTDB™), highlighting its promise as a tool for developing better injury prevention programs and for improving care of the injured patient.

During the briefing, COT Chair Wayne Meredith, MD, FACS, and

NQF suggests “safe practices”

John Fildes, MD, FACS, Chair of the COT subcommittee on the NTDB, urged Congress to quickly pass the Trauma Care Systems Planning and Development Act of 2003 and to significantly increase funding for the program in 2004.

At its annual meeting in Los Angeles, CA, last May, the National Quality Forum (NQF) released a report outlining “safe practices” that hospitals should report to the public. One practice identified in the report advises patients that they may benefit from being treated at hospitals that perform a high volume of the specific procedures they need. These include operations such as abdominal aortic aneurysm repair, coronary artery bypass graft, carotid endarterectomy, esophagectomy, and pancreatectomy.

Large health care purchasers, including the Centers for Medicare & Medicaid Services, have asked NQF to develop standard measures of health care quality so that consumers may use the information to compare providers and to purchase services that fit their individual needs.

In addition, demonstration projects are under way to determine whether financial incentives encourage high performers to maintain an acceptable level of care. The “pay for performance” movement has been advanced by the LeapFrog Group, which represents large employers who are concerned about escalating health insurance rates. These purchasers hope to find new ways to control costs while allowing their employees to assume a greater role in selecting their care.

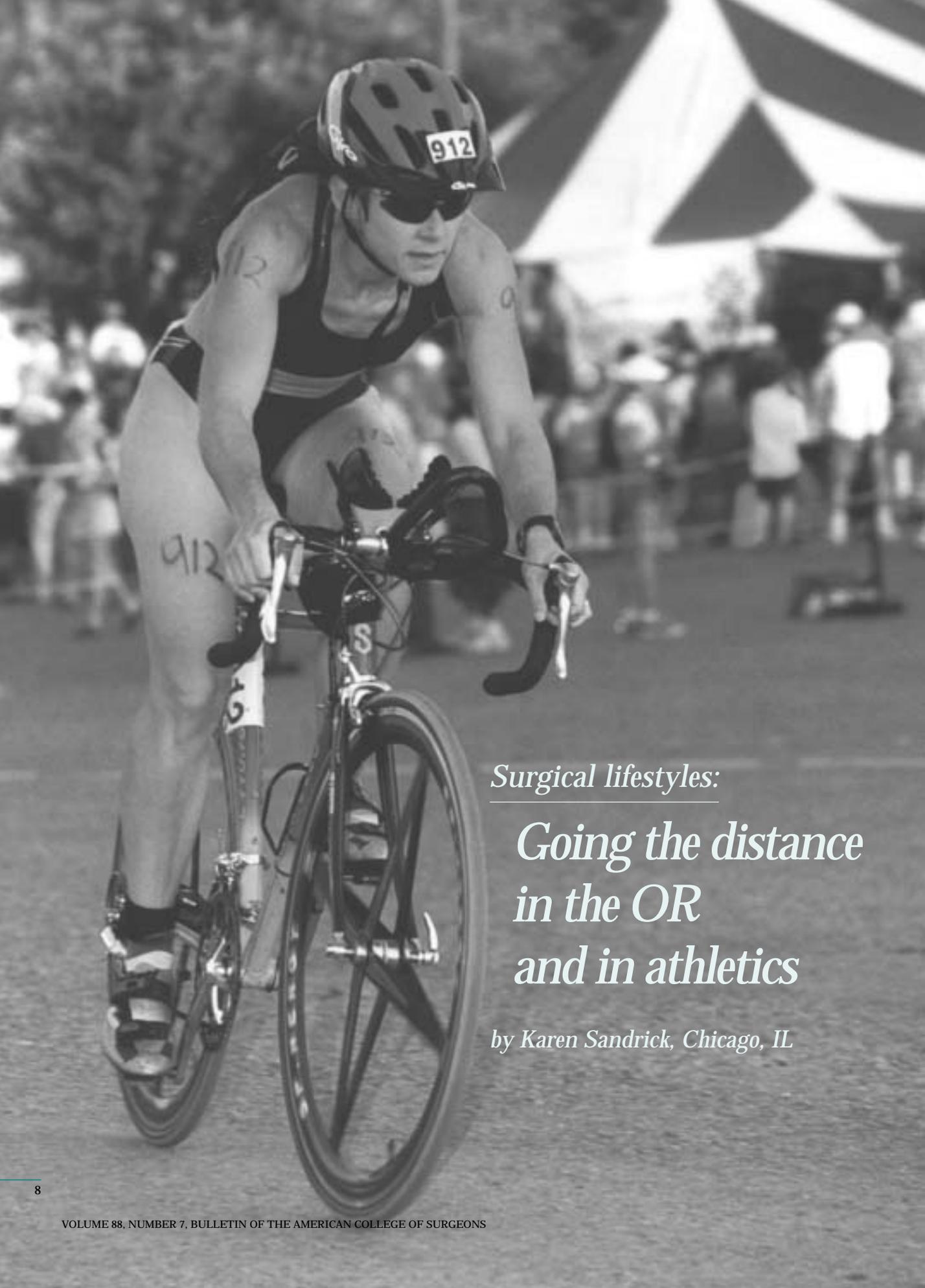
In the course of these discussions, the College has insisted that proper risk adjustment is essential to measuring the quality of surgical care. In addition, the College believes that so-called pay for performance strategies are problematic because the current designs focus on process measures that are best used to manage chronic rather than surgical care. Finally, the College has continued to highlight its promising efforts to validate the Veterans Affairs’ National Surgical Quality Improvement Program’s (NSQIP’s) use in the private sector, as well as other measurement efforts developed by the surgical specialty societies.

Hearings focus on physician quality

As part of the yearlong series of hearings on health care competition law and policy, the Federal Trade Commission (FTC) and the Department of Justice focused their joint May and June sessions on quality and consumer information. LaMar S. McGinnis, Jr., MD, FACS, testified on behalf of the College at a May 29 hearing.

“Quality improvement is an important aspect of practice that has efficiency-enhancing effects greatly outweighing their anticompetitive effects,” Dr. McGinnis said. “The College stresses the importance of practices implementing, tracking, incorporating, and updating data measures or standards of care suggested by their professional societies—formulated in conjunction with patient advocates and consumers at large.

“We continue to encourage surgeons to include the consumer dimension in their clinical discussions,” Dr. McGinnis added. “The give and take of that dialogue will help formulate what is best for the patient’s care in a truly collaborative way.”



Surgical lifestyles:

*Going the distance
in the OR
and in athletics*

by Karen Sandrick, Chicago, IL

Almost every weekday morning before day-break in and around Memphis, TN, trauma surgeon and triathlete Gayle Minard, MD, FACS, undergoes some sort of vigorous workout. Three times a week, before she teaches surgical residents how to perform endoscopy, Dr. Minard intersperses low-intensity aerobic runs with high-intensity track workouts. Another two or three days a week, before she acquaints third-year medical students with the fine points of trauma and critical care, Dr. Minard tests her speed and endurance in freestyle sprints and 500-yard repeats in master swim practice, then does 10 to 12 sets of strength-building exercises. Before sunset two evenings a week—after supervising the surgical ICU at the Memphis Veterans Affairs hospital, consulting on nutritional support at the regional medical center and the VA, and scrubbing in on trauma cases—she bumps up her overall fitness on her bike. When she leaves work late, she sets her bike up on a stationary trainer in her living room and rides for an hour or two. Then on weekends, she tries to get in an extra long run and bike ride.

How long and how far Dr. Minard goes depends on the specific event for which she's training. If she's preparing for an Olympic triathlon, which entails a swim of about 1.5-k, a 40-k bike ride, and 10-k run, her longest workout is three hours or less. If she's readying for an Ironman competition, which is a 2.4-mile swim, 112-mile bike ride, and a 26.2-mile marathon, her longest training runs are about three hours, and her bike rides lengthen to six or seven hours.

Athletic competition

Dr. Minard, associate professor of surgery and assistant professor of emergency medicine at the University of Tennessee Health Science Center, has always been athletic. She was a competitive swimmer in high school and competed with the University of Cincinnati swim team. She kicked into high gear as a dedicated triathlete just seven years ago when she was the swimming member of a triathlon relay team competing in the annual Memphis in May Triathlon. The head of

the trauma center, Timothy Fabian, MD, FACS, who is now the chair of surgery at the University of Tennessee, Memphis, decided to enter that competition. The associate director of the trauma center challenged Dr. Fabian, saying he'd run the race the next year and beat him. Their wives then decided to run the race as a relay team and asked Dr. Minard to handle the swimming. Over time, the wives dropped out, and Dr. Minard replaced them with other people. Finally, she decided, as long as her knees could take it, she'd run the race herself.

She now competes on her own every year in all three arms of the triathlon, which is part of the month-long Memphis in May International Festival. The competition consists of a 1.5-k swim along a triangular course in 45-acre Casper Lake, a 40-k bike ride around northern Shelby County, and a 10-k run back and forth from Edmund Orgill Park. In the last few years Dr. Minard also has competed in a Powerman Duathlon and the twelfth annual Great Floridian Half Ironman. Last October she participated in her first Ironman competition—Ironman Wisconsin in Madison.

Sure, training for and competing in a triathlon are grueling and time-consuming, but the rewards extend to both the body and the mind. Dr. Minard works out early each morning not only because it fits into her schedule, but because it prepares her for the day. "Training gives me more energy. I may start out tired and achy and feeling miserable, but usually within 20 minutes I start to feel good and after a two-hour run, I feel good for the rest of the day," she said. Repetitive, endurance exercise, such as long-distance running, also reduces tension and stress and clarifies thought processes.

But it's the tremendous sense of accomplishment that gets her to the starting line of the toughest all-around tests of stamina—Ironman races. Ironman competitions are held all over the world, from Langkawi Island, Malaysia, to Lake Taupo in New Zealand. Dr. Minard picked Ironman Wisconsin for her first outing because she's familiar with the city. She has a friend who lives in the area and has been attending football games in Madison for years. Another positive attribute of Ironman Wisconsin is the freshwater swim. "At some Ironman competitions,

Left: Dr. Minard cycling in competition.

you swim with sharks and jellyfish. There are no sharks in the lake in Madison,” she joked.

She didn’t even mind the “nasty” hills she had to cover during the race, because the countryside was so picturesque and the people were so supportive. About 75,000 spectators lined the Ironman route to cheer on the triathletes and attend the accompanying festivals, such as the Ironman Pig Roast, she said.

And it didn’t take her long to move up to an Ironman distance. “When people first get into triathlons, they can’t imagine doing an Olympic distance. But then you work on it, and your endurance improves, and you find you can finish the race. So then you think you’ll do a Half Ironman, and after you get a few of those under your belt, you ask, ‘What’s next?’”

Competing in an Ironman turns out to be less daunting than one might expect. Dr. Minard explained that all Ironman contests except the world championship in Hawaii accept all comers. All a racer has to do is sign up, pay the fee, train heartily for four to five months, and compete. Active triathletes include a 72-year-old nun named Madonna Buder, who was the only competitor in the women’s 70-74 age group, and 75-year-old Bill Albrecht, who was the oldest athlete to finish the 2002 Ironman Triathlon World Championship last year.

For amateurs like Buder, Albrecht, and Dr. Minard, an Ironman is not “a killer,” she said. “You’re not trying to race until you fall over; you go at a pretty moderate pace and essentially turn the race into a long training day.”

Discipline

Balancing the demands of triathlon training and competition with the rigors of critical care and academic surgery as well as a home life with her husband and four dogs takes careful plan-



ning. “I don’t have an extra minute during the day; every single minute is planned,” Dr. Minard said.

Day-by-day, week-by-week planning extends to her triathletic workouts. While Dr. Minard learned how to train for an Olympic-distance triathlon from other triathletes in the Memphis triathlon community, as well as books and magazines, she felt she needed a highly structured training program for Ironman Wisconsin. So she turned to a programmed online training plan developed by six-time World Ironman champ Mark Allen. Mr. Allen recommends: 12 weeks of gradually building a racing base by increasing mileage and speed; four weeks of honing racing skills through speed work, short-distance triathlons (Half Ironmen or less), and fitness development; and four weeks of tapering down from peak volume and intensity workouts to none two days before a race.

The time and effort have paid off in top finishes. In the sprint and Olympic distance triathlons, Dr. Minard frequently places first in her age group, and she’s occasionally won the



masters' division, which includes all competitors age 40 and up. In Ironman Wisconsin, Dr. Minard ranked tenth out of 30 in her age group, "which isn't bad," she said, "but it won't get me to Hawaii."

The Ironman Triathlon World Championship in Hawaii, which has been called a lesson in humility, was established in 1978 to settle an argument about which athletes—runners, swimmers, or cyclists—were the fittest in the world. To settle the debate, then-Navy Captain John Collins proposed combining the three toughest endurance races on the island into one and calling the winner "Ironman."

The original field of 15 Ironman competitors has grown over the years to 1,500 triathletes, who cover 140.6 miles while bucking crosswinds of 45 miles an hour and sweltering in temperatures in excess of 90 degrees.

Despite the wind, the heat, and the unforgiving black lava rock along the Kona Coast of Hawaii, the Ironman Triathlon World Championship is Dr. Minard's athletic goal. "I don't know how realistic that is, but I've done Ironman Wisconsin once, and I know I can improve on that," she said.

Regardless of what sort of athletic event she chooses to compete in next, odds are it won't be the last. Dr. Minard said she keeps up with the triathlons and Ironman competitions because she has a lot of fun and gets a tremendous sense of accomplishment. She also said that training in general gives her more energy for her "day job," and she gets a lot of "good thinking done" when she's running. □

Ms. Sandrick is a freelance writer in Chicago, IL.

STATE AFFAIRS:

A mid-year update

With the arrival of summer, many of the state legislatures have closed up shop for the year. Others are still grappling with such issues as medical liability reform, disaster preparedness and trauma care system needs, scope of practice battles, and regulation of office-based surgery or other invasive procedures. The following is a mid-year update on the status of all of these issues and serves as an overview of some of the new resources at the College that chapters may use in furthering advocacy and grassroots activity at the state level.

Medical liability reform

Over the past two years, medical liability reform has rocketed to the primary issue for surgeons in a majority of the states around the country. Always a major concern for physicians, the problems associated with escalating insurance premiums, or lack of availability of any insurance at any price, are now driving many high-risk specialists to take drastic steps to ensure their practices' survival.

by CHRISTOPHER GALLAGHER,

Manager State Affairs, Washington Office,

and JON SUTTON,

State Affairs Associate, Division of Advocacy and Health Policy

STATE MEDICAL LIABILITY REFORM ENACTED 2002-2003

(as of 5/2/03)

STATE	CAPS	OTHER REFORMS
Arkansas	Punitive damages of \$1 million	Modified joint and several liability; venue restrictions; expert witness standards; periodic payments; pretrial affidavits
Idaho	Cap reduced to \$250,000	---
Mississippi	\$500,000; \$750,000 in 2011; \$1 million in 2017	Venue reform; abolished joint and several liability; certificate of merit; joint underwriting association
Nevada	\$350,000	Several liability for noneconomic damages; collateral source rule; periodic payments; shorter statute of limitations; \$50,000 limit on damages for trauma care
Ohio	\$250,000 or three times economic loss up to \$350,000; \$500,000 per occurrence	Several liability for noneconomic damages; periodic payments; collateral source rule
Pennsylvania	Lost/unconstitutional	Modified collateral source rule; periodic payments; limited statute of limitations; joint underwriting association; venue reform
West Virginia	\$250,000	Patient compensation fund; \$500,000 cap on civil damages for trauma care; collateral source rule; abolition of joint liability; expert witness standards; physicians' mutual insurance company

These steps include: closing practices and moving to states with lower liability premiums; modifying practices to provide lower-risk care; retiring early; and even obtaining additional state licensure and enduring long commutes, sometimes across a number of state lines, in order to practice where there is a more stable insurance market.

To respond to this crisis, the College has increased its staff resources devoted to state affairs and is actively working with the chapters (see list, p. 16) to activate grassroots efforts. Reforms being advocated include: revision of joint and several liability; implementation of collateral source

rules; periodic payment of damages; limits on attorneys' contingency fees; and, most importantly, a \$250,000 cap on noneconomic damages.

In addition to traditional letter writing campaigns, physicians have begun taking to the streets, marching on a number of state houses to educate their legislators about the medical liability insurance crisis and its effects on patient access to care. In response to these rallies and other events, virtually every form of media is now beginning to cover both the direct and indirect effects of this crisis, including trauma center closures, lack of access to obstetrics care in large geo-

PATIENT SAFETY PRINCIPLES FOR OFFICE-BASED PROCEDURES

The following 10 principles were developed by representatives from over 35 health care organizations during a March 17, 2003, consensus meeting, which was coordinated by the American Medical Association and American College of Surgeons.

