

BULLETIN

AMERICAN COLLEGE OF SURGEONS



June 2001
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**Training
residents
in
advanced
technologies**

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About the cover...

This month's cover story and an accompanying article shed light on possible mechanisms for training general surgery residents in the use of surgical technology. "Advanced surgical technology experience valuable to the basic education of general surgery residents," (p. 11-15) focuses on how one program is ensuring that surgical residents will be prepared to perform operations requiring the use of new technology. Robert S. Rhodes, MD, FACS, responds to the concepts set forth in that article in his piece, "New technology and new approaches to surgical education" (p. 16-17). (Cover photo by Hoby Finn.)

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Rhonda Peebles

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From my perspective

Although it may have been a number of years since many of you were seniors in medical school, I'm sure you remember the anticipation of participating in the National Residents Matching Program. Through this system, you selected various specialties, ranked your preferences, and then you were matched with a program.

The results of the 2001 match were announced recently, and there was a good, strong pool of candidates for many of the surgical specialties. In talking to the Regents who represent the various specialties, it was clear to me that many of them had a good experience this year. Indeed, ophthalmology, otolaryngology, and urology reportedly did better than in previous years. Other surgical specialties were also satisfied with their match rates. Alarming, however, many excellent programs did not fill their general surgery training positions.

Another concern is that studies indicate that the surgical specialties attract around 10 percent of medical school graduates, which is, collectively, lower than the number of individuals who select internal medicine, family practice, and pediatrics. Finally, academic medical centers report that the attrition rate in surgical programs has increased dramatically to nearly 25 percent.

Clearly, the American College of Surgeons is keenly interested in making sure that a surgical career is attractive to "the best and brightest" U.S. medical students.

Deterrents to surgical training

What factors are deterring medical students from choosing a surgical career or finishing a residency program? Certainly, one possibility is the lack of exposure to the surgical discipline during medical school. Medical schools have reduced surgical rotations in both the junior and senior years and in the didactic components of surgical education. Without the proper exposure during those formative years, outstanding medical students are less likely to be attracted to surgical careers.

Moreover, the surgical experience that medical students do undergo may not always encourage them to elect surgery as their career choice. The long hours that surgical residents work, the difficulty of the tasks, and the environment in the operating room and intensive care unit may be daunting and disconcerting to some medical stu-



“We must be committed to influencing in all possible ways, the surgical career path of bright medical students.”

dents. While many attendings may reflect back on the lengthy hours and competitiveness of their residencies with fond memories, today's medical students may not see the allure.

Other issues inherent in surgical training also may prevent some medical students from entering surgery. These possible drawbacks include the length of training, the need to obtain a breadth of cognitive and technical skills, the aggressiveness of the health care marketplace, and the economic burdens engendered by many years of training, especially when coupled with continuing reductions in reimbursement for surgical services.

All of these factors, to a greater or lesser extent, may dissuade capable students from embarking on a surgical career.

The College's efforts

The College has always been interested in maintaining the integrity of surgical training. For many years, we have carried out longitudinal studies of

surgical residents and have tracked resident data. Also, through the Committee on Surgical Education in Medical Schools, we have attempted to inculcate the principles of the practice and ethics of a surgical career during medical school. Further, the committee has attempted to encourage all of its Fellows to accept responsibility for teaching medical students and for formulating a solid curriculum of the surgical disciplines in medical school. (Thomas G. Lynch, MD, FACS, of Omaha, NE, and Leigh Anne Neumayer of Salt Lake City, UT, are the Chair and Vice-Chair, respectively, of this important committee.) In addition, each year the College sends a number of medical students to the Clinical Congress at no cost to them.

Although the College has done much to monitor surgical residents and to encourage medical students to choose surgical careers, there is much we could do in the future to have a positive influence on medical students. For example, the chapters could make a greater effort to reach medical students on the local level and to offer career counseling in a uniform fashion across the country. Because medical students are sophisticated computer users, we could enhance the College's Web site to help medical students engage in more personal contact with Fellows. Other possible innovations include developing a surgical career packet for dissemination to all medical students, presenting awards to outstanding medical students, and appointing medical student representatives to articulate the College's position and promote opportunities in surgery.