CORE PRINCIPLE #1: Guidelines or regulations should be developed by states for office-based surgery according to levels of anesthesia defined by the American Society of Anesthesiologists' (ASA's) "Continuum of Depth of Sedation" statement dated October 13, 1999, excluding local anesthesia or minimal sedation.

CORE PRINCIPLE #2: Physicians should select patients by criteria including the ASA patient selection Physical Status Classification System and so document.

CORE PRINCIPLE #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities, the American Association for Ambulatory Health Care, the American Osteopathic Association, or a state-recognized entity, or are state licensed and/or Medicare certified.

CORE PRINCIPLE #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

CORE PRINCIPLE #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent.

CORE PRINCIPLE #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally-privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of continuous quality improvement.

CORE PRINCIPLE #7: Physicians performing office-based surgery must be currently board certified/qualified by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board. The procedure must be one that is gen-

graphic areas, and long waits for elective procedures. The latter problem is a result of physicians being forced to focus their time and attention on the legislative process to secure reforms that will stabilize the insurance market in their respective states.

The scope of this activity has prompted more than 30 state legislatures within the last two years to address the liability issue. Unfortunately, only a few states—Mississippi, Nevada, Ohio, and West Virginia—passed legislation with the cap on noneconomic damages. See the table on page 13 for a brief summary of liability reforms enacted during the first four months of this year.

Trauma system development

States continue to work toward shoring up their trauma care systems following the events of September 11. In addition to using the new Surgery State Legislative Action Center (SSLAC) to help a number of ACS chapters mobilize their grassroots on this issue, the College has been working hard to educate policymakers in every state across the country about new federal funding opportunities for trauma care system development.

In early 2003, the federal government approved \$500 million for the Health Resources Services Administration's Bioterrorism Hospital Preparedness Program. Through the SSLAC, the College's Committee on Trauma (COT) has mobilized more than 1,000 trauma care providers to reach out to their Governors about the critical role that trauma care systems

can play in disaster preparedness. The COT's nationwide alert is currently posted on the state action center Web page: <http://capwiz.com/sslac/issues/alert/?alertid=1662331&type=SW>.

Under the preparedness program, states may tap this funding for a number of priorities, including developing and enhancing trauma care systems. Our goal is to demonstrate that comprehensive trauma care systems not only save the lives of countless Americans who fall victim to injury every day, but also that these systems are the critical foundation in a state's plan to respond to conventional and unconventional acts of terrorism.

Office-based procedures

In the past few years, the number of invasive procedures being performed in the office setting has increased noticeably. Recognizing that many states have yet to issue patient safety guidelines in this area, the College sponsored a resolution, which the American Medical Association's (AMA's) House of Delegates passed at a December 2002 interim meeting. In brief, the resolution called on the AMA to work with the ACS in "convening a work group of interested specialty societies and state medical associations to identify specific requirements for optimal office-based procedures and utilize those requirements to develop guidelines and model state legislation for use by state regulatory authorities to assure quality of office-based procedures."

erally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

CORE PRINCIPLE #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

CORE PRINCIPLE #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is currently trained in advanced resuscitative techniques (Advanced Trauma Life Support[®], Advanced Cardiac Life Support, or PALS), must be present or immediately available with age and size-appropriate resuscitative equipment until the patient has been discharged from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in basic life support.

CORE PRINCIPLE #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.

MARCH 17, 2003 MEETING PARTICIPANTS:

Accreditation Association for Ambulatory Health Care, American Academy of Cosmetic Surgery, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Pediatrics, American Association for Accreditation of Ambulatory Surgery Facilities, American College of Obstetricians and Gynecologists, American College of Surgeons, American Gastroenterological Association, American Medical Association, American Osteopathic Association, American Society for Dermatologic Surgery, American Society for Reproductive Medicine, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of General Surgeons, American Society of Plastic Surgeons, American Urological Association, Federation of State Medical Boards, Indiana State Medical Society, Institute for Medical Quality-California Medical Association, Joint Commission on Accreditation of Healthcare Organizations, Kansas Medical Society, Massachusetts Medical Society, Medical Association of the State of Alabama, Medical Society of the State of New York, Missouri State Medical Association, National Committee for Quality Assurance, Pennsylvania Medical Society, and Society of Interventional Radiology.

CHAPTERS THAT HAVE USED THE SURGERY STATE LEGISLATIVE ACTION CENTER TO ADVOCATE ON BEHALF OF MEDICAL LIABILITY REFORM: Florida, Georgia, Kentucky, Mississippi, New Jersey, South Carolina, Texas, Washington, and West Virginia.

On February 5, 2003, the ACS convened a meeting of interested surgical specialty societies to discuss the surgical community's perspective on this issue. In addition, the College invited representatives from the American Society of Anesthesiologists (ASA) to provide information and guidance regarding ASA's anesthesia guidelines. As a result of this meeting, most of the surgical community reached consensus on a set of 10 core principles that states should examine when attempting to regulate office-based procedures.

After observing the College's catalytic efforts in this area, the AMA quickly followed suit, convening a March 17 meeting that included the following interested parties: surgical and medical specialty societies; state medical associations; the National Committee on Quality Assurance; and the major accrediting organizations for ambulatory and office-based surgery. The March meeting, held in consultation with the ACS, used the 10 principles from the February 5 meeting as the foundation for discussion and debate.

The March 17 meeting was chaired by LaMar S. McGinnis, Jr., MD, FACS, and Clair Callan, MD, of the AMA. The discussion focused on a walk-through of the February 5 principle document with the workgroup debating the merits of each principle. After a few minor changes, the panel unanimously approved the revised set of 10 principles. These principles and a list of the organizations that crafted them appears in the sidebars on pages 14 and 15.

Scope of practice

The College is working closely with surgical specialty societies and chapters to monitor scope-of-practice issues at the state level. One such issue involves efforts to redefine the practice of dentistry to permit single-degree oral surgeons (DDS) to perform cosmetic surgery of the head and neck (such as rhinoplasty, blepharoplasty, laser resurfacing, browlift, and rhytidectomy). Over the last

12 months, the College has signed on to a number of joint statements, authored by the American Society of Plastic Surgeons and the American Academy of Otolaryngology-Head and Neck Surgery, opposing this expansion of dental practice in states such as Montana, Colorado, and Tennessee.

In the continuing scope of practice battle between ophthalmologists and optometrists, the College worked closely with the New Jersey Chapter of the ACS to successfully defeat legislation that would have inappropriately expanded optometric scope of practice to include surgery. Through the SSLAC, New Jersey Fellows were able to inundate their legislators with letters opposing the bill. The legislation in question would have allowed the New Jersey State Board of Optometrists to grant optometrists the authority to perform laser surgery and prescribe the full range of prescription drugs without any oversight or scrutiny by the New Jersey Board of Medical Examiners.

State advocacy resources

Legislative Action Center. As mentioned earlier, we are now using a Surgery State Legislative Action Center that the College and 15 other surgical specialty societies established at the beginning of the year. Briefly, the SSLAC is an electronic advocacy tool that engages the same software program (CapWiz) and zip code matching technology that the ACS and many other national specialty societies use for federal advocacy efforts. This system will match surgeons with their elected state representatives, allowing them to reach out to members of their state legislatures on an ad-hoc basis or through a coordinated grassroots campaign.

The SSLAC includes a home page highlighting the logo of each participating surgical specialty society. Participating members are able to access a list of state legislative issues or action alerts that both their particular organizations and other participating specialty societies are currently advocating.

StAR program. A new grassroots network-building project began earlier this year, when the College began calling on one to three Fellows in each state around the country to become an ACS State Advocacy Representative (StAR). Program participants would be recognized as the College's point people to carry the surgical community's message

continued on page 60

An aerial night photograph of the Chicago skyline, featuring the Willis Tower (then Sears Tower) as the central focus. The image is overlaid with light trails from traffic on a major highway, creating a sense of motion and urban energy. The text is overlaid in white on the top portion of the image.

89th ANNUAL CLINICAL CONGRESS
TOMORROW'S SURGERY: WHAT YOU NEED TO LEARN TODAY
OCTOBER 19-23, 2003 • CHICAGO, IL

PRELIMINARY PROGRAM

FROM THE CHAIR, BOARD OF REGENTS COME TO THE 2003 CLINICAL CONGRESS



Dear Colleagues:

On behalf of the entire College, I would like to extend our warmest invitation for you to join us in Chicago for the 89th Annual Clinical Congress of the American College of Surgeons.

The multitude of changes and the latest advances in health care require that surgeons learn new skills and take an active approach to learning throughout their professional careers. The College's Program Committee has exerted outstanding efforts to bring to all of our members an extensive array of educational sessions and courses that it hopes will meet the needs of Fellows and enhance the care of their surgical patients.

The program spans virtually every area of surgical research and practice, including topics such as management of surgical complications, best practices relating to abdominal and pelvic radiation, and advances in the field of genomics. Competency issues are incorporated into the program through topics such as the current and future state of laparoscopic colon and rectal surgery, patient safety, evidence-based surgery, and the role of the surgeon in injury prevention. Advances in technology will be addressed in sessions on image-guided surgery, robotic-assisted surgery, and enhancing care to the patient through the use of handheld devices (PDAs). The program also includes contemporary educational issues, such as training and mentoring surgeons, ethics, and surgical infection and antibiotics. Programa Hispanico will be offered again this year. The named lecturers include an outstanding collection of clinicians, academicians, surgeon scientists, surgeon historians, and surgeon ethicists.

In addition to these sessions, the Clinical Congress offers a myriad of postgraduate courses, including skills-oriented courses on topics such as lymphatic mapping, ultrasound, stereotactic breast biopsy, and bariatric surgery. Didactic postgraduate courses that provide a more in-depth exposure to a variety of clinical topics will be offered, including minimal access surgery, head and neck surgery, and a review course in urology. Presentations of papers on leading-edge clinical research, presentations by young investigators, and video-based educational sessions complete the comprehensive selection of sessions and activities. The meeting will include extraordinary scientific and technical exhibits.

The Clinical Congress has been designed to offer surgeons a wide range of educational opportunities and will inspire you not only to keep abreast of the latest scientific developments in surgery, but to meet the various professional challenges you face today and will encounter in the future. I hope you will join us in Chicago this year.

With best wishes,

A handwritten signature in teal ink that reads "Edward R. Laws".

Edward R. Laws, MD, FACS
Chair, Board of Regents

TOMORROW'S SURGERY: WHAT YOU NEED TO LEARN TODAY

Changes in health care and continuing advances in science and technology require surgeons to acquire new knowledge and skills to provide the best care to surgical patients and remain competitive well into the future. The 2003 Clinical Congress offers a wide range of educational programs that will help surgeons and surgical trainees meet their individual learning needs.

GOAL AND OBJECTIVE

The Clinical Congress is designed to provide a broad range of learning opportunities and experiences that will enable individuals to participate in activities that match their educational and professional development needs. At the conclusion of the Clinical Congress, participants should be able to gain and apply the knowledge to improve surgical practice, research, and care.

Participants will be allowed to select from a variety of named lectures, as well as general, multidisciplinary, and specialty session topics.

NAMED LECTURES

Opening Ceremony and American Urological Association Lecture

Sen. William H. Frist, MD, FACS, *Washington, DC*

John H. Gibbon, Jr., Lecture: Lessons from the Titans

Sir Magdi H. Yacoub, MBBCh, FACS(Hon), *London, UK*

Charles G. Drake History of Surgery Lecture: The Evolution of Understanding and Clinical Monitoring of Traumatic Brain Injury and Unconsciousness

Graham M. Teasdale, MBBS, FACS(Hon), *Glasgow, UK*

Scudder Oration on Trauma: Prehospital Care from Napoleon to Mars: The Surgeon's Role

Norman E. McSwain, Jr., MD, FACS, *New Orleans, LA*

Ethics and Philosophy Lecture: Do No Harm? The Ethical Challenge of Using Living Persons As Sources of Organs and Tissues

Arthur Caplan, PhD, *Philadelphia, PA*



CHUCK GIORNO PHOTOGRAPHY

Sculptured owls grace the corners of the Harold Washington Public Library downtown.

Please note changes for Convocation, Annual Meeting

New this year, the Convocation Ceremony will take place **Sunday, October 19, 6:00–8:00 pm**, at the Hilton Chicago.

The Annual Meeting of Fellows and Initiates has been renamed the Annual Meeting of Fellows, and will take place **Thursday, October 23, 2:00–2:45 pm**, at the McCormick Place Lakeside Center.

Commission on Cancer Oncology Lecture: Pre-emption of Malignant Expression: The Role of the Surgical Oncologist

Andrew C. Von Eschenbach, MD, FACS, *Bethesda, MD*

I.S. Ravdin Lecture in the Basic Sciences: The Development of Immunotherapy for the Treatment of Patients with Cancer

Steven A. Rosenberg, MD, FACS, *Bethesda, MD*

Distinguished Lecture of the International Society of Surgery: Chaos Theory, Uncertainty, and Surgery

Jose Patino, MD, FACS(Hon), *Bogota, Colombia*

Martin Memorial Lecture: Professionalism, the Profession, and Public Policy

Richard L. Cruess, MD, *Deep River, ON*

GENERAL SESSION HIGHLIGHTS

- Thermal Ablation of Malignant Tumors: Too Hot to Handle?
- Acquiring Skills to Perform New Procedures: Principles, Challenges, and Opportunities
- Recognition, Management, and Prevention of Operating Room Catastrophes
- Controversies in Inguinal Hernia Surgery
- Agents of Bioterrorism
- Graduate Surgical Education in the Era of the 80-Hour Workweek
- Genomics and Proteomics in Surgical Research
- The Surgeon and the Law: Medical Liability Crisis: Different Viewpoints
- Trauma Surgery in Military and Urban Areas of Warfare
- Abdominal and Pelvic Radiation Injuries: Early Management

SPECIALTY SESSIONS

- Laparoscopic Colon and Rectal Surgery: Where Are We and Where Are We Going?
- Advances in the Management of Common Venous Disease
- Ovarian and Uterine Neoplasms in Childhood: Update on Diagnosis and Management
- Vascular Emergencies: New Approaches to Old Problems

ADDITIONAL ACTIVITIES

- Select from 18 video-based education sessions
- More than 250 leading-edge research papers presented at Surgical Forum and Paper Sessions
- Peer-reviewed scientific exhibits
- Approximately 300 technical exhibits

MULTIDISCIPLINARY PROGRAMS

- Controversies in Carotid Surgery
- Management of General Surgical Complications in the Thoracic Transplant Patient

SCIENTIFIC PROGRAM REGISTRATION

American College of Surgeons
89th Annual Clinical Congress
Chicago, IL
October 19–23, 2003

Register online at
www.facs.org

or

Mail to:
 American College of Surgeons
 Attn: Registration Services
 PO Box 92340
 Chicago, IL 60675-2340

or

Fax to:
 800/682-0252 or
 312/202-5003

SPECIALTY	
<input type="checkbox"/>	SUR - General Surgery
<input type="checkbox"/>	THO - Cardiothoracic Surgery
<input type="checkbox"/>	CRS - Colon & Rectal Surgery
<input type="checkbox"/>	OBG - Gynecology & Obstetrics
<input type="checkbox"/>	NEU - Neurological Surgery
<input type="checkbox"/>	OPT - Ophthalmic Surgery
<input type="checkbox"/>	ORT - Orthopaedic Surgery
<input type="checkbox"/>	ORL - Otorhinolaryngology
<input type="checkbox"/>	PED - Pediatric Surgery
<input type="checkbox"/>	PLA - Plastic & Maxillofacial Surgery
<input type="checkbox"/>	URO - Urology
<input type="checkbox"/>	VAS - Vascular Surgery
<input type="checkbox"/>	Other: _____

- ▶ *The deadline for advance registration is August 28 for U.S. registrants and August 8 for international registrants.*
- ▶ *Cancellation deadline: August 28 for U.S. registrants and August 8 for international registrants. Refunds will not be issued after these dates.*
- ▶ *Do not include hotel deposit with this form. It will delay your reservation.*

ACS FELLOWSHIP ID NUMBER _____		
FIRST NAME AND MIDDLE INITIAL _____	LAST NAME _____	
ADDRESS (NUMBER AND STREET) _____		
CITY _____	STATE/PROVINCE _____	ZIP/POSTAL CODE _____
COUNTRY _____		
TELEPHONE _____	FAX _____	
E-MAIL _____		

CATEGORY	On or Before 8/8 (international) or 8/28 (U.S.)	After 8/8 (international) or 8/28 (U.S.)
1 <input type="checkbox"/> Fellow of the American College of Surgeons ...	No fee	No fee
2 <input type="checkbox"/> Initiate	No fee	No fee
3 <input type="checkbox"/> Associate Fellow	No fee	No fee
4 <input type="checkbox"/> Candidate Group Member	No fee	No fee
New <input type="checkbox"/> Medical Student—Member	No fee	No fee
5 <input type="checkbox"/> Surgical Resident—with verification letter*	\$215 _____	\$240 _____
6 <input type="checkbox"/> Guest Physician (U.S.)*	\$590 _____	\$640 _____
7 <input type="checkbox"/> Guest Physician (international)*	\$590 _____	\$640 _____
8 <input type="checkbox"/> Medical Student—Nonmember*	\$20 _____	\$20 _____
A <input type="checkbox"/> Hospital Administrator (non-MD)	\$250 _____	\$300 _____
B <input type="checkbox"/> Hospital Purchasing Agent	\$250 _____	\$300 _____
C <input type="checkbox"/> Medical Association Personnel	\$250 _____	\$300 _____
D <input type="checkbox"/> Nurse	\$250 _____	\$300 _____
E <input type="checkbox"/> Physician Assistant	\$250 _____	\$300 _____
F <input type="checkbox"/> Technician	\$250 _____	\$300 _____
H <input type="checkbox"/> PhD	\$590 _____	\$640 _____
K <input type="checkbox"/> Social Program	\$ 50 _____	\$ 75 _____
	(Name) _____	
R <input type="checkbox"/> Commercial Press	\$440 _____	\$490 _____
	(Company Name) _____	

*Includes membership application fee.

Registration Subtotal \$ _____ \$ _____

Register Online & Save Time
www.facs.org

(Form continues on back)

POSTGRADUATE COURSES

<input type="checkbox"/>	101	SC 1	Breast Imaging for the General Surgeon.....	\$250	_____
<input type="checkbox"/>	102	SC 2	Vascular Ultrasound*	\$750	_____
<input type="checkbox"/>	103	SC 3	Surgical Education: Principles and Practice	\$275	_____
<input type="checkbox"/>	104	SC 4	Ultrasound for Surgeons ...	\$250	_____
<input type="checkbox"/>	105	SC 5	Advanced Stereotactic Breast Biopsy*	\$300	_____
<input type="checkbox"/>	106	SC 6	Ultrasound Instructors Course*	\$100	_____
<input type="checkbox"/>	107	SC 7	Stereotactic Breast Biopsy*	\$750	_____
<input type="checkbox"/>	108	SC 8	Head and Neck Ultrasound*	\$750	_____
<input type="checkbox"/>	109	SC 9a	Computers in Surgery: Creating a Scientific Presentation— Monday AM Workshop	\$325	_____
<input type="checkbox"/>	110	SC 9b	Computers in Surgery: Creating a Scientific Presentation— Monday PM Workshop	\$325	_____
<input type="checkbox"/>	111	SC 10	Foundations in CPT and ICD-9-CM Coding	\$350	_____
<input type="checkbox"/>	112	SC 11	Ultrasound in the Acute Setting*	\$750	_____
<input type="checkbox"/>	113	SC 12	Computers in Surgery: Basic Course	\$425	_____
<input type="checkbox"/>	114	SC 13	Mastering Surgical Coding	\$350	_____
<input type="checkbox"/>	115	SC 14	Breast Ultrasound*	\$1,000	_____
<input type="checkbox"/>	116	SC 15	Abdominal Ultrasound: Transabdominal/Intra-operative/Laparoscopic* ..	\$1,500	_____
<input type="checkbox"/>	117	SC 16	Bariatric Surgery Primer ...	\$850	_____
<input type="checkbox"/>	118	SC 17	Lymphatic Mapping and the Significance of Sentinel Node Biopsy	\$350	_____
<input type="checkbox"/>	119	SC 18a	The Basics of Handheld PDA Devices for Surgeons— Wednesday AM Workshop .	\$325	_____
<input type="checkbox"/>	120	SC 18b	The Basics of Handheld PDA Devices for Surgeons— Wednesday PM Workshop .	\$325	_____

* Requires prerequisite for registration.

- **Cancellation Policy:** Registration and postgraduate course fees will be refunded if a written request is received at the College and postmarked no later than August 8 for international registrants or August 28 for U.S. registrants. A \$50.00 handling fee will be retained.
- The American College of Surgeons reserves the right to cancel any regularly scheduled session prior to the start of the meeting.
- Formal, written confirmation will be mailed to all registrants.
- Please ensure legibility prior to mailing or faxing.
- Payment must accompany registration. Purchase orders are not accepted.

POSTGRADUATE COURSES

<input type="checkbox"/>	201	PG 19a	ACOSOG Clinical Trials— Monday–Tuesday Lectures	\$100	_____
<input type="checkbox"/>	202	PG 19b	ACOSOG Clinical Trials— Wednesday–Thursday Lectures	\$100	_____
<input type="checkbox"/>	203	PG 20	Head and Neck Surgery	\$225	_____
<input type="checkbox"/>	204	PG 21	Diseases of the Liver, Biliary Tract, and Pancreas	\$400	_____
<input type="checkbox"/>	205	PG 22	Vascular and Endovascular Surgery	\$325	_____
<input type="checkbox"/>	206	PG 23	Thoracic Surgery	\$400	_____
<input type="checkbox"/>	207	PG 24	Gastrointestinal Disease	\$400	_____
<input type="checkbox"/>	208	SC 25	Bedside Procedures Workshop	\$850	_____
<input type="checkbox"/>	209	PG 26	Colon and Rectal Surgery	\$275	_____
<input type="checkbox"/>	210	PG 27	Safety for Office-Based Surgery	\$275	_____
<input type="checkbox"/>	211	PG 28	Charting a Sound Course for Surgical Practices	\$450	_____
<input type="checkbox"/>	212	PG 29	Evidence-Based Surgery	\$275	_____
<input type="checkbox"/>	213	PG 30	The Challenges in Trauma Management and Clinical Strategies for Risk Reduction	\$400	_____
<input type="checkbox"/>	214	PG 31	Cardiac Surgery	\$300	_____
<input type="checkbox"/>	215	PG 32	Career Development	\$100	_____
<input type="checkbox"/>	216	PG 33	Contemporary Issues in Breast Cancer	\$325	_____
<input type="checkbox"/>	217	PG 34	Minimal Access Surgery	\$400	_____
<input type="checkbox"/>	218	PG 35	Pediatric Surgery: Polyposis Syndromes	\$275	_____
<input type="checkbox"/>	219	PG 36	Contemporary Approaches to Healing the Difficult Wound	\$275	_____
<input type="checkbox"/>	220	PG 37	Urology Review for Recertification Candidates	\$300	_____
<input type="checkbox"/>	221	PG 38	The Business Aspects of Health System Management	\$275	_____
<input type="checkbox"/>	222	PG 39	Surgical Infection and Antibiotics	\$275	_____

I plan to attend the Candidate and Associate Society Symposium on Sunday, October 19.



Check here if ADA (Americans with Disabilities Act) accommodation is desired. An ACS staff person will contact you.

Daytime Phone: _____

Fees payable in U.S. funds to: American College of Surgeons

- Check (enclosed) MasterCard VISA American Express

Card Number _____ Exp. _____ / _____

Card Issued to _____

Signature _____

Registration Subtotal \$ _____

PG Course Fee Subtotal \$ _____

Total Amount \$ _____

POSTGRADUATE COURSES

The Clinical Congress offers a wide variety of postgraduate courses. This year, select from 19 skills-oriented and from 20 didactic postgraduate courses. Descriptions of each postgraduate course are listed on the following pages.

SC 1

Breast Imaging for the General Surgeon

CHAIR: Philip Z. Israel, MD, FACS, *Marietta, GA*

4 hours

Sunday, October 19, 7:30 am–12:00 noon

Fee: \$250

The course is designed to provide the practicing surgeon with increased imaging skills in the analysis of both mammographic and breast sonographic images. Emphasis will be placed on correlation of normal breast anatomy to both mammographic and sonographic images. The pathology of breast disease will be highlighted by analyzing sonographic and mammographic images and correlating the pathophysiology presented to the image seen. The course will be presented in an interactive fashion.

SC 2

Vascular Ultrasound

CHAIR: David B. Pilcher, MD, RVT, FACS, *Burlington, VT*

5 hours

Sunday, October 19, 12:00–5:30 pm

Fee: \$750

Prerequisite: Ultrasound for Surgeons (SC 4). *(Due to limited seating and workshop capacity, early registration is encouraged.) If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, or registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain the necessary documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.*

The objective of this course is to provide the practicing surgeon and surgical resident with core education

and training in the indications, techniques, advantages, and limitations of ultrasound examinations in the diagnosis and treatment of patients with vascular diseases. Emphasis is given to those procedures that require some surgeon participation in image acquisition, such as intraoperative ultrasound. The surgeon should be able to obtain optimal images to improve therapy and direct treatment in the operative setting.

SC 3

Surgical Education: Principles and Practice

CHAIRS:

Mary Maniscalco-Theberge, MD, FACS, *Reston, VA*

Michael R. Marohn, DO, FACS, *Alexandria, VA*

6 hours

Sunday, October 19, 8:30 am–12:30 pm and 2:00–5:00 pm

Fee: \$275

The objective of this course is to enhance the teaching skills of surgeons active in student and/or resident teaching. The principles of adult learning, needs assessment, questioning and feedback skills, and performance evaluation will be reviewed. In addition, participants will develop a thorough understanding of the practical applications of these principles, both in and out of the operating room.

SC 4

Ultrasound for Surgeons

CHAIR: Lawrence N. Diebel, MD, FACS, *Detroit, MI*

4 hours

Sunday, October 19, 7:30–11:45 am

Fee: \$250

The objective of this course is to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. The basic core module or its equivalent is a prerequisite for education in advanced training modules in the management of specific clinical problems.

The basic course is an introduction to ultrasound and does not qualify the surgeon to apply the technique independently. At the conclusion of this course, the surgeon will have completed didactic preparation necessary to undertake ultrasound skills training.

SC 5

Advanced Stereotactic Breast Biopsy

CHAIR: Darius Francescatti, MD, FACS, *Chicago, IL*

4 hours

Sunday, October 19, 1:00–5:30 pm

Fee: \$300

This course has been designed to provide those surgeons already using stereotactic breast biopsy with the requisite number of CME hours required for the stereotactic recredentialing process. Topics will be discussed didactically and in interactive case presentation format. This four-hour course will stress practical solutions to targeting dilemmas, in-depth mammographic lesion analysis, mammographic/pathologic correlation, and image-guided intervention, as well as the rationale for stereotactic versus ultrasound-guided biopsy.

SC 6

Ultrasound Instructors Course

CHAIR: Michael R. Marohn, DO, FACS, *Alexandria, VA*

4 hours

Monday, October 20, 8:00 am–12:00 noon

Fee: \$100

Prerequisite: Approval by the National Ultrasound Faculty Vice-Chair for Education; application required. Contact Cherlynn Sherman by e-mail at csherman@facs.org for additional information.

This course is designed to provide the experienced surgeon sonographer with the skills necessary to teach ultrasound to surgical residents at the local level and to practicing surgeons at the national level.

SC 7

Stereotactic Breast Biopsy

CHAIR: Richard E. Fine, MD, FACS, *Marietta, GA*

8 hours

Monday, October 20, 8:00 am–12:00 noon and 1:00–5:15 pm

Fee: \$750

The objective of this course is to introduce surgeons to the principles and practice of stereotactic biopsy as a minimal access means of obtaining tissue samples for diagnosing indeterminate or suspicious mammographic lesions. An overview of radiation safety issues related to stereotaxis, as well as the technical efficacy and cost analysis of stereotactic versus other alternatives, will

be presented. It is highly recommended that surgeons complete the Breast Imaging for the General Surgeon skills-oriented course before enrolling in this course.

SC 8

Head and Neck Ultrasound

CHAIR: Jay K. Harness, MD, FACS, *Oakland, CA*

7 hours

Monday, October 20, 8:30 am–12:00 noon and 1:00–5:00 pm

Fee: \$750

Prerequisite: Ultrasound for Surgeons (SC 4). (*Due to limited seating and workshop capacity, early registration is encouraged.*) If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, or registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain the appropriate documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to provide the practicing surgeon with knowledge and practical skills in the application of diagnostic and interventional head and neck ultrasound. The program will consist of lectures and hands-on skill stations, using a variety of ultrasound equipment. Live-model and phantom mouldages will be used to develop skills in head and neck ultrasound imaging and ultrasound-guided head and neck biopsy.

SC 9 (A OR B)

Computers in Surgery: Creating a Scientific Presentation

CHAIR: David A. Krusch, MD, FACS, *Rochester, NY*

3 hours

Workshops (choice of one):

9(a) Monday, October 20, 9:45 am–12:45 pm

9(b) Monday, October 20, 2:00–5:30 pm

Fee: \$325

The objective of this course is to provide the advanced computer user with instruction in creating a successful scientific presentation using PowerPoint™, electronically manipulating still and moving images for presentation, improving presentation skills, and publishing the

presentation on the Web. The course will focus primarily on advanced PowerPoint techniques and is designed to enhance the ability of the surgeon in the presentation and publication of scientific material in electronic format. As a prerequisite, participants should have knowledge of basic computer concepts and a familiarity with PowerPoint. This three-hour course will be presented entirely in a workshop format and does not include a lecture component.

SC 10

Foundations in CPT and ICD-9-CM Coding

CHAIR: John T. Preskitt, MD, FACS, *Dallas, TX*

6 hours

Monday, October 20, 9:45 am–12:45 pm and 2:00–5:30 pm

Fee: \$350

This course will introduce participants to the key principles of ICD-9-CM and *Current Procedural Terminology* coding, including use of the books. ICD-9-CM topics will include diagnosis codes, carriers' use of these codes to establish medical necessity, the neoplasm table, and coding comorbidities. CPT topics include CPT concepts, guidelines and definitions, evaluation and management (E/M) codes, add-on versus stand-alone codes, and the use of modifiers. Participants will learn how the accurate use of both coding systems to report patient encounters results in the appropriate reimbursement for services.

At the conclusion of the basic coding program, participants will have mastered essential principles of CPT and ICD-9-CM coding that are specific to general surgery to ensure accurate claim submission and be able to select appropriate CPT E/M code levels of service and provide documentation to meet requirements. Participants are required to bring their copy of *CPT Coding, 2003 Edition*.

SC 11

Ultrasound in the Acute Setting

CHAIR: Amy C. Sisley, MD, FACS, *Baltimore, MD*

7 hours

Monday, October 20, 9:00 am–12:15 pm and 1:15 pm–5:15 pm

Fee: \$750

Prerequisite: Ultrasound for Surgeons (SC 4). (Due to limited seating and workshop capacity, early registration is encouraged.) If you have not taken the ACS-spon-

sored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, or registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain the appropriate documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to familiarize the participant with areas of ultrasound frequently used by general surgeons to evaluate patients with acute surgical problems. The participant will learn focused ultrasound examinations through individual hands-on experience and will acquire an understanding of the essentials of ultrasound technology and physics.

SC 12

Computers in Surgery: Basic Course

CHAIR: David A. Krusch, MD, FACS, *Rochester, NY*

6 hours

Lecture: Monday, October 20, 9:45 am–12:45 pm

Workshop: Tuesday, October 21, 8:30–11:30 am

Fee: \$425

The objective of this course is to teach basic PC techniques to the beginning user. A lecture session, as well as a hands-on workshop, will provide the practicing surgeon with a practical working knowledge of current concepts. The course content will include an introduction to basic PC hardware and concepts, types and methods of Internet connectivity, remote access to clinical data, medical knowledge-based searching techniques, and medical resources available on the Internet. Upon successful completion of the course, participants should be able to choose appropriate personal computers and use the Internet to enhance professional productivity. Participants are required to attend the lecture and the workshop.

SC 13

Mastering Surgical Coding

CHAIR: John T. Preskitt, MD, FACS, *Dallas, TX*

6 hours

Tuesday, October 21; 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$350

This course will provide an in-depth discussion of advanced concepts in ICD-9-CM diagnosis coding, CPT surgical coding and modifier use, reporting staged operations, consultations, and variables that influence the correct reporting of physician services, including the national Correct Coding Initiative (CCI) and the impact of carrier medical review policies. Hands-on coding of surgical case studies will be included. At the conclusion of the advanced coding program, participants will: (1) expand their understanding of proper modifier usage on evaluation and management services as well as general surgical cases; and (2) be able to comply with Medicare rules, CCI edits, and the resource-based relative value scale when reporting services.

SC 14

Breast Ultrasound

CHAIRS:

Eric B. Whitacre, MD, FACS, *Ellicott City, MD*

Patrick W. Whitworth, MD, FACS, *Nashville, TN*

7.5 hours

Tuesday, October 21, 8:00 am–12:00 noon and 1:00–5:00 pm

Fee: \$1,000

Prerequisite: Ultrasound for Surgeons (SC 4). (Due to limited seating and workshop capacity, early registration is encouraged.) If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, or registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain the appropriate documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to introduce the practicing general surgeon to a focused module in diagnostic and interventional breast ultrasound. The program will consist of lectures and hands-on skill stations using a variety of ultrasound equipment. Live models and phantom breast moulages will be used to develop skills in breast ultrasound imaging and ultrasound-guided breast biopsy.