Strategies for the future

Educators must be very sensitive to the needs of medical students when they rotate through surgical services. We must shield them from activities that could dissuade them from entering surgery simply because of the long hours or the amount of work. They should not be intimidated or overwhelmed by the clinical experience, and surgeons must take an interest in them personally and professionally, pointing out the many positive aspects of a surgical career. The days of subjecting medical students to overwork, abuse, demeaning attitudes, and unrealistic demands must end. To make surgical training more attractive to medical students, we must make every effort to ensure that they are treated with compassion, that their expe-

riences are rewarding, and that their assignments are constructive.

Further, although we may sometimes be frustrated by our health care system, we must not project our feelings onto our medical students. Instead, we must be committed to influencing, in all possible ways, the surgical career path of bright medical students.

Taking this year's match in general surgery as a wake-up call, I hope to energize the College to focus more attention on this important area. If you have any suggestions as to how the College might stimulate enthusiasm for a surgical career among medical students, please contact me. I would appreciate hearing your thoughts.



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*

This column provides brief reports on important items of interest to members of the College. It will appear in the Bulletin when there is "hot news" to report. In-depth coverage of activities announced here will appear in columns and features published in the Bulletin and in the College's weekly electronic newsletter, ACS NewsScope.



The College's Office of Continuing Medical Education has announced the launch of a **CME Joint Sponsorship Program**. The program will be conducted by the College as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to surgical organizations nationwide for their CME programs. For further information, contact kgoldsmith@facs.org.



In recent weeks, Thomas R. Russell, MD, FACS, Executive Director, represented the College at several surgical meetings. In mid-April, he visited the **France Chapter** and the **Royal College of Surgeons of England**. Later that month, he participated in the annual scientific meeting of the **Society of American Gastrointestinal and Endoscopic Surgeons** and of the **Southwestern Surgical Congress**.



The Regental **Health Policy Steering Committee** held its second meeting in Washington on May 7. Issues on the agenda included managed care reform, burdens imposed on surgeons by the Emergency Medical Treatment and Active Labor Act, and Medicare reform.



Slide presentations of **program highlights from the College's annual Spring Meeting** are now online on the College's Web site at http://www.facs.org/spring_meeting/presentations.html. Planned by the Advisory Council for General Surgery, the Spring Meeting is intended to promote advances in surgery and other areas of science.



On May 21, members of the **Regental Patient Safety and Professional Liability Committee** participated in a congressional staff briefing in Washington, DC, on the need for medical liability reform.

Dateline Washington

prepared by the Washington Office, Health Policy and Advocacy Department

HHS holds summit on patient safety

On April 23 and 24, an interagency task force of the U.S. Department of Health and Human Services (HHS) convened a “National Summit on Patient Safety Data Collection and Use.” The Patient Safety Task Force, which HHS Secretary Tommy Thompson formally introduced at the beginning of the summit, is composed of the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration, and the Health Care Financing Administration (HCFA).

The summit served as a forum for discussing methods of collecting and using data for patient safety efforts, as well as for reviewing topics such as confidentiality, administrative burdens, and the means for translating data into actual safety improvements. In addition, the task force presented a broad outline of a proposed patient safety reporting system, the details of which were still being developed by both Congress and the Administration at press time.

OSHA petitioned to regulate resident work hours

Three organizations sent a petition to the Occupational Safety and Health Administration (OSHA) on April 30, requesting that new federal regulations be implemented to govern work hours for medical residents and fellows. The petition was submitted by: Public Citizen, a consumer and health advocacy group; the Committee of Interns and Residents, a house staff union representing medical students; and the American Medical Student Association, an organization that represents physicians-in-training. The organizations are calling for work hour limits more stringent than those currently effective in New York, including:

- An 80-hour work week.
- No more than 24 consecutive hours worked in one shift.
- On-call shifts only every third night.
- At least 10 hours off-duty between shifts.
- At least one 24-hour period off-duty each week.
- No more than 12 consecutive hours on-duty each day for emergency medicine residents working in hospitals receiving more than 15,000 unscheduled patient visits per year.