SC 15

Abdominal Ultrasound: Transabdominal/Intraoperative/Laparoscopic

CHAIRS:

Maurice E. Arregui, MD, FACS, *Indianapolis, IN*

Junji Machi, MD, PhD, FACS, *Honolulu, HI*

12 hours

Tuesday, October 21, 7:30 am–9:30 am, 10:00 am–12:00 noon, 1:00–5:00 pm;

Wednesday, October 22, 7:30 am–12:00 noon

Fee: \$1,500

Prerequisite: Ultrasound for Surgeons (SC 4). (Due to limited seating and workshop capacity, early registration is encouraged.) If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, or registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain the appropriate documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to provide the practicing surgeon and surgical resident with advanced education and training in abdominal ultrasound, including transabdominal, intraoperative, and laparoscopic ultrasound, as it is used in the diagnosis and treatment of abdominal diseases. This one-and-a-half-day course will consist of lectures and individual hands-on sessions. Human models, live animals, excised livers, and phantom moulages will be used to develop skills in abdominal ultrasound imaging and ultrasound-guided procedures. Endoscopic ultrasound and anorectal ultrasound also will be discussed.

SC 16

Bariatric Surgery Primer

CHAIR: Henry Buchwald, MD, PhD, FACS, *Minneapolis, MN*

ASSOCIATE CHAIR: Sayeed Ikramuddin, MD, *Minneapolis, MN*

14 hours

Tuesday, October 21, 8:00 am–4:30 pm; Wednesday, October 22, 8:00 am–4:30 pm

Fee: \$850

This intense, two-day course will feature didactic presentations, panels, and live, interactive, closed-circuit televised sessions to provide a broad overview of bariatric surgery. Participants will be able to describe

the epidemiology, etiology, and incidence of morbid obesity and outline the physiologic basis for bariatric surgery. Criteria for identification of appropriate surgical candidates will be outlined, and various bariatric surgical procedures, such as laparoscopic adjustable gastric banding, vertical banded gastroplasty, gastric bypass, and duodenal switch, will be presented. The pre-, intra-, and postoperative care associated with each procedure will be described, along with the possible postoperative complications and their appropriate management and prevention strategies. In addition, principles underlying a multidisciplinary approach to bariatric surgery and the consequences of postbariatric weight loss will be discussed. Live, interactive, closed-circuit televised operations, primarily featuring laparoscopic techniques, will be performed by world-renowned surgeons. The course will also include presentations regarding insurance, billing, coding, and liability issues related to bariatric surgery and the ethical perspectives on elective surgery for metabolic disease. A special evening presentation by an international expert and dinner are included as part of the course.

SC 17

Lymphatic Mapping and the Significance of Sentinel Node Biopsy

7 hours

CHAIR: Armando E. Giuliano, MD, FACS, *Santa Monica, CA*

Wednesday, October 22, 8:00 am–12:00 noon and 1:00–5:00 pm

Fee: \$350

The objective of this course is to teach basic intellectual and practical aspects of sentinel lymph node dissection. Participants will learn about the use of sentinel node biopsy for melanoma and breast cancer. They will learn different techniques to perform the procedure and will come to understand the use of radioisotopes and lymphoscintigraphy. In addition, the histopathologic evaluation of sentinel node and the controversies surrounding special techniques will be discussed.

SC 18

The Basics of Handheld PDA Devices for Surgeons

CHAIRS:

Ronald B. Hirschl, MD, FACS, *Ann Arbor, MI*

David A. Krusch, MD, FACS, *Rochester, NY*

6 hours

Lecture: Tuesday, October 21, 1:30 – 5:00 pm

Workshops (choice of one):

18(a) Wednesday, October 22, 8:30 am–12:00 noon

18(b) Wednesday, October 22, 1:30–5:00 pm

Fee: \$325

This session will highlight the role of personal data assistants (PDAs) and the use of interactive information for the surgeon's daily practice. The workshop session is designed for beginners who have never owned or used a PDA and will feature a hands-on demonstration of the use and function of PDAs. A PDA will be provided to participants. Participants are required to attend the lecture session and select one workshop session.

PG 19A/B

The American College of Surgeons' Oncology Group Clinical Trials

CHAIR: Samuel A. Wells, Jr., MD, FACS, *Durham, NC*

12.25 hours

Monday and Tuesday, October 20–21, 8:30 am–4:30 pm, or

Wednesday and Thursday, October 22–23, 8:30 am–4:30 pm

Fee: \$100

The purpose of this course is to familiarize Fellows with the opportunities they have to participate in the clinical trials conducted by the American College of Surgeons Oncology Group (ACOSOG). The program will be designed to provide a general educational format for surgeons who are unfamiliar with the surgical trials in general and the ACOSOG trial group in particular. Participants will learn how protocols for trials are developed and how the clinical trials are conducted. A section of the program will be devoted to active clinical trials in several of the organ sites, such as breast, lung, and upper gastrointestinal. This course will primarily appeal to surgeons who are already active in ACOSOG but seek an update on the progress of current trials and plans for new studies.

PG 20

Head and Neck Surgery

CHAIR: Paul W. Nelson, MD, FACS, *Kansas City, MO*

6 hours

Monday, October 20, 9:45 am–12:45 pm and 2:00–5:30 pm
Fee: \$225

This course will review the elements of surgery of the head and neck, geared to the needs of the practicing general surgeon. Emphasis will be placed on surgery of the thyroid and parathyroid glands. The management of malignant tumors of the head and neck will also be reviewed, with emphasis on newer surgical techniques and on the role and efficacy of multimodality therapy. At the conclusion of the course, participants will be familiar with fundamental techniques and recent advances in the field of head and neck surgery.

PG 21

Diseases of the Liver, Biliary Tract, and Pancreas

CHAIR: Steven C. Stain, MD, FACS, *Nashville, TN*

6 hours

Monday, October 20, 1:30–5:00 pm; Tuesday, October 21, 8:30 am–12:00 noon
Fee: \$400

The objective of this course is to provide an update on the etiology, pathophysiology, diagnosis, and treatment (both surgical and nonsurgical) of patients with diseases of the liver, biliary tract, and pancreas. A number of new innovations in the area, especially in diagnostics and therapeutics, as well as the evolution of surgical operations in this complicated area, will be presented. A multidisciplinary approach that includes medicine, surgery, radiology, and other subspecialties will be used.

PG 22

Vascular and Endovascular Surgery

CHAIR: Bauer E. Sumpio, MD, FACS, *New Haven, CT*

6 hours

Monday, October 20, 1:30–5:00 pm; Tuesday, October 21, 1:30–5:00 pm
Fee: \$325

The objective of this course is to review the best evidence for the appropriate selection of open versus endovascular therapy for common arterial and venous diseases.

PG 23

Thoracic Surgery

CHAIR: William H. Warren, MD, FACS, *Chicago, IL*

6 hours

Monday, October 20, 1:30–5:00 pm; Tuesday, October 21, 1:30–5:00 pm
Fee: \$400

The objective of this course is to discuss controversial topics and the use of new technology in general thoracic surgery.

PG 24

Gastrointestinal Disease

CHAIR: Lee E. Swannstrom, MD, FACS, *Portland, OR*

6 hours

Monday, October 20, 1:30–5:00 pm; Tuesday, October 21, 1:30–5:00 pm
Fee: \$400

The objective of this course is to review up-to-date and contemporary treatments of surgical gastrointestinal disease, as well as the medical therapies that pertain to them. Emphasis will be placed on the diagnosis, especially the highly technical aspect, of the etiology and investigation of gastrointestinal disease as it applies to patients who may be candidates for surgery. This course is intended to be of value to practicing general surgeons, surgical residents, and Fellows who have a specific interest in gastrointestinal disease.

SC 25

Bedside Procedures Workshop

CHAIR: George C. Velmahos, MD, FACS, *Los Angeles, CA*

7.5 hours

Tuesday, October 21, 8:00 am–12:00 noon and 1:30–5:30 pm

Fee: \$850

The objective of this workshop is to teach surgeons how to perform three bedside procedures: percutaneous dilational tracheostomy, percutaneous endoscopic gastrostomy, and percutaneous vena caval filter placement. Bedside procedures have been shown to be safe, convenient, teachable, and cost-effective. Reimbursement rates are significant. Surgeons will be expected to perform these procedures with increasing frequency in the near future. Other specialists treating critically ill patients—such as medical intensivists, pulmonologists, cardiologists, and anesthesiologists—will compete with surgeons in this field. Surgeons should be adequately prepared to take an early lead in performing procedures by the bedside.

PG 26

Colon and Rectal Surgery: Colon and Rectal Cancer

CHAIR: Robert D. Madoff, MD, FACS, *St. Paul, MN*

6 hours

Tuesday, October 21, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$275

Management of the patient diagnosed with colon and rectal cancer is frequently complex and challenging. Decision making is involved at multiple points and is often multidisciplinary. Evolving technologies, including the role of laparoscopy and genetic/molecular knowledge, often add to the complexity. This course will look at the spectrum of disease and patient scenarios to elucidate the salient components of high-quality care.

PG 27

Safety for Office-Based Surgery

CHAIR: Philip T. Siegert, MD, FACS, *Moline, IL*

6 hours

Tuesday, October 21, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$275

The objective of this course is to instruct Fellows and other physicians in the management of problems specific to ambulatory surgical units. The course will specifically address various forms of management for airway difficulties, problems in anesthesia (including conscious sedation), instruction in the supervision of anesthesia personnel, and the recognition and management of treatable cardiac dysrhythmias. This course is designed to significantly increase the skill level of the surgeon or other physician for the specific management of these potential problems. Because the ambulatory surgical units developing across the country are unique from the hospital setting, these areas of concern need to be addressed for improvement in the surgeon's education, reduction in complication risk, and improvement in patient safety.

PG 28

Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons

CO-CHAIRS:

Charles D. Mabry, MD, FACS, *Pine Bluff, AR*
Frank G. Opelka, MD, FACS, *Boston, MA*

6 hours

Tuesday, October 21, 8:30 am–12:00 noon and 1:30–5:00 pm
Fee: \$450

This educational seminar is designed for surgeons interested in improving the management and efficiency of their surgical practices. The course will include lectures and skills laboratories, in which participants will work with the instructors to solve real-life practice management problems.

PG 29

Evidence-Based Surgery

CHAIR: Robin S. McLeod, MD, FACS, *Toronto, ON*

8 hours

Tuesday, October 21, 8:00 am–12:30 pm; Wednesday, October 22, 8:00 am–12:30 pm

Fee: \$275

This course will educate surgeons in the concept of evidence-based surgery, the fundamentals of designing a clinical trial, and issues specific to surgical trials. Participants will learn how to participate in clinical trial groups and to recognize the indications/limitations of using administrative data to assess outcome following surgery. Participants will also learn about methods to synthesize data in order to keep abreast of advances in medical knowledge.

PG 30

The Challenges in Trauma Management and Clinical Strategies for Risk Reduction

CHAIR: Rao R. Ivatury, MD, FACS, *Richmond, VA*

6 hours

Tuesday, October 21, 8:30 am–12:00 noon; Wednesday, October 22, 8:30 am–12:00 noon

Fee: \$400

The objective of this course is to provide an update on current issues in trauma care with an emphasis on specific elements designed to reduce clinical risk. The focus will be on more difficult or controversial areas of clinical management, stressing decision-making, operative, prophylactic, and organizational methods for reducing specific risks, minimizing complications, and limiting errors.

PG 31

Cardiac Surgery

CHAIR: John Calhoun, MD, FACS, *San Antonio, TX*

6 hours

Tuesday, October 21, 8:30 am–12:00 noon; Wednesday, October 22, 1:30–5:00 pm

Fee: \$300

The objective of this course is to provide practicing cardiac surgeons and residents-in-training with current information on timely topics in myocardial revascularization, surgery of the mitral and aortic valves, and surgery for congenital heart disease.

PG 32

Career Development

CHAIR: Julie Ann Freischlag, MD, FACS, *Baltimore, MD*

6 hours

Tuesday, October 21, 1:30–5:00 pm; Wednesday, October 22, 1:30–5:00 pm

Fee: \$100

The objective of this course is to support the career advancement of young faculty members, with special emphasis on women faculty. At the end of the course, participants will be able to develop a plan for their career advancement, more effectively manage their time, and enhance their negotiating skills to obtain the resources needed for their academic activities.

PG 33

Contemporary Issues in Breast Cancer

CHAIRS:

Kirby I. Bland, MD, FACS, *Birmingham, AL*

Nathalie M. Johnson, MD, FACS, *Portland, OR*

6 hours

Tuesday, October 21, 1:30–5:00 pm; Wednesday, October 22, 1:30–5:00 pm

Fee: \$325

The objective of this course is to address contemporary issues in breast cancer management for ductal carcinoma in situ (DCIS). On Tuesday, four key aspects in the management of patients with early stage breast cancer will be discussed. On Wednesday, risk assessment and the management of locally advanced breast cancer will be the topics. At the completion of the course, participants will understand: (1) the details of margin assessment in breast conserving surgery; (2) the role of radiation therapy and sentinel lymph node biopsy in DCIS and the surgical options for DCIS; (3) how to conduct optimal risk assessment in women with breast cancer; (4) the role of neoadjuvant approaches for locally

advanced breast cancer, as well as the role of radiation therapy; and (5) the latest information on selective estrogen receptor modulators.

PG 34

Minimal Access Surgery

CHAIR: Gerald M. Fried, MD, FACS, *Montreal, PQ*

6 hours

Wednesday, October 22, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$400

Minimal access surgery has revolutionized surgical care. The implementation of minimally invasive techniques has continued to increase over the past five years based on evidence of benefit and facilitated by enabling technology. Controversies continue regarding the use of minimal access surgical techniques and the value of some of these innovative technologies. The participant will learn of the outcome measures used to provide high-level evidence to assess minimal access surgical procedures, and will learn about the innovative enabling technologies and specific technical pointers that can be used immediately in their clinical practice.

PG 35

Pediatric Surgery: Polyposis Syndromes—Manifestations, Biology, and Management

CHAIRS:

Michael A. Skinner, MD, FACS, *Durham, NC*

Henry E. Rice, MD, FACS, *Durham, NC*

6 hours

Wednesday, October 22, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$275

This course will focus on the spectrum of inherited polyposis syndromes with discussion of natural history, pathophysiology, and treatment. Pivotal issues regarding molecular genetics and testing, timing and types of surgical interventions, novel gene and pharmacologic therapies will be discussed. A special emphasis on the technical issues for preservation of continence and minimizing long-term complications will be presented.

PG 36

Contemporary Approaches to Healing the Difficult Wound

CHAIR: Mary H. McGrath, MD, FACS, *San Francisco, CA*

6 hours

Wednesday, October 22, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$275

Wound healing continues to be an incompletely defined biologic process, and there are multiple strategies for approaching the nonhealing wound. This course will review management of the chronic wound and the effectiveness of clinical interventions, including topical and systemic biologicals, dressings, nutrients, and hormones. It will cover pharmacologic interventions with vasoactive drugs, analgesics, anabolic steroids, and gene therapy. Physical interventions with hydrotherapy, hyperbaric oxygen, ultrasound, and warming will be discussed. Finally, the role of wound closure with sealants, adhesives, vacuum devices, off-loading devices, and adjuvant surgical procedures will be covered. Guidelines for selecting the optimal intervention for specific difficult wounds will be offered. Participants are invited to bring examples of difficult cases.

PG 37

Urology Review for Recertification Candidates

CHAIRS:

Richard D. Williams, MD, FACS, *Iowa City, IA*

Jerome P. Richie, MD, FACS, *Boston, MA*

6 hours

Wednesday, October 22, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$300

This course will help participants prepare for the recertification examination in urology. Faculty will review five domains of urology: pediatric urology; oncology and urinary diversion; obstruction, calculus disease, and trauma; impotence, infertility, and infection; and incontinence and voiding dysfunction.

PG 38

The Business Aspects of Health System Management: The Surgeon's Role in Health System Leadership

CHAIR: Paul A. Taheri, MD, FACS, *Ann Arbor, MI*

6 hours

Wednesday, October 22, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$275

Over the past decade, there have been major reductions in hospital capacity, increasing demand for clinical services due to an aging population, and increased clinical access secondary to advances in technology. Physicians are frequently asked to participate in the daily management and operations of various clinical activities, yet they have little management training. The goal of this physician-developed and -tested curriculum is to introduce fundamental business and managerial tools to the practicing physician. This program is a condensed version of the University of Michigan management training program that has been delivered to more than 500 physicians within various health systems across the U.S. Although the roots of the program are derived from an academic perspective, the design and delivery of the content is focused on the practicing physician. The goal of this curriculum is to provide the clinician and administrator with the tools necessary to change their practice and optimize the delivery of health care tomorrow. This offering includes content on the basic economics of health care, cost accounting, operations management, finance, risk management, and physician leadership.

PG 39

Surgical Infection and Antibiotics

CHAIR: Nicolas V. Christou, MD, FACS, *Montreal, PQ*

6 hours

Wednesday, October 22, 1:30–5:00 pm; Thursday, October 23, 8:30 am–12:00 noon

Fee: \$275

The proliferation of antibiotics, as well as their various specificities, has made infectious disease a surgical subspecialty over the past 20 to 30 years. This course provides an excellent review of the mechanisms of antibiotic effects on various organisms, as well as the data concerning contemporary use of antibiotics in surgery, both prophylactically and therapeutically.

GENERAL INFORMATION



CHICAGO CONVENTION & TOURISM BUREAU

Buckingham Fountain at night.

Registration is open to all physicians and individuals in the health care field. Registration includes a name badge, program, and entrance to the exhibits and all sessions other than postgraduate courses. Registered attendees may purchase postgraduate course tickets based upon availability. Advance registration is strongly encouraged. Please use one of the following registration options:

Internet—Register online at: www.facs.org. Visa, MasterCard, or American Express payment of all applicable fees must be paid at the time of your online registration.

By mail—Complete and mail the registration form to: American College of Surgeons, Attn: Registration Services, PO Box 92340, Chicago, IL 60675-2340. Payment may be made by check (payable to ACS) or credit card.

By fax—Complete the form and fax to: 800/682-0252 or 312/202-5003. Credit card payments only.

Payment of applicable fees must accompany the registration form. All fees are payable in U.S. dollars. Purchase orders are not accepted. If registration is submitted via fax or online, the original form from this program is not required.

Registration confirmation will be mailed to all advance

registrants upon processing. Before the meeting, advance registrants will receive their official name badge, attendance verification card, and postgraduate course tickets(s), if applicable. Course syllabi will be distributed on site in Chicago.

If advance registration is not possible, bring the completed registration form with proper credentials to on-site registration at McCormick Place Lakeside Center. There is no on-site registration fee for Fellows, Initiates, Associate Fellows, Candidate Group members, or Medical Student members. Postgraduate course tickets may be purchased on site in Chicago, subject to availability.

INITIATES

Initiates of the ACS will automatically be registered for the Clinical Congress and need only to return the registration form if postgraduate course or social program event tickets are desired.

FAMILY/GUESTS

Accompanying spouses/guests and young adults (16 years or older) may register under the Social Program category, which includes a badge, admittance to the ex-

hibit area, shuttle buses, and all sessions other than postgraduate courses. Spouses and guests who are physicians must register under the appropriate physician category in order to receive CME credit. The Social Program registration fee is nonrefundable.

POSTGRADUATE COURSES AND FEES

Only registered meeting attendees may purchase postgraduate course tickets. Seating capacities are limited, and ticket requests will be filled on a first-come, first-processed basis. All courses require a ticket for admission. Tickets may only be exchanged before the beginning of a course. A complete listing of postgraduate courses begins on page 23.

REGISTRATION LOCATION AND HOURS

Registration locations and hours are listed below:

	McCormick Place Lakeside Center	Hilton Chicago
Saturday, 10/18	*	1:00–6:00 pm
Sunday, 10/19	10:00 am–5:00 pm	7:00 am–5:00 pm
Monday, 10/20	7:00 am–4:00 pm	7:00am–4:00 pm
Tuesday, 10/21	7:00 am–4:00 pm	*
Wednesday, 10/22	7:00 am–4:00 pm	*
Thursday, 10/23	7:00 am–1:30 pm	*

*Registration will not be available.

REGISTRATION FEES AND CREDENTIALS

Category	By 8/8 (intl.) or 8/28 (U.S.)	After 8/8 (intl.) or 8/28 (U.S.)
ACS Fellow 2003 dues paid	No fee	No fee
Initiate	No fee	No fee
Associate Fellow	No fee	No fee
Candidate Group member	No fee	No fee
Medical student-member	No fee	No fee
Surgical resident*	\$215	\$240
Guest physician*	590	640
Medical student-nonmember*	20	20
PhD	590	640
Allied health care personnel	250	300
Commercial press	440	490

*The American College of Surgeons is pleased to offer discounted registration fees for residents and medi-

cal students. Please submit a letter verifying your educational status with the completed registration form to expedite processing. Residents should obtain a letter from their program director; students should contact their department chairs. Nonmember physicians and medical students who pay the applicable registration fees will have their membership application fees waived if they apply for membership by December 31, 2003.

Commercial representatives may obtain the commercial registration form by faxing a request to: 312/202-5003.

DEADLINE FOR REGISTRATION

The registration deadline for international registrants is August 8. The deadline for U.S. registrants is August 28. Registrations received and postmarked after the deadlines will be billed according to the pricing structure published on the registration form.

CANCELLATION

Refunds will be issued if written requests are postmarked no later than August 8 for international registrants and August 28 for U.S. registrants. A \$50 handling fee will be retained for all refunds. Cancellations and registrations postmarked after the deadline will not be eligible for refunds.

CME CREDIT

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians.

The American College of Surgeons designates this educational activity for a maximum of 46 credits in Category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

The Clinical Congress program book will contain an attendance verification card for recording CME credit. The program book will be available in the registration area.

ANNUAL MEETING AND CONVOCATION

New days and times. Please note the new days and times for the following events.

- Annual Meeting of Fellows: Thursday, October

23, 2:00–2:45 pm, McCormick Place Lakeside Center.

- Convocation Ceremony: Sunday, October 19, 6:00–8:00 pm, Hilton Chicago.

PROGRAM FOR MEDICAL STUDENTS

Students from all four years of medical school are welcome to attend the Clinical Congress and to participate in a program designed specifically for medical students who may be interested in pursuing surgery as a career. Afternoon sessions with leading surgeon faculty members and residents will include topics such as deciding if surgery is the best career choice, taking the appropriate steps in each year of medical school to be competitive for surgery residency programs, identifying the qualities that program directors want in applicants, asking for letters of recommendation, interviewing successfully, choosing residency programs, preparing to optimize the resident experiences, and beginning to consider various surgical specialties and settings in which to practice. Be sure to take advantage of this unique opportunity to interact with other students interested in surgery, residents, program directors, faculty, and surgeons practicing in academe and the community. For additional information and free registration for the Medical Students Program, please contact Rosemary Morrison, at tel. 312/202-5028, or via e-mail at rmorrison@facs.org. Students interested in this program must register with Ms. Morrison.

PROGRAM FOR SURGICAL RESIDENTS

This year, for the first time, a special series of sessions and receptions have been planned for surgery residents at all levels. These sessions will address issues facing most residents, such as financial planning (managing debt and building for the future), pursuing career opportunities as fellows or as academic or community surgeons, practice management, contracts and negotiation, time management, leadership development, conflict resolution, stress management, and balancing personal and professional commitments. Join residents from other programs and interact with experts who may help you manage the residency experience more effectively and better prepare for the future. For additional information and free registration for the Surgery Residents Program, please contact Cherlynn Sherman at 312/202-5424 or csherman@facs.org. Residents interested in this program must register with Ms. Sherman.

CAS-ACS SYMPOSIUM

Sunday, October 19, from 1:00 to 5:00 pm, the Candidate and Associate Society of the American College of Surgeons (CAS-ACS) will sponsor a symposium, Resident Work-Hour Limitations: Practical Solutions. A panel will discuss how different surgical residency programs cope with the new regulations. Topics will include the impact on resident education, staffing difficulties, and methods to ensure compliance with the regulations. An open-microphone discussion will include audience participation. For more information, contact the Division of Member Services, Candidate and Associate Society staff liaison Peg Haar at phaar@facs.org. Please indicate on the registration form that you plan to attend.

AFFILIATE GROUP FUNCTIONS

Groups planning a social function or business meeting to take place in conjunction with the Clinical Congress will need to make arrangements through the ACS. For information and a function space request form, please contact ACS Convention and Meetings at 312/202-5293.

SHUTTLE BUS SERVICE

Complimentary shuttle bus service will be provided for all registrants at regular intervals between McCormick Place Lakeside Center and most designated ACS Clinical Congress hotels. Schedules and routes will be available at McCormick Place Lakeside Center and participating hotels.

CLINICAL CONGRESS NEWS

The official Congress newspaper, *Clinical Congress News*, will be distributed at McCormick Place Lakeside Center and at major hotels each morning during the Clinical Congress.

CHILDREN

The ACS policy regarding children is as follows:

- Under 12—not permitted on Social Program tours.
 - Under 16—not permitted on exhibit floor or in scientific sessions.
 - 16 and over—must have a badge to enter exhibit area or meeting rooms.
- This policy includes infants in strollers and arms.

The American College of Surgeons does not provide child care arrangements. If child care arrangements are needed, contact Mary Jane Sellers at American Registry for Nannies & Sitters, Inc., at 800/240-1820 or www.american-registry.com.

HELP AND INFORMATION CENTER

The Help and Information Center will be located at McCormick Place Lakeside Center, and will be available during registration hours. Assistance with general information, travel, housing, local information, and a messaging center will be available.

FRIENDS OF BILL W

Friends of Bill W will meet Monday, October 20, through Wednesday, October 22, from 7:00–8:30 pm at the Hilton Chicago.

CLIMATE

Average Chicago temperatures for October range between a high of 63° to a low of 42° Fahrenheit.

SOCIAL PROGRAM

A Social Program (SP) is offered. Participants must pay a nonrefundable fee, which entitles them to attend scientific sessions, view the technical exhibits, purchase event tickets, and use the shuttle service. Registered SP spouses and guests will also receive a travel tote bag that will include coupon books and brochures from local merchants, visitor guides, city map, and more. Because tour capacities are limited, advance registration is strongly encouraged. For more information, please visit the Web site at www.facs.org.

Important note: All tours will depart from and return to the Hilton Chicago. Unless otherwise indicated, please meet in the Main Lobby of the Hilton Chicago, 8th Street side. We strongly recommend comfortable walking shoes for all tours. Unless otherwise indicated, all lunches referred to are included in the price of the tour. Children under 12 years of age are not permitted on Social Program tours.

Registration forms must be received by **August 8, 2003** (all international, including Canada) or **August 28, 2003** (U.S.) in order to receive a badge and tickets before the meeting. Registrations received after the deadline date will be held for pickup at the Congress social program registration desk.

TRANSPORTATION

Fly United or Delta and save on airfare to Chicago. Special meeting saver airfares are available on United or Delta airlines.

Choose from the following savings options:

- Receive 5 percent off lowest applicable domestic published fares.
- Receive 10 percent off the published unrestricted coach fares.

Obtain an additional 5 percent discount on the above fares if tickets are purchased at least 60 days in advance. Area/zone fares based on geographic location are also available with *no Saturday night stay required*. Minimum stay (one to two nights) varies by airline; seven-day advance purchase required.

These special discounts are available either by calling the official airline directly or through the ACS Web site. *Be sure you or your travel agent mention the name of the meeting to which you will be traveling and the ACS file number indicated in order to obtain the special fares.*

United Airlines	Delta Air Lines
1-800/521-4041	1-800/241-6760
7:00 am–10:00 pm	(ET)8:00 am–11:00 pm (ET)
ACS File 501CR	ACS File 193001A

New: Save time and book your travel online through the ACS Web site. Go to the Clinical Congress page at www.facs.org for further details. (Area/zone fares not available through online ticket purchase; please call numbers shown above.)

Car rental

Avis, the official car rental company for the 2003 Clinical Congress, offers convenient locations at O'Hare International Airport, Midway Airport, and downtown at 214 N. Clark St. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates and discounts, be sure to mention your Avis Worldwide Discount (AWD) number when you call. AWD number: B169699.

Avis reservations: 1-800/331-1600
Web site: www.avis.com

GENERAL HOUSING INFORMATION

Applying for hotel accommodations

The following housing procedures apply to all general registrants of the Clinical Congress. If you are a

Regent, Officer, Past Officer, Advisory Council member, Governor, recipient of the Distinguished Service Award, or standing committee chair and are applying for the Hilton Chicago, please use the special housing application sent to you.

Housing procedures

ACS has appointed the ITS Group of ExpoExchange to coordinate housing for the 89th Annual Clinical Congress. Reservation requests will be processed on a first-come, first-served basis and must be received by **September 19, 2003**. Requests received after this deadline or after the room blocks are filled are subject to rate and space availability. Housing requests may be made using one of the following options:

Phone—Call the ACS/ITS housing bureau at 800/650-6928 or 847/940-2155 between the hours of 8:00 am and 5:00 pm CT, Monday through Friday. Credit card deposit only.

Fax—Complete the hotel reservation form and fax to 800/521-6017 or 847/940-2386. Credit card deposit only.

Mail—Complete the hotel reservation form and mail with check or credit card deposit to:

ACS/ITS Housing Bureau
108 Wilmot Road, Suite 400
PO Box 825
Deerfield, IL 60015

Online—Go to www.facs.org and visit the “travel information” page in the Clinical Congress section. Complete the hotel reservation form via the housing link. Credit card deposit only.

Reservations received after the housing deadline of **September 19, 2003**, or after the room blocks are filled, are subject to space and rate availability.

Please do not send your request directly to the hotel or to the ACS office; doing so will only delay the processing of your request. The ACS/ITS Housing Bureau will send you a reservation confirmation. Please verify your confirmation for accuracy. This is the only confirmation you will receive. If you do not receive a confirmation via e-mail, fax, or mail within 14 days after sending a request, please contact ITS at the numbers indicated above.

DEPOSIT POLICIES

All reservations must be accompanied by a deposit check of \$175 per room paid by check (payable to “ACS 2003” in U.S. funds drawn on a U.S. bank) or credit card

(American Express, VISA, MasterCard or Discover). Without a deposit, your reservation will not be processed and your application will be returned to you. The deposit will guarantee your room for late arrival for the day of arrival only. Credit cards will be charged at the time the reservation is made.

CHANGES AND CANCELLATIONS

Do not call or write the ACS office to change or cancel your reservation. Changes to and/or cancellation of your reservation should be made with the ACS/ITS Housing Bureau until September 30, 2003. After September 30, 2003, you must contact the hotel directly to make any changes. Please ask for a confirmation number when canceling your reservation.

Deposits are refundable only if cancellations are made at least 72 hours in advance of arrival date. Reservations canceled after September 19, 2003, are subject to a \$21 processing fee. Allow 90 days for processing of your refund.

CHICAGO HOTELS

For information about hotel locations and rates, please refer to the program planner sent via mail earlier this year or visit the Web site at www.facs.org.

Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first and only Web-based and continually updated surgical reference. See the box below for a special announcement for ACS Fellows, Associates, and Candidates.

Keeping current in 2003 with *ACS Surgery: Principles and Practice*

ACS Surgery 2003 is now available. Receive a free three-month trial to www.acssurgery.com, a \$50 value, by ordering your copy today. For only \$199, you can be among the elite group of surgeons who subscribe to the only continually updated surgery textbook, *ACS Surgery*. (ACS members save \$30 over the regular price of \$229.) Updated monthly online and annually in print, the *ACS Surgery* 2003 volume features 40 percent new and updated information to provide the most contemporary views on best practice and technique. Minimize complications, lower expenditures, and increase patient satisfaction with this unique reference—the only one with an accompanying online continuing medical education program. Call 1-800/545-0554 today to order your copy and be sure to request offer number S37S0G1C.

- Prefer online access only? For ACS Fellows, Associates, and Candidates, we are pleased to offer a \$20 discount on annual subscriptions to the online version of the textbook; you pay only \$179, instead of the customary \$199 rate. Visit www.acssurgery.com/learnmore.htm for more information and to save \$20 now.

- Free, convenient *ACS Surgery* updates by e-mail—no subscription necessary. Each month we'll bring you a synthesis of the latest contributions from the *ACS Surgery* team of master surgeons. Simply visit http://www.acssurgery.com/wnis/wnis_sign.htm to register to receive "What's New in *ACS Surgery*" by e-mail.

I. Resuscitation

7. *Disorders of acid-base and potassium balance*. Robert M. Black, MD. In this new chapter, the author describes acid-base physiology and discusses the diagnosis and treatment of disorders associated with metabolic acidosis and metabolic alkalosis, as well as plasma potassium disorders. For example, he notes that in the diagnosis of hyperkalemia, symptoms are related to impaired neuromuscular transmission. However, the neuromuscular manifestations are not specific. The earliest findings are paresthesias and weakness, which may progress to paralysis affecting respiratory muscles. These symptoms are similar to the ones associated with hypokalemia; however, cranial nerve function characteristically remains unaffected. Generally, severe symptoms of hyperkalemia do not occur until the plasma $[K^+]$ is greater than 7.5 mEq/L. Nonetheless, there is substantial variability among patients because such factors as concomitant hypocalcemia, metabolic acidosis, and the rate at which hyperkalemia develops can increase the toxicity of excess potassium.

Subscribers to *ACS Surgery* may view the full text of "Disorders of acid-base and potassium balance" at www.acssurgery.com.