The petitioners are requesting these regulations “on the grounds that work hours in excess of the requested limits are physically and mentally harmful to medical residents and fellows, and that a federal work-hour standard is necessary to provide them with safe employment.” The petition connects a typical resident’s work schedule to harm in three specific areas: motor vehicle accidents, mental health, and pregnancy.

This petition was sent to OSHA, which deals with safety in the workplace, because, in November 1999, the National Labor Relations Board (NLRB) overturned a 1976 precedent and ruled that medical residents are primarily employees rather than students. If OSHA decides that it does, in fact, have authority over residents’ working conditions, its procedures require an advisory panel to be formed with equal representation from both the “employer” and “employee” sides of the issue. That panel will debate and make recommendations to the agency. Then, if

OSHA decides there is a case, the matter will proceed through the normal rulemaking process with a notice published in the *Federal Register* and opportunity for public comment.

Former ACS President testifies before Congress

On May 9, former College President LaSalle D. Leffall, Jr., MD, FACS, testified before the U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. Along with Dr. Leffall, representatives from the National Cancer Institute, the CDC, and the National Breast Cancer Coalition gave testimony to encourage Congress to increase its current funding initiatives for breast cancer research. Although the budget resolution for fiscal year (FY) 2002 includes a \$3.4 billion, or 11.8 percent, increase for the National Institutes of Health (NIH), witnesses told subcommittee chair Arlen Specter (R-PA) that a 20 percent increase was needed to stay on track to complete the five-year target to double the NIH budget by 2003.

Dr. Leffall, Charles R. Drew Professor of Surgery at Howard University, will begin a two-year term as chair of the Susan G. Komen Breast Cancer Foundation in 2002. An advocate for increased public awareness of the new scientific advances in technology and therapy, Dr. Leffall is especially concerned about the plight of minorities and the medically underserved.

Hospital payment increases announced

The approximately 4,800 acute care hospitals that are paid under Medicare's prospective payment system (PPS) would experience a 2.55 percent increase in reimbursement rates in fiscal year 2002 under a proposed rule issued on May 4 by HCFA. The proposed increase is based on a formula enacted into law and would become effective October 1, 2001. The draft regulation also contains provisions to implement a number of mandates under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), including a proposed mechanism to facilitate access to high-cost new services and technologies by authorizing special payments to cover increased costs. In addition, HCFA intends to make revisions to the diagnosis-related group (DRG) classifications, including the addition of two new pancreas transplant DRGs. The text of the proposed inpatient PPS rule can be found on HCFA's Web site, www.medicare.gov, under "What's New."

Patient safety initiatives

following the IOM report

by Christian Shalgian,
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Patient safety has always been a concern and a priority among all physicians and other health care providers, but the 1999 Institute of Medicine (IOM) report made the issue front-page news. As a result, the reduction of medical, or health system, errors continue to be the focus of countless efforts both from a policy perspective in Washington, DC, and from a practical perspective in operating rooms throughout the country.

In November 1999, the IOM released its report *To Err Is Human: Building a Safer Health System*, which took a critical look at patient safety and concluded that 44,000 to 98,000 Americans die each year because of medical errors. These statistics were derived from two studies that were conducted in the late 1980s and early 1990s.

In its widely publicized report, the IOM offered a series of recommendations on ways to reduce medical errors, including the creation of a Center for Patient Safety within the Agency for Healthcare Research and Quality (AHRQ) to establish and track progress toward meeting national patient safety goals. In addition, the IOM called on Congress to extend peer review protections to data related to patient safety and quality improvement.

The IOM also recommended that two reporting systems be established to encourage health care organizations to identify errors, evaluate their causes, and take appropriate actions to improve future performance. The most controversial recommendation was the development of a mandatory reporting sys-

tem for all errors that lead to serious injury (which was never defined) or death. The data from this reporting system would be available to the public. The IOM report also called for all additional errors to be reported voluntarily through a system that would be closed to the public.

While these recommendations appeared novel when they surfaced, the American College of Surgeons has devoted considerable attention to patient safety for many years. For example, the College initiated a Hospital Standardization Program in 1918 that served as the foundation for establishing the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Additionally, the College offers surgeons a variety of educational opportunities to ensure that they maintain their skills and learn about current practice standards. One such opportunity is the Surgical Education and Self-Assessment Program (SESAP), which provides practicing surgeons with the opportunity to stay abreast of current standards in surgical practice by reproducing the diagnostic and treatment challenges faced in the practice of surgery.