V. Operative management

23. *Carotid arterial procedures*. Wesley S. Moore, MD, FACS. This chapter covers the identification of and surgical intervention for carotid artery disease, including preoperative evaluation, operative planning and technique, postoperative management, and follow-up. The author discusses selective identification of patients who require shunting. The most direct—and perhaps safest—method is to employ local or cervical block anesthesia so that the effect of temporary carotid clamping may be assessed in a conscious patient; if clamping leads to a neurologic deficit, then the patient clearly requires an internal shunt. Other meth-

ods of identifying patients who require a shunt make use of techniques such as continuous electroencephalographic monitoring, measurement of somatosensory evoked potential, and monitoring of middle cerebral blood flow with transcranial Doppler ultrasonography. Subscribers to *ACS Surgery* may view the full text of "Carotid arterial procedures" at www.acssurgery.com.

V. Operative management

32. *Aortoiliac reconstruction*. Mark K. Eskandari, MD. The author reviews surgical revascularization procedures for the treatment of aortoiliac occlusive disease. The article also presents step-by-step techniques for aortoiliac endarterectomy, iliofemoral bypass, aortofemoral bypass, thoracofemoral bypass, axillofemoral bypass, and femorofemoral bypass, including troubleshooting techniques for all procedures. Complications and outcome evaluation are also described, and endovascular therapy is discussed.

For example, the author notes aortoiliac endarterectomy occasionally results in a very thin residual wall, or the distal termination points are too steep to fix with tacking sutures alone. In such cases, the best recourse is to replace this section of the aorta and the common iliac vessels with a short, standard bifurcated prosthetic interposition graft. Proximally, the graft is sewn to the infrarenal aorta in an end-to-end fashion. Distally, the two limbs are sewn to the two common iliac arteries in the same manner. Subscribers to *ACS Surgery* may view the full text of "Aortoiliac reconstruction" at www.acssurgery.com.

V. Operative management

33. *Sclerotherapy*. William R. Finkelmeier, MD, FACS. Dr. Finkelmeier describes the use of sclerotherapy for the treatment of varicose veins, reticular veins, and spider veins. He presents preoperative evaluation, and operative planning and techniques, and discusses complications and cost considerations. One technique that the author reviews is the use of 30-gauge needles for all sclerotherapy treatments; some physicians prefer 27-gauge needles for larger reticular and small varicose veins. The needle is bent at a 45° angle, with the bevel up. Countertraction is applied with the nondominant hand, and the needle is inserted parallel to the vessel and the skin surface. As the ves-

sel is entered, the sclerosant is gently injected. The slight reduction of pressure that occurs when the vessel is entered becomes increasingly easy to appreciate as the physician accumulates experience with sclerotherapy. Blanching of the vein is another signal of entry into the vessel. If the solution is injected outside the vein, a small superficial wheal will appear, in which case the injection should be discontinued and a new site selected for injection. Such wheals are unlikely to be a problem when sodium tetradecyl sulfate (STS) concentrations lower than 0.25 percent are used. When more concentrated solutions are used in larger veins, aspiration of blood ensures correct placement of the needle within the vein before injection. Subscribers to *ACS Surgery* may view the full text of "Sclerotherapy" at www.acssurgery.com.

VI. Special perioperative problems

2. *Venous thromboembolism*. John T. Owings, MD. The author discusses the methods of prophylaxis of thromboembolism and describes management of deep vein thrombosis, pulmonary embolism, and superficial thrombophlebitis. He also presents the general principles of anticoagulation and lytic therapy, and describes the screening, assessment, and treatment of hypercoagulability states.

The author notes that low molecular weight heparin (LMWH) possesses the same antithrombin-potentiating pentasaccharide chain that unfractionated heparin does. Consequently, like heparin, it is ineffective if antithrombin levels are depleted. The main advantage of LMWH over unfractionated heparin is that it has a more dependable half-life and bioavailability. Thus, it can be given without monitoring drug effect or plasma heparin level.

Most of the clinical trials documenting the efficacy of LMWH evaluated patients undergoing elective hip or knee operations. A few, however, addressed other patient populations (such as trauma patients). In these studies, the incidence of DVT in patients receiving unmonitored LMWH therapy was generally lower than that in patients receiving

continued on page 54

Mr. Kelly is editor, *What's New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

In compliance...

...with HIPAA rules

by Tom Loughrey, Pittsburgh, PA

The College and Economedix recently completed a series of teleconferences about the new Health Information and Privacy Accountability Act (HIPAA) privacy standards. The following is a sample of questions raised and answered during the conference.

- *We understand we were to be in compliance with the HIPAA privacy standards by April 14. We have not sent any notices or enacted any new policies. Are we too late? What should we be doing now?*

It is not too late to comply with the HIPAA regulations. The most important things to do right now are to send out the required notice of privacy practices to patients, establish policies and procedures with regard to privacy, and arrange for staff to be trained in the policies and procedures.

- *We assist other surgeons from time to time without ever seeing the patients in our office. Can we rely on the privacy notice the primary surgeons give their patients?*

Unless you are specifically mentioned in it, the primary surgeon's notice is unlikely to cover your practice. A good policy in this instance is to send a copy of your notice to the patient with an acknowledgment of the notice for the patient to sign. Check with the hospital or ambulatory surgery center to see if the notice it is using protects surgeons providing services to patients covered by an organized health care arrangement.

- *We're still confused about the definition of a "business associate." Are attorneys and accountants considered business associates?*

To be considered a business associate for privacy purposes, the individual or firm must have access to protected health information (PHI). If an attorney working on contracts never accesses patient records, there are no privacy issues requiring a contract. However, a billing service, collection agency, and outside transcription service would need access to PHI and, therefore, must have a contract obligating them to the same privacy standards as the practice meets.

- *Our practice has an answering service. Should an answering service be HIPAA compliant?*

Around the corner

August

- ACS-sponsored practice management course for surgeons August 23 in St. Louis, MO. Visit the ACS Web page at <http://www.facs.org/dept/hpa/workshops/pmworkshop.html> to register.

September

- ACS-sponsored basic and advanced coding workshops for surgeons in St. Louis, MO, September 18-19, 2003. Visit the ACS coding workshop webpage at <http://www.facs.org/dept/hpa/workshops/cdworkshop.html> to register.

If not, what forms should the service sign for my protection?

Answering services are not covered under HIPAA. However, if they are provided with protected health information as part of their duties, they would be classified as business associates, and a contract covering their responsibilities for the privacy of your patients should be created. Check to see if they already have suggested language for a contract or use the model language available from Economedix. (Web site listed on page 40.)

- *Our office collects data from a particular surgical procedure that the surgeon performs. Does this count as research, and do we have to address this in our policies and procedures beyond stating that we don't use identifying patient information, such as name or social security number? We collect data on age, gender, procedure performed, and success of the procedure and use this data for presentations.*

Using PHI for research purposes requires a written authorization from the patient specific to the research project unless the information is sufficiently deidentified. Based only on age, gender, procedure and outcome, this information would lack identification of individuals and would not

require an authorization. Be careful that the research documents do not track back to the underlying data. Information on privacy and research is available at: http://privacyruleandresearch.nih.gov/pdf/HIPAA_Privacy_Rule_Booklet.pdf.

- *If another physician's office requests the records of one of our patients for treatment purposes, must we get authorization from the patient?*

You do not need authorization. This is part of the health care operations of your office and the release of PHI for this purpose is covered by the notice to the patient.

- *If a patient requests confidential communications, do we include this information in the chart, or just on the log? Also, if we forward the chart to another provider, do we have to provide the confidential communications information, or is it the patient's responsibility to let the other provider know his or her wishes?*

Such a request from the patient should be noted prominently on the chart so that staff see it every time they access the medical record. It also should be entered into the computer record of the patient so that if staff contacts the patient by phone they know not to leave messages with anyone other than the patient. Records sent to another office should also prominently note that the patient requests confidential communications.

- *We understand the HHS Office of Civil Rights (OCR) is hiring agents to investigate practices. Is this true? Can they just come into our practice without any complaint to check on our compliance?*

While the OCR is hiring staff for investigations, the agency maintains it only will initiate investigations based on complaints. The OCR also says its focus will be on education, resolution of complaints, and compliance. A final interim rule on sanctions and penalties was published on April 17, 2003, and is available at: <http://frwebgate4.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=51031612436+0+0+0&WAIAction=retrieve>.

- *Where can we get more information on the HIPAA privacy rule?*

A summary of the HIPAA privacy rule is available at: <http://www.hhs.gov/ocr/privacysummary.pdf>.

A fact sheet on HIPAA is available at <http://www.hhs.gov/news/facts/privacy.html> and an extensive list of frequently asked questions that is

updated regularly is available from the OCR at: <http://www.hhs.gov/ocr/>.

A CD-ROM containing the transcripts of the entire teleconference presentation with model forms, policies, and procedures can be purchased directly from Economedix at: <https://yourmedpractice.securelook.com/ACS-HIPAA-Reg.html>. 

This column responds to questions from the Fellows and their staffs and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site. If you like to see specific topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or e-mail ahp@facs.org

Mr. Loughrey is chief executive officer of Economedix, a national practice management consulting and education company with offices in Pittsburgh, PA, and Southern California. He can be reached at tel. 714/633-2251 or via e-mail at toughrey@economedix.com

The ACS grassroots agenda for tort reform: Call to action

by F. Dean Griffen, MD, FACS, Shreveport, LA

The time has come to cease our random ineffectual bantering about the current medical liability crisis. The crisis is a catastrophic problem. But now an even greater problem has evolved—our totally ineffective efforts to mollify it. Our most effective tools, physicians and their patients, have lain dormant. It is time to act.

The cost and availability of insurance for physicians is only one aspect of the problem. Patient access to care is increasingly challenged. Physicians are retiring early, leaving, or otherwise avoiding practice in states beset by crisis and are avoiding training in high-risk specialties. Women are especially disadvantaged, as obstetricians are opting out of the highly litigious obstetrical portion of their practices to practice only gynecology. Trauma care is disproportionately threatened in crisis states as level I trauma units find it difficult if not impossible to find the required 24/7 specialty coverage. High-risk procedures may be avoided in favor of less litigious albeit possibly less efficacious care.

As a result of the medical liability malpractice crisis, patients face quality and affordability issues as well. There is an incentive to conceal errors and near misses, which limits the effectiveness of peer review. Defensive medicine as a

shield from liability may increase cost by as much as 5 to 9 percent. Innovation in the area of uncommon illnesses is especially stymied, since drug companies cannot risk litigation in areas where volume sales are not available to offset losses from litigation.

It is apparent that federal tort reform is imperative if we are to meet the needs of both patients and health care providers. The American College of Surgeons (ACS) has been lobbying aggressively for federal medical liability reform. To this end, the ACS endorsed H.R. 5, the Help Efficient Accessible Low-Cost Timely Healthcare (HEALTH) Act. It is a comprehensive federal tort reform package and is fashioned after California's Medical Injury Compensation Reform Act (MICRA), which includes a cap on noneconomic damages of \$250,000.

While this legislation passed the House of Representatives in March, the problem lies in the Senate, where we may not currently have the votes to support this legislation. The ACS is working desperately to narrow the gap. (See the "From my perspective" column by ACS Executive Director Thomas R. Russell, MD, FACS, on page 3 of this issue.) Nonetheless, the gap remains insurmountable without the as

yet unrealized grassroots support for their efforts.

The College's Division of Advocacy and Health Policy and the Patient Safety and Professional Liability Committee have provided a Surgeon's Liability Action Kit on the College's Web site, which may be found at www.facs.org/ahp/proliability.html. The site provides important supports for grass-roots initiatives:

1. ACS Fact Sheets that can be downloaded, copied, and distributed to patients by mail or in offices.
2. The ACS letter endorsing H.R. 5.
3. A postcard that physicians may download and give to patients who can send them to their senators.
4. Other links to sites of related interest.

The need for federal legislation has never been felt more acutely. Eighty-four percent of Americans indicate that they are concerned about the impact rising liability costs are having on access to quality health care. Seventy-six percent support legislation that caps pain and suffering awards. These concerned Americans, as well as individual physicians who are as yet poorly mobilized, represent an untapped source of grassroots support for meaningful federal tort reform. Or-

ganized medicine can only do so much. Now it's the responsibility of each of us to become involved.

This is your call to action. There is not one day to waste. The participation of each of us is absolutely essential to success. To view your competition, simply log onto www.atla.org. The Association of Trial Law-

yers of America (ATLA) has long been hard at work undermining the efforts of organized medicine for tort reform. They have one advantage—the members of ATLA are politically active. Our lack of action is inexplicable given the crisis at hand. Our resources are immense and untapped. We have only to act. Your patients, who

have already been shown to share your views, await your requests. Log on to www.facs.org and click on "Liability Action Kit." It can't get any easier than that.

Dr. Griffen is Chair of the ACS Regents' Committee on Patient Safety and Professional Liability.

Dr. Bartlett receives Jacobson Award

Robert H. Bartlett, MD, FACS, became the ninth recipient of the Jacobson Innovation Award of the American College of Surgeons during a ceremony June 6, 2003, at the College's headquarters in Chicago, IL.

Initiated in 1994, the award honors living surgeons, or surgical teams, who have been innovative in the development of a new technique in any field of surgery. The award is made possible through a donation from Julius H. Jacobson II, MD, FACS, a general vascular surgeon known for his pioneering work in the development of microsurgery. Dr. Jacobson is director emeritus and the Distinguished Service Professor of Surgery at the Mount Sinai School of Medicine of the City University of New York.

Dr. Bartlett received the award in honor of his work in the development and establishment of the first extracorporeal membrane oxygenation (ECMO) program, as well as



Dr. Bartlett

his pioneering efforts in the use of both arterial venous and venovenous hemofiltration. Dr. Bartlett developed a world registry to compile information about the procedures, which has resulted in saving the lives of thousands of infants. In addition, Dr. Bartlett's work stan-

dardized extracorporeal membrane oxygenation and eventually led to outcomes in which many varieties of neonatal lung failure were changed from a 90 percent mortality rate to a 90 percent survival rate. His efforts have achieved significant survival rates for adult patients treated for respiratory distress syndrome.

Dr. Bartlett, who currently resides in Ann Arbor, MI, received a BA degree from Albion (MI) College in 1960, and attended the University of Michigan Medical School, receiving his MD degree, cum laude, in 1963.

After medical school, Dr. Bartlett moved to Boston, MA, where he served (1963-1969) as an intern, resident, and senior resident in surgery at Peter Bent Brigham and Children's Hospital. He also served as both chief resident in thoracic surgery (1968) and chief resident surgeon (1969) at the institution. During his time at Brigham, he was named the

Arthur Tracy Cabot Teaching Fellow in Surgery and became a Harvey Cushing Fellow. In addition, he was also a National Institutes of Health Trainee in Academic Surgery at Harvard University Medical School (1966-1970).

From 1970 to 1980, Dr. Bartlett served on the faculty of the University of California, Irvine, as an assistant professor of surgery, assistant director of surgical services, director of the burn center, and professor of surgery. Following his time at the University of California, Dr. Bartlett returned to the University of Michigan Medical Center, where he currently holds the positions of director of the surgical intensive care unit, program director of the surgical critical care fellowship, program director of the extracorporeal life support program, division chief of critical care in the general surgery section, and professor of surgery in the sections of general and thoracic surgery.

A Fellow of the College since

1973, Dr. Bartlett served as senior member on the ACS Pre- and Postoperative Care Committee from 1985 to 1995. Throughout his career, Dr. Bartlett has remained active in clinical practice and is a member of many prominent surgical societies, including leadership roles in most of the professional societies associated with critical care and the development of artificial organs. He has served as president of both the American Society for Artificial Internal Organs and the International Society for Artificial Organs. He has also served on the editorial boards of 10 major medical journals.

In addition, Dr. Bartlett has been committed to disseminating knowledge about his work in critical care and bioengineering. His first publication, in 1969, was an account of a membrane oxygenator that allowed partial bypass in animals for up to four days. In 1970, he described a simple, reliable membrane oxygenator for organ perfusion.

Since then he has written more than 300 articles in peer-reviewed publications.

Dr. Bartlett's efforts in extracorporeal life support started shortly after he began his work at Brigham and Children's Hospital. At that time, he observed that cardiopulmonary bypass was limited to a few hours, because direct exposure of blood to oxygen for prolonged periods of time was lethal. This observation led to the development of gas-permeable membranes that were interposed between the blood and gas. In 1975, while at the University of California, Dr. Bartlett became the first surgeon to successfully treat an infant using ECMO. When he moved the neonatal ECMO program to the University of Michigan, his experience in performing the procedure increased gradually from a few cases annually to a few cases monthly. Since 1982, the technology has been adapted to pediatric patients experiencing respiratory failure—70 percent have sur-

Jacobson Innovation Award recipients

1994, Professor Francois Dubois, Paris, France: Laparoscopic cholecystectomy.

1995, Thomas Starzl, MD, FACS, Pittsburgh, PA: Liver transplantation.

1996, Joel D. Cooper, MD, FACS, St. Louis, MO: Lung transplantation and lung volume reduction surgery.

1998, Juan Carlos Parodi, MD, Buenos Aires, Argentina: Treatment of arterial aneurysms, occlusive disease, and vascular injuries by using endovascular stented graphs.

1999, John F. Burke, MD, FACS, Boston, MA: Development and implementation of a number of in-

novative techniques in burn care, including the co-development of an artificial skin (Integra™).

2000, Paul L. Tessier, MD, FACS(Hon), Boulogne, France: Development of a new surgical specialty (craniofacial surgery).

2001, Thomas J. Fogarty, MD, FACS, Portola Valley, CA: Design and development of industry standard minimally invasive surgical instrumentation, especially for cardiovascular surgery.

2002: Michael R. Harrison, MD, FACS, San Francisco, CA: Creator of the specialty of fetal surgery and developing techniques of fetoscopy for minimally invasive fetal technology.

vived, and none have suffered from long-term pulmonary disability. As if his work in cardiopulmonary care was not enough, in recent years, Dr. Bartlett has expanded his work to include extended care for patients suffering from liver failure; he and his

team at the University of Michigan have been developing an artificial liver system for use in patients awaiting liver transplants.

The Jacobson Innovation Award is administered by the Honors Committee of the

American College of Surgeons. Original thought combined with the first presentation of work that has led to a milestone in the advancement of surgical care is the main criterion for choosing a recipient of the Jacobson Innovation Award.



Panel considers changes in surgery

A “Town Meeting” held during this year’s Spring Meeting in New York, NY, considered Changes in Surgical Practice: Getting Ahead of the Game.

Pictured front row, left to right: Moderator Richard J. Finley, MD, FACS, Regent of the College, and presenters Donald J. Palmisano, MD, JD, FACS, then-AMA President-Elect, and Thomas R. Russell, MD, FACS, ACS Executive Director.

Back row, left to right: Presenters Mark A. Malangoni, MD, FACS; Frank G. Opelka, MD, FACS; and Nathaniel J. Soper, MD, FACS.

Profiles in Leadership

C. Rollins Hanlon, MD, FACS

Fellow of the American College of Surgeons since 1953. Retired thoracic surgeon. Director of the ACS, 1969-1986; ACS Past-President; current ACS Executive Consultant.



"Even before I joined the College 50 years ago, I enjoyed the benefits of its education programs. Later, as a Fellow participating in its committees and teaching programs, I saw the need to support and extend College activities beyond what was possible with mere payment of dues.

The ACS is an organization that has brought untold benefits to millions of patients throughout the world by improving levels of surgical care and enforcing ethical standards in our profession. With decreased government subsidy and rising threats of litigation, personal gifts to the College are both financially necessary and strongly indicative of our belief in its ideals.

The College has given me the opportunity to contribute to an enterprise of greater scope and more lasting significance than any individual surgical career. Not least of all has been the inspiring benefit of innumerable professional friendships."

Dr. Hanlon supports the College financially through active membership in the Fellows Leadership Society.

For information about joining the Fellows Leadership Society, please contact the College's Development Office via telephone at 312/202-5376, via e-mail at fholzrichter@facs.org, or by visiting the ACS Web site at www.facs.org.



We invite you to consider joining Dr. C. Rollins Hanlon in the Fellows Leadership Society of the American College of Surgeons.



College hosts ASA Blue Ribbon Committee on Surgical Education

The American College of Surgeons hosted the second meeting of the American Surgical Association's (ASA's) Blue Ribbon Committee on Surgical Education. The meeting was held at College headquarters in Chicago, IL, February 20-21, 2003. Haile T. Debas, MD, FACS, chaired the meeting.

The membership of this committee includes leaders from the field of surgical education. Both academic institutions and community hospitals are represented in the membership, and there is resident represen-

tation as well. The Blue Ribbon Committee has appointed five subcommittees to address resident work hours and lifestyle, structure of general surgery training, medical student issues, surgical practice, and relationships with other groups. The subcommittees are chaired by Andrew L. Warshaw, MD, FACS; Frank R. Lewis, Jr., MD, FACS; J. Roland Folse, MD, FACS; Michael J. Zinner, MD, FACS; and Paul Friedmann, MD, FACS, respectively. The subcommittees presented their

progress reports during the February meeting of the committee.

The next four meetings of the Blue Ribbon Committee were scheduled for April, July, October, and December of this year. Staff support for the Blue Ribbon Committee is being provided by the Division of Education of the College.

For further information, please contact Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, at 312/202-5405 or via e-mail at asachdeva@facs.org.



ASA Blue Ribbon Committee on Surgical Education: front row, left to right: Thomas R. Russell, MD, FACS; Julie A. Freischlag, MD, FACS; Dr. Folse; Dr. Debas; Lazar J. Greenfield, MD, FACS; Murray F. Brennan, MD, FACS; and Barbara L. Bass, MD, FACS.

Back row: Dr. Friedmann; Richard E. Welling, MD, FACS; George F. Sheldon, MD, FACS; Eric A. Rose, MD, FACS; Dr. Zinner; Timothy C. Flynn, MD, FACS; Dr. Sachdeva; Carlos A. Pellegrini, MD, FACS; Mark A. Malangoni, MD, FACS; Dr. Lewis; Rosemary Morrison; Linda K. Stewart; Dr. Warshaw; and Patrice Gabler Blair, MPH.

Not pictured: R. Scott Jones, MD, FACS.



CREATE YOUR OWN ID/PASSWORD

for "Members Only" area of ACS Web site

Can't think of your ACS ID number when you want to visit the "Members Only" side of the College's Web site? *Your days of frustration are now over.*

The College has updated the Members Only section to allow you to set your own user ID and password to access its many features. To make that change, go to the College's home page at <http://www.facs.org> and click on the "Members Only" link at the top of the page.

You will still need your ACS ID when you log in for the first time. You can then enter your user ID, password, and security questions. If you forget your password the next time you visit the page, you can recover your password online by answering your previously set up security questions.

While you are in the "Members Only" area, please check to be sure that your mailing address, telephone numbers, and e-mail address are both current and accurate. Be assured that the College does not provide your e-mail address to outside entities. E-mail addresses are used only for College communications.

Nominations sought for Daland Fellowships/Judson Daland Prize

The American Philosophical Society is seeking nominations for a limited number of Daland Fellowships in Clinical Investigation and for the Judson Daland Prize. The fellowships are for research in the several branches of clinical medicine, including surgery, internal medicine, neurology, pediatrics, and psychiatry, with an emphasis on patient-oriented research. The fellowships are designed for qualified persons who have held an MD or MD/PhD degree for less than eight years, with preference generally given to candidates who

have not had more than two years of postdoctoral training and research.

Applicants must expect to perform their research at an institution in the U.S. under the supervision of a scientific advisor. Stipends for the fellowship are \$50,000 each for the first and second years. The term of the fellowship is one year, with renewal for one year if satisfactory progress is demonstrated.

The Judson Daland Prize is awarded to recognize outstanding achievement in patient-oriented research. Nominees for

this \$18,000 prize must have done their work in an institution in the U.S., but need not be U.S. citizens. The award will be presented during the April 2004 meeting of the society.

Application forms for the Daland Fellowships, which are due by September 1, 2003, are available at <http://www.amphilsoc.org>.

Nominations for the Judson Daland Prize are due by October 1. Details are available at <http://www.amphilsoc.org>. After mid-August, questions may be sent to Eleanor Roach at eroach@amphilsoc.org.

College works to address expert witness issues

Because itinerant plaintiff expert witnesses who provide inappropriate and inaccurate testimony are still commonplace, there is a need for an expanded and comprehensive database to track such testimony. To that end, the ACS is working with IDEX—a national network of more than 3,800 defense law offices, corporations, and governmental entities sharing expert witness information. The network's database contains more than 800,000 records of experts who have been involved in cases throughout the U.S. Typically, 4,500 to 6,500 new records are added every month.

IDEX states that it can provide:

- Expert witness case history.
- Transcript/document archival searches.
- Abstracts of articles/books written by the expert or naming an expert.
- "Challenges to Exclude an Expert" search.
- Information on professional disciplinary action taken against an expert's license to practice.
- Scientific literature research information on cases similar to that of the client.
- Assistance in locating an expert to help build a defense.

If you are named as a defendant in a lawsuit, the College recommends that either you or your counsel contact IDEX at

800/521-5596 concerning the plaintiff expert witness in your case. When calling, advise the representative that you are a Fellow of the American College of Surgeons. IDEX will send you the appropriate form to request the testimonial history of a particular itinerant plaintiff expert witness. A modest fee will be required only if the search succeeds in finding a case history. Any additional documents that are available through IDEX will be noted in the report, along with the additional fees that would be required to obtain copies.

Active participation by the defendant surgeon cannot be overestimated.

From the ACS Archives

Lest we forget: College headquarters at 55 E. Erie Street

by Susan Rishworth, Archivist

The College has been headquartered in several buildings in the course of its 90-year history, and one that is in danger of being forgotten is the lovely building at 55 E. Erie Street, Chicago, IL. That structure no longer exists. A very tall condominium building is under construction where it once stood.

The College maintained its headquarters at that location from 1963 to 1997. The building was spacious enough to allow the College, for the first time, to operate all of its departments under one roof. When the College first moved to 55 E. Erie Street, a staff of 120 people served approximately 26,000 Fellows. As the number of Fellows grew and their needs became broader, the staff expanded. By 1997, the College had outgrown the space and went on to purchase its current headquarters at 633 N. Saint Clair Street, only three blocks from the historic College-owned properties on Erie Street—the Nickerson Mansion and Murphy Memorial Auditorium buildings.

Origins

The groundbreaking for the 55 E. Erie Street building occurred during the Clinical Congress in Chicago, IL, on October 2, 1961. The move from



The 55 E. Erie headquarters building in the 1960s.

three separate residential buildings on the opposite side of the block of Erie Street occurred September 15, 1963, during the College's fiftieth anniversary year. All of the College's administrative of-

fices, including the editorial office of *Surgery, Gynecology and Obstetrics* (which became the *Journal of the American College of Surgeons*, or *JACS*, in 1994), were thus brought under one roof.

BALTAR KORAB - ACS ARCHIVES

The history of the 55 E. Erie building actually dates back to the middle 1950s, when the Board of Regents realized that the operations of the College were burgeoning beyond the limited office space available to the College staff at the time. The Board called on the Real Estate Research Corporation in 1956 to study the space problem and to recommend solutions.

Based on the recommendation of that study, a Building Committee, chaired by Loyal Davis, MD, FACS, then editor of *Surgery, Gynecology & Obstetrics*, was established to oversee the construction of an office building to be placed at the southwest corner of Rush and Erie Streets, on College-owned property.

The Building Committee also determined that the College should continue to use the Murphy Memorial building as an auditorium, thereby preserving that historic structure. The committee concluded that at least 45,000 square feet of space would be necessary to accommodate existing staff and to allow for a 50 percent growth in staff, which, by 1950s standards, was visionary.

Award-winning architecture

The architectural firm of Skidmore, Owings & Merrill designed both the interior and exterior of the building. It received an Award of Merit from the American Institute of Architects and the Chicago Chamber of Commerce for “architectural excellence.” The building rose eight stories above ground and had two underground levels, one



The fountains at night (outside the library).

of which extended out beneath the plaza. Originally one and one-half floors were left unfinished to provide for future growth and development, and the College duly expanded into them.

During the summer months, fountains added to the attractiveness of the entrance court. Effective lighting illuminated

the building and pools at night. The poured-concrete walls and central housing core—enclosing elevators and utilities—were economical construction methods. The roughened, stone-aggregate walls and tinted-glass windows, combined with translucent-onyx slabs set in the first floor, added interest to the building.



The library at 55 E. Erie.

College historian George Stephenson, MD, FACS, described it as a building of

...clean line, utilitarian design, with a plaza entrance court off Erie Street, to the west of the eight-story tower of rough, sandblasted, concrete and stone-mix pillars, enclosing floor-height panels, contained in anodized aluminum frames, with black rubber gaskets. At the first floor, the panels are of translucent onyx, set back one 'module' (6'6") to provide an outside walkway. Above, they are clear glass imported from Herzogenrath, West Germany.... There is a central core, containing eleva-

tors, dual stairways, and sanitary facilities, set so that most of the clear floor space lies to the east of it and is unbroken, except for the pillars which run from basement to roof. The facings of the core on the east and west aspects are rosewood panels. (Stephenson GW: *College Properties*. Chicago, IL: ACS, 1996.)

Layout

Each floor of the structure was devoted to one or more of the College's specific functions, and the walls were decorated with a selection of the many paintings donated by Fellows of the College. The original layout was as follows:

- The first floor was the reception area and library with display cases containing rotating exhibits of the library's treasures. In 1986, the Board of Regents designated the new entrance area the C. Rollins Hanlon, MD, FACS, Foyer, in recognition of his service as Director of the College from 1969 to 1986.
- The second floor housed the Business and Assembly departments, the latter of which planned and coordinated scientific programs for the Clinical Congress and Sectional Meetings.
- The editorial offices of *Surgery, Gynecology and Obstetrics* were located on the third floor.

- The fourth floor housed the executive offices, including those of the Director and the Assistant Directors.

- The fifth floor housed the Fellowship Department, as well as the staff who compiled the *Yearbook* when it was still a College publication. Staff members with responsibility for the Commission on Cancer and the Committees on Trauma and Motion Pictures also were located on the fifth floor.

- The sixth floor was left vacant for future expansion.

- The seventh floor housed the Communications Division, including offices for the *Bulletin*, the ACS employee newsletter, and press relations. The College lunch room and staff lounge were also located here.

- Finally, the eighth floor contained meeting rooms and dining facilities for the Board of Regents, the Governors, and

many other College committees.

The building at 55 E. Erie Street still stirs many fond memories for staff members at the College who worked there and for Fellows who had meetings there. We should not forget it.

For further information on the history of College properties, contact Susan Rishworth, College Archivist, at 312/202-5270, or via e-mail at srishworth@facs.org.

Coding workshops

The American College of Surgeons will sponsor a series of basic and advanced CPT and ICD-9-CM coding workshops during 2003. **Foundations in CPT and ICD-9-CM Coding** and **Mastering Surgical and Office-Based Coding** will be offered back-to-back in five locations. These one-day workshops are designed for all surgeons and their staffs and will be presented by representatives of KarenZupko and Associates.

<u>Level</u>	<u>Date</u>	<u>City</u>
Basic	July 17, 2003	Boston, MA
Advanced	July 18, 2003	Boston, MA
Basic	September 18, 2003	St. Louis, MO
Advanced	September 19, 2003	St. Louis, MO

The American College of Surgeons designates each coding workshop for up to a maximum of seven hours in Category 1 credit towards the Physician's Recognition Award of the American Medical Association. Visit the ACS Web site for more information about the workshops, locations, and online registration at <http://www.facs.org/dept/hpa/workshops/cdwkshop.html>. ACS coding workshops will also be offered as postgraduate courses during the College's Clinical Congress.

NTDB™ data points

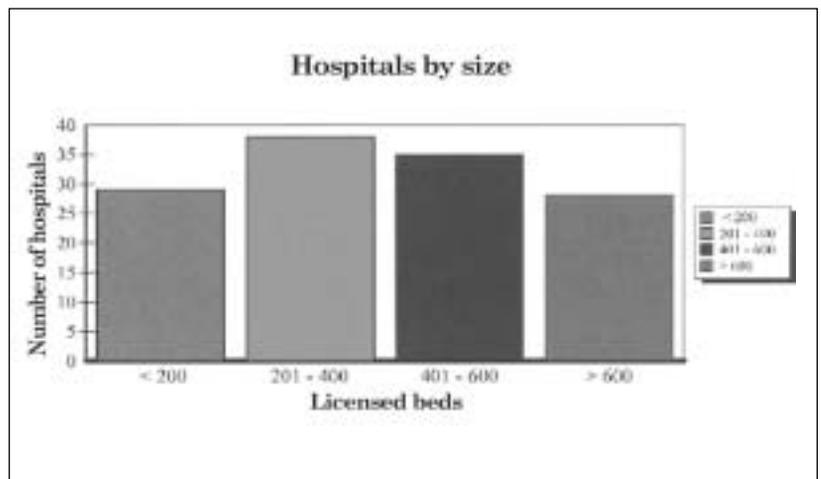
How do trauma centers compare?

by Richard J. Fantus, MD, FACS, Chicago, IL, and John Fildes, MD, FACS, Las Vegas, NV

The National Trauma Data Bank™ (NTDB) is experiencing significant growth as case accrual continues to be brisk. As the data bank reaches a critical mass, there will be opportunity for trauma centers to benchmark their performance against other trauma centers with similar demographic characteristics. For this comparison to be meaningful, the data bank needs to not only have sufficient numbers of records but also an equitable distribution among the various demographic variables used to define trauma centers.

One of these variables relates to the size of the institution as measured by the number of licensed beds. In the NTDB 2002 annual report, hospital size is broken down into four ranges based on the number of licensed beds. The figure represents the classification of the 130 trauma centers that contributed their data to the NTDB for the annual report. The number of hospitals in each group is fairly similar, with the percentages ranging from 22 percent to 29 percent.