Medicine unites around common agenda

The College was concerned about the IOM's approach to reporting systems. In an effort to provide policymakers with a clearer understanding of what must be included in an effective patient safety reporting system, the College joined the American Medical Association, the JCAHO, and U.S. Pharmacopeia to draft a set of General Principles for Patient Safety Reporting Systems. Summaries of the principles, which have now been endorsed by more than 90 physician and other health care organizations, follow.

- *Creating an environment for safety.* There should be a nonpunitive culture for reporting health care errors that focuses on systems failures and not on individual or organizational culpability.

- *Data analysis.* Information submitted to patient safety reporting systems must be comprehensively analyzed to identify actions that would minimize the risk of reported events recurring.

- *Confidentiality.* Confidentiality protections for patients, health care professionals, and health care organizations are essential to the ability of any reporting system to obtain information about errors and effect their reduction.

- *Information sharing.* Reporting systems should facilitate the sharing of patient safety information among health care organizations and foster confidential collaboration with other health care reporting systems.

- *Legal status of reported information.* The absence of federal protection for information submitted to patient safety reporting systems discourages the use of such systems, which reduces the opportunity to identify trends and implement corrective measures. Information developed in connection with reporting systems should be privileged for purposes of federal and state judicial proceedings in civil matters, and for purposes of federal and state administrative proceedings, including discovery, subpoena, testimony, or any other form of disclosure.

Patient safety efforts in Congress

ACS Executive Director Thomas R. Russell, MD, FACS, brought many of these positions to the attention of Congress last year when he testified before a joint hearing of the Senate Health, Education, Labor, and Pensions Committee and the Senate Appropriations' Subcommittee on Labor, Health and Human Services (HHS), Education, and Related Agencies. During his testimony, Dr. Russell highlighted the College's long history of involvement with patient safety and urged Congress not to create a mandatory reporting system. Instead, he urged Congress to give physicians and health care providers the tools they need to reduce health system errors at the local level.

Following the hearings, several members of Congress introduced patient safety legislation. Sens.

For further information

The Agency for Healthcare Research and Quality

<http://www.ahrq.gov>

The Institute of Medicine Report: *To Err Is Human: Building a Safer Health System*

<http://books.nap.edu/books/0309068371/html/index.html>

Charles Grassley (R-IA) and Joseph Lieberman (D-CT) introduced legislation last year that followed the IOM's recommendations very closely. That legislation did not gain much support, but other bills introduced by Sens. James Jeffords (I-VT) and Edward Kennedy (D-MA) gained considerable attention and sponsorship. Their legislative proposals are very similar. Both include a reporting system that is comparable to the voluntary reporting system proposed in the IOM report. In addition, both bills provide peer review protections. At press time, however, the two senators were still unable to agree on whether the legislation should include whistleblower protections and if the system should be administered at the federal or local level.

At the end of last year (also the end of the congressional session), Congress could agree only to designate \$50 million to the AHRQ for the purpose of patient safety research. No other patient safety proposals were acted upon.

AHRQ moves forward on patient safety

To identify the appropriate areas for patient safety research and take preliminary steps toward setting national patient safety goals, AHRQ held two meetings: a National Summit on Medical Errors and Patient Safety Research in September and a meeting on Patient Safety at the Clinical Interface in November. Both meetings were attended by a diverse group of public and private organizations, including the College. They consisted of breakout sessions that included discussion of topics such as the epidemiology of medical errors, communicating with patients and families about the risks of medical errors, and the methods for training clinicians and health care managers in improving safety.

These meetings generated a series of grants from the AHRQ that are aimed at improving patient safety and reducing errors. These grants target research in a variety of areas, including the effect of working conditions on patient safety and the use of clinical informatics to improve patient safety. In addition, AHRQ will fund up to 13 demonstration projects that assess the effectiveness of various methods of collecting and using information to reduce medical errors and their impact on patient outcomes. The AHRQ also is expected to provide grants for patient

safety research, information dissemination, and education.