This parity with respect to hospital size becomes significant when we want to perform subset analyses or compare a trauma center with other trauma centers of similar size, level of designation, or location of trauma center (urban versus



Size of hospitals submitting data to the NTDB as indicated by number of licensed beds. Total N = 130.

rural). The NTDB is looking for data from trauma centers of all levels, sizes, and location. By actively submitting data to the NTDB, we will expand not only the total number of records but also achieve parity with the other trauma center demographic variables. This result will allow for valid benchmarking and lead to improved care of the injured patient, which is in keeping with the mission of the American College of Surgeons' Committee on Trauma: "To improve the care of the injured through systematic efforts in

prevention, care, and rehabilitation."

Throughout the year we will be highlighting these data through brief reports that will be found monthly in the *Bulletin*. For a complete copy of the *National Trauma Data Bank Annual Report 2002*, visit the ACS Web site at <http://www.facs.org/dept/trauma/ntdbannualreport2002.pdf>.

If you are interested in submitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Patient management problems in trauma/critical care available on CD-ROM

The Committee on Trauma of the American College of Surgeons has developed *Patient Management Problems in Trauma and Critical Care*, an easy-to-use CD-ROM comprising four clinical postgraduate continuing medical education programs per year. Rao R. Ivatury, MD, FACS, is the editor for this project, which presents patient cases in an interactive

question-and-answer format with immediate feedback on each choice made by the user. Problems include initial assessment through lab studies, imaging, surgery, possible complications, and medical therapy, as well as postoperative care and follow-up. Visuals include animated graphics, imaging studies, diagrams, surgical photographs, and video clips showing

steps in surgical procedures.

Participants in this easy-to-use, peer-reviewed educational program may earn 16 category 1 CME credits per volume. Online subscriptions are available for \$179 (regularly \$199) for individuals and \$399 (regularly \$441) for institutions at <http://www.bcdecker.com>, or by contacting CustomerCare@bcdecker.com.

KEEPING CURRENT, from page 38

ing placebo or low-dose heparin. LMWH therapy and adjusted-dose heparin therapy were of roughly equal efficacy.

In light of these data, it appears that LMWH may be recommended over low-dose unfractionated heparin in elective, emergency, and trauma patients. Whether it is superior to adjusted-dose unfractionated heparin therapy remains uncertain, though it is clearly easier to manage. Where compliance with monitoring and dose-adjusting protocols is an issue, unmonitored LMWH therapy may well be preferable. Subscribers to *ACS Surgery* may view the full text of "Venous thromboembolism" at www.acssurgery.com.

VII. Care in the ICU

1. Cardiopulmonary monitoring. James W. Holcroft, MD, FACS, and John T. Anderson, MD, FACS. In their updated chapter, the authors discuss the generation and interpretation of invasive and noninvasive measurements of cardiopulmonary function in critically ill patients, including an enumeration of the problems associated with Swan-Ganz catheterization. For example, ventricular dysrhythmias are common during passage of a Swan-Ganz catheter, particularly in patients who have suffered recent myocardial infarctions or who have an irritable myocardium as indicated

by a preexisting arrhythmia or conduction defect. For some of these patients, prophylactic administration of lidocaine is indicated. In rare instances, aggressive treatment of such dysrhythmias may be required. Usually, the dysrhythmia subsides when the end of the catheter finally passes through the ventricle and enters the pulmonary artery; however, sometimes it can be ablated only by complete removal of the catheter. The balloon on the end of the catheter should be kept inflated during passage to cushion the tip and minimize myocardial irritability. Subscribers to *ACS Surgery* may view the full text of "Cardiopulmonary monitoring" at www.acssurgery.com.

Looking ahead

New and revised chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in the coming months include the following:

- "Cardiac resuscitation," by Terry J. Mengert, MD.
- "Obesity," by Harvey J. Sugerman, MD, FACS.
- "Pulmonary insufficiency," by Robert H. Bartlett, MD, FACS, and Preston B. Rich, MD.
- "Varicose vein stripping," by John Bergan, MD. 



Letters

The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the "From my perspective" columns written by Executive Director Thomas R. Russell, MD, FACS.

Britain's NHS

I was very alarmed by Dr. Josef Fischer's article "Whither goest?" in the February issue of the *Bulletin*. Instead of taking a look at Britain's National Health Service as the title purports, this leader of American surgery presents an inaccurate depiction of other health care systems and accuses those of us who find fault with the foundations of the American health care system to be "liberals" and "self-haters." As an American surgeon who happened to attend a Canadian medical school and complete pediatric surgery training in Canada, I can assure Dr. Fischer that there is no "wholesale flight of anyone who can afford to come south of the border to receive care." Canadian patients and physicians have overwhelmingly and consistently refused an American-style system. Canadian schools have not been "gutted." On the contrary, the academic caliber of Canadian medical institutions has continued to increase and produce surgeons of the greatest caliber. Hundreds of Canadian Fellows of the College would be deeply offended by Dr. Fischer's remarks.

As a pediatric surgeon, I am horrified by what our health care in this country has disintegrated into. The surgical care of children is fragmented in order to meet the financial appetites of hospitals and insurers. It is no longer simply a problem of the uninsured. Even those individuals with "good" insurance are experiencing difficulties, hurdles, and huge additional expenses to receive appropriate care. Many physicians have become

advocates for their employers, not their patients. As long as we treat health care in this country as a commodity to generate profit and not as an inalienable right of every one of our citizens, no incremental reform can succeed. Some of us happen to believe very strongly that a single-payor, publicly financed system is the only ethical and practical way to restore integrity to American health care. We are not the "liberal left" or "self-haters" or an "intellectual elite." We are physicians who believe in an oath we took.

Sherif Emil, MD,CM, FRCS
(Associate Fellow)

Quality of care

Dr. Russell, I read with interest and some surprise your contribution to the March *Bulletin*. Your initial focus on the quality and cost of medical services as major issues is clear and appropriate. You comment twice on the problem of reduced payments and rising expenses and the problem of malpractice insurance premiums. And, you cite some of the studies aimed at improving the quality of care using volume indices and practice guidelines as a means to the goal.

But, while offering to engage in the dialogue on quality and cost, you have not offered a single direct criticism of the current health maintenance organizations' impact on the quality and cost of medical and surgical care in this country. With up-front guaranteed returns of 25 percent or better on the premium dollar from health insurance and an additional 25 percent in management fees, the health care system is losing half of its financing to the profit-driven corporations currently in ascendency. Medicare may not be an ideal system, but the management fee is in the neighborhood of 1 percent, and there is no stockholder profit extracted from the financial pool,

and there are no overly paid administrators and managers.

In 2003, as in the past decade and for a long time to come, greater emphasis should be placed on wresting control of medical care from the HMOs and putting it back in the hands of the consumers and physicians. Our health care system, which was formerly envied by the world, is deteriorating and this is clearly related to the siphoning off of almost half of our health care expenditure in the nongovernmental sector.

Robert C. Wallach, MD, FACS

Commitment to surgery

The March issue of the *Bulletin* includes Dr. Mabry's eloquent response to Dr. Trunkey's criticism of the private practice of surgery in America and my letter is prompted by sheer gratitude. His words speak for the silent men and women in the trenches and should be required reading in every medical school.

One of my wartime classmates, Dr. Lahey, became a professor of surgery; he was a gifted man who I could phone when I needed advice, but as a technician he was excelled by many surgeons I have observed through the years, some even in primitive Idaho. Dr. Lahey once told me: "It takes surgery to make a surgeon."

As my own surgical volume increased, I kept falling behind on the literature and, quite frankly, relied on a series of younger (and smarter) partners to keep me up to date. Unlike the university setting, my group of six originally required 10 employees, one of whom spoke Basque, a requisite in this area. Eventually, insurance companies drove a wedge between doctors and patients, and vague federal mandates proliferated until our payroll exploded to 38 for the same core of six. Those we had known as patients were cast as litigants. We hired an office manager and kept a lawyer

on retainer. Both earned more than I did. ACS publications, formerly devoted to advances in surgery, were soon dominated by forlorn attempts to appease Washington.

For 20 years our small hospital could not afford to staff an emergency room that was sure to lose money. However, even calls in the middle of the night were more welcome than those during a busy day in the office that forced the surgeon to abandon paying patients, who were usually sicker than those patients we were rushing to see. The typical ER patient was critical, unappreciative, demanding, and an unfailing source of litigation. Our surgeons were soon on a first-name basis with the Saturday night clientele who loved to fight but never won. As their welfare check increased, they could afford to graduate from the lowly .25 cal. (a woman's gun) to the .357 magnum, the ultimate status of manhood out here. Over five years, one gunshot victim was operated three times and ultimately outlived his surgeon, who died unpaid. Things like this don't happen to Dr. Trunkey.

Dr. Trunkey, to whom Dr. Mabry was most gracious, is now the professor of surgery at the same medical school from which I graduated before disciples of political correctness replaced "medical" with "health science" so no student would suffer discrimination. As a concession to aging alumni, Oregon is still called Oregon so we'll know where to send our check.

Our archaic teaching staff did not include a lawyer and had no need for an *ethicist*. Ethics, like compassion and honor, were basic qualities you were expected to bring with you from home. These were the prime motivations for becoming a doctor.

In 1960, probably before Dr. Mabry was born, I served as President of the Boise Valley

Chapter of the American College of Surgeons. Because of two remarkable pioneer scholar-surgeons, we had been issued Charter #7 (hard to believe but true, and a source of great local pride). Among our early speakers were Alton Ochsner, MD, FACS, and Warren Cole, MD, FACS, who were generous with their time, preferring an appreciative small Idaho group to an inattentive thousand in San Francisco. As his gratuity, Dr. Cole settled for a sprig of sagebrush. In those days, speaker and audience had much in common because the gap between small hospitals and ivory towers had not widened into the chasm it is today.

Dr. Trunkey is a surgical giant to whom I am indebted for his contributions but, unfortunately, events beyond our control have so profoundly changed American medicine that through creeping (lately, galloping) socialism he has become our reluctant antagonist. The standards of medical care continue to be proclaimed by blue ribbon committees invariably headed by some prestigious professor whose only contact with reality is through the chief resident.

My father practiced medicine in Idaho for 55 years and did not charge about 30 percent of his patients, explaining: "This is not a duty but a privilege." He offered one caveat: "I expect to do charity but I hate surprises."

Thank you, Dr. Mabry, for fighting my battle.

Les Montgomery, MD, FACS

I appreciate the interesting articles by Drs. Trunkey and Mabry in the *March Bulletin*. I thank these gentlemen for their time and their wisdom in contributing these articles. I was, however, interested in the graph (p. 19) attached to Dr. Mabry's article.

First of all, I have been a general surgeon in practice more than 20 years, and I believe that I am a busy

and successful surgeon. However, I have never consistently reached the annual salary quoted for the general surgeon in this chart. Realistically, I think that for general surgeons younger than 50, a figure in the range of 75 to 80 percent of the figure that is quoted is probably more accurate. As regards my hours a week, I will note that there are 168 hours in a week and of these I generally work about 50 hours a week on an average outside of my vacation weeks, which average around three a year.

If we subtract 50 from 168, we have 118 remaining hours and since I am generally on call every other day at least for my own practice, my overall impression of hours worked per week is more on the order of 50 hours per week plus half of 118, which is 59, and as such my typical work week is roughly 105 to 110 hours a week. If we multiply 110 times 48, we get 5,280 hours as opposed to 3,360 hours. Obviously, this is a considerable difference in the sense that it only amounts to about \$36 per hour.

In addition, many general surgeons are providing benefits out of pocket, sometimes with after-tax dollars that are available to other employees as part of a benefits package. Such a benefits package can be worth in the range of \$20,000 a year worth of benefits or more, such as health, disability, and so forth.

Having made these statements, it really strikes me that the average general surgeon probably has an equivalent pay to a worker in a unionized industry who is making about \$25 an hour. (The real income advantage comes from the very long hours worked.) Many skilled workers in unionized industry such as skilled mechanics and machinists make income in this range. In addition, these individuals have more flexibility in scheduling and less overall responsibility in some cases.

I think it is important for surgeons to be realistic about the level of their compensation, which I do not think is excessive given the hours that are worked.

F. Andrew Morfesis, MD, FACS

As much as I admire Dr. Donald Trunkey for his past accomplishments, the opinions expressed in the recent *Bulletin* suggest he's living in a kinder and gentler era, not unlike Cervantes' Knight Errant of La Mancha. The reality for the community surgeon is that trauma call leads to lawsuits, often for care rendered under the worst possible circumstances (that is, overworked and exhausted operating room staff and anesthesiologists) at considerable emotional and physical sacrifice by the surgeon. Usually the only "reward" is to be named in the inevitable lawsuit. With unlimited liability and little prospect of ever being paid for their time and effort (unlike Dr. Trunkey, who draws a salary) is it little wonder surgeons are

either retiring early or refusing to take trauma call?

Stuart A. George, MD, FACS

Rural surgery

I was very pleased to read the article in the May *Bulletin* by Drs. Hunter and Deveney about training rural surgeons. I have felt strongly for years that this has been a seriously neglected area of surgery. I have practiced for 19 years in the Upper Peninsula of Michigan in two small communities.

For a general surgeon interested in a broad range of procedures, rural practice can be very exciting, challenging, and professionally rewarding. A well-trained general surgeon can be the backbone of a small community hospital.

In my practice, we have been able to offer a broad range of general surgical procedures, basic and advanced laparoscopy, general thoracic, vascular, gynecologic, urologic, and endoscopic procedures. We have also been intimately involved in trauma and critical care.

Opportunities exist for academic

associations. I serve as a clinical assistant professor of surgery for Michigan State University's College of Human Medicine, and act as an attending for rotating medical students and residents. I am an ATLS® instructor and actively participate in teaching this course to regional primary care and emergency physicians.

It has been my hope that we could design a program in Michigan similar to the one described in Drs. Hunter and Deveney's article. I also look forward to the day that the College organizes a section devoted to rural surgery, and I would be pleased to help in any way.

The message for our young colleagues should be that there is a real need for quality surgical expertise in rural America and that surgeons may have a very satisfying career as well as a positive impact on their community. I applaud Drs. Hunter and Deveney for their efforts on behalf of rural surgery.

Richard A. Armstrong, MD, FACS

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Membership in the American College of Surgeons



Here's why it's important:

As a body representing all of surgery, the College:

- Provides a cohesive voice addressing societal issues related to surgery.
- Is working toward having an increasingly proactive and timely voice in setting a national tone and agenda with regard to health care.
- Is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients.
- Serves as a national forum through which surgeons can reinforce the values and ethics that traditionally have characterized the surgical profession.

There IS strength in numbers.

Our members represent every specialty, practice setting, and stage of practice. Their views and concerns are helping to shape the College's agenda for the future.

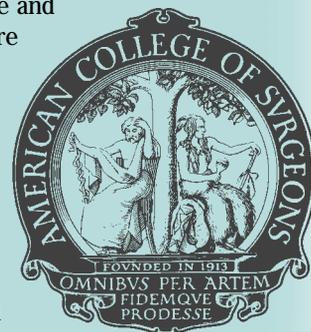
If you aren't a member of the American College of Surgeons, apply for Fellowship today. If you are already a member, maintain that status and consider getting involved in the work of the College.

Only by banding together and using our collective strength can we bring about positive change for our patients and ourselves—and for surgeons of the future.

Here are some of the many benefits being a member of the College affords you:

- Free registration at the Clinical Congress
- Access to the College's free coding consultation hotline
- ACS NewsScope, the College's weekly electronic newsletter
- *The Bulletin of the American College of Surgeons*
- *The Journal of the American College of Surgeons*
- Access to all College-sponsored insurance, credit card, collection service, and other helpful programs
- Access to the College's free job and resume data bank

Information on becoming a member of the College and an application form are available online at: <http://www.facs.org/dept/fellowship/index.html>(.) Or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 312/202-5284, or via e-mail at chicks@facs.org.



STATE AFFAIRS, from page 16

to statehouses around the country. These individuals would be responsible for reaching out to their counterparts in the specialty societies and state medical societies who are performing the same service for their organizations.

Expanded Web site. This summer, the Division of Advocacy and Health Policy will update its state affairs area on the College's Web site. The revamped section will include key contact information for Fellows who serve as College advocates at

the state level. In addition, Fellows will be able to access Issue Action Kits on such subjects as regulation of office-based surgery and trauma care systems.

For more information about these activities, contact Christopher Gallagher, Manager of State Affairs, Washington Office, tel. 202/672-1502, or Jon H. Sutton, State Affairs Associate, at Chicago headquarters, tel. 312/202-5358. 

Next month in *JACS*

The August issue of the *Journal of the American College of Surgeons* will feature:

Original Scientific Articles:

- Incidence of Hernia and Bowel Obstruction
- Percutaneous Cholecystostomy
- Pancreaticogastrotomies Without Mortality

Collective Review:

- Treatment of Iatrogenic False Aneurysms

What's New in Surgery:

- Pediatric Surgery
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