This year, the Administration and Congress have kept patient safety high on their respective agendas. On March 1, the IOM released its latest report, *Crossing the Quality Chasm*. While this report focused more broadly on health system reform, some specific references were made to patient safety and the recommendations in the previous IOM report. In addition, the Health Care Financing Administration (HCFA) began providing grants to the local peer review organizations in order to stimulate patient safety efforts at the local level. Moreover, on April 9, President Bush released his 2002 budget proposal, which earmarks another \$53 million for patient safety research for the coming fiscal year.

What's next?

In Congress, Senators Jeffords and Kennedy have been attempting to reach a compromise that would allow them to jointly introduce patient safety legislation. It is possible that such legislation could be attached to the passage of a Patients' Bill of Rights.

Meanwhile, the Bush Administration is moving forward in anticipation of some directions from Congress. Tommy Thompson, the Secretary of Health and Human Services, has created a multiagency Patient Safety Task Force to address the issue of medical errors. The task force consists of representatives from the AHRQ, HCFA, the Centers for Disease Control and Prevention, and the Food and Drug Administration. In the near future, the task force is expected to release a proposed error-reporting system.

The College will continue to closely examine all of the proposals put forth by both the Administration and Congress. In addition, the College will continue to devote considerable resources to the area of patient safety. For example, the Board of Regents recently expanded the jurisdiction of the College's Committee on Professional Liability to include patient safety. This committee has already begun the process of developing new resources and tools to help surgeons participate in developing workable solutions to current and emerging patient safety concerns. □



Advanced surgical technology experience
*valuable to the basic education
of general surgery residents*

by
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Robert C. G. Martin II, MD, *New York, NY*
Jeff W. Allen, MD, *Louisville, KY*, and
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The recent visible increase in surgical innovations began ostensibly in 1989 with the introduction of laparoscopic cholecystectomy. Since then, the variety of technology-driven procedures has increased steadily (see Table 1, right).¹⁻⁶ In many cases, the minimal access approach has become the “standard of care.” Furthermore, there has been substantial broadening of innovation in many areas.⁷⁻⁹

Given the rapid acceptance of these techniques, the need to train general surgery residents in these areas is paramount. It is also imperative that these minimal access and technology-driven procedures not be exclusively limited to fellowship training but, instead, be kept in the basic curriculum for general surgery residents. Effective training in these techniques is maximized by frequent exposure over a short period of time; thus, the “learning curve” is mastered more promptly.¹⁰

In light of the evolving surgical environment, this training in advanced technology is a necessity and no longer a luxury for the practicing surgeon. Patient demand and referring physicians substantially influence the current need for persistent refinement and evolution of new procedures and methods. In fact, the breadth of public demand has led to a diversification of the forum in which these procedures are performed. They are no longer performed solely in specialized or tertiary centers but, rather, in community and rural hospitals as well. These events have created a major demand for surgeons trained in the entire spectrum of new surgical technologies.

Obtaining this type of advanced technical experience is difficult because of the other requirements placed on residency directors and residents. With the demand to meet the required number of mainstream surgical cases, the tendency is to encourage post-residency fellowships in many advanced surgical techniques. In some instances, a resident may need to obtain on-the-

Table 1.
Laparoscopic reports in the literature (1990-2000)

Procedure	Early report	Identified no. of publications since early report
Laparoscopic inguinal hernia	1990 ¹	704
Laparoscopic colectomy	1991 ²	746
Laparoscopic fundoplication	1991 ³	337
Laparoscopic nephrectomy	1991 ⁴	411
Laparoscopic splenectomy	1991 ⁵	433
Laparoscopic adrenalectomy	1992 ⁶	330

job experience after starting a surgical practice in fields such as advanced laparoscopy and sentinel lymph node biopsy.

The need for advanced training

Many surgeons consider minimal access abdominal surgery, or laparoscopy, the focal point of technological surgical advances that have occurred within the past decade or so. In fact, it is only the tip of the iceberg, because other conceptual and technical changes of equal significance have emerged in parallel. Surgeons safely and efficaciously provide imaging and image-directed biopsy of breast lesions. Surgeons perform endovascular placement of prosthetic grafts in the arterial tree. Surgeons regularly perform diagnostic and interventional endoscopic retrograde cholangiopancreatography (ERCP) and have taken the lead in many other diagnostic and therapeutic procedures as exemplified by ethical group trials of sentinel lymph node biopsy, a technique that has moved from melanoma to breast cancer to other forms of neoplastic disease.

Hence, rather than focus an educational program purely on minimal access abdominal surgery, the surgical faculty of the University of Louisville School of Medicine decided to create a program that is broad-based and depends on our unusual institutional collaboration and liaison with other specialists in diagnostic and interventional radiology,

Table 2.
Examples of advanced laparoscopic surgery

Adhesiolysis
 Adrenalectomy
 Cholecystectomy with common bile duct exploration
 Donor nephrectomy
 Fundoplication
 Gastric bypass
 Inguinal hernia repair
 Laparoscopic-assisted aortobifemoral bypass
 Large and small bowel resection
 Ostomy creation and reversal
 Pancreatic resection
 Partial colectomy
 Pediatric procedures for Hirschsprung's disease
 Splenectomy
 Ventral hernia repair

Table 3.
Examples of advanced endoscopy

Cyst duodenostomy
 Cyst gastrostomy
 Evaluation during Heller myotomy
 Pancreatic or common bile duct stent placement
 Percutaneous endoscopic jejunostomy
 Sphincterotomy
 Therapeutic ERCP

as well as emergency medicine, gastroenterology, and cardiology.

Center established

The formation of the Center for Advanced Surgical Technologies (CAST) at Norton Hospital and Norton Healthcare has become an invaluable resource and has spawned a new resident rotation with a dual role for upper-level residents in our training program. First, it provides a “break” in the intensity of the senior resident years (PGY4 and PGY5) when the volume of work and the severity of illness in the patient

Table 4.
Average monthly CAST experience for general surgery resident (PG4 and PG5 levels)

Experience	Average per month
Advanced laparoscopy	14
Advanced breast imaging with or without biopsy, including stereotactic mammatone	7
Noninvasive vascular lab procedures	6
Interventional endoscopy, with emphasis on therapeutic ERCPs	5
Endoscopic and endorectal ultrasounds	5
Radioguided parathyroidectomy	4
Sentinel lymph node biopsy	3
Photodynamic therapy and YAG laser	3
Advanced laparoscopy (pig laboratory)	2
Liver tumor radiofrequency ablation	1
Endovascular procedures	1
Total	51

population is high. Second, it creates a “finishing school” type of attitude for the senior resident with a vital and focused opportunity to refine advanced skills, especially in laparoscopy. A consistent mechanism to test, implement, assess, and refine new technologies is required, with the goal of keeping only the best procedures and discarding those that represent “fool’s gold.”

Initially funded through a grant from Alliant Community Trust, Norton Healthcare, Louisville, KY, the training program benefits enormously from the resources and financial support of two private hospitals in addition to our university and veterans’ hospitals. Fortunately, one of our private hospitals sponsors CAST and has provided enough financial support to make the center the focal point for perfecting advanced techniques. CAST allows the resident to master these skills before entering the competitive job or academic market. Recent graduates of our

program who have gone through the CAST rotation have noted an increase in their marketability as potential recruits to established practices as a direct result of this working knowledge of emerging technology and procedures.

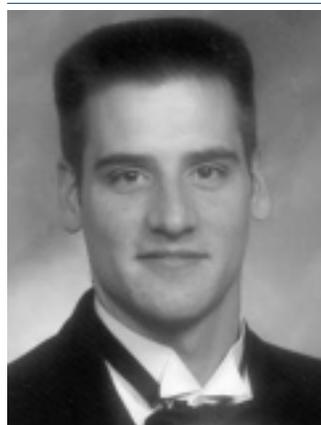
Exposure to a range of techniques

The breadth of exposure to new techniques in the CAST rotation cannot be overstated. It includes an extensive experience in advanced laparoscopy (see Table 2, p. 13), in addition to other advanced technologies such as advanced interventional endoscopy (see Table 3, p. 13), sentinel lymph node biopsy, photodynamic therapy, image-guided breast biopsy, and radioguided surgery. Additionally, while our residency maintains a high level of emphasis on endoscopy, it is the CAST rotation that has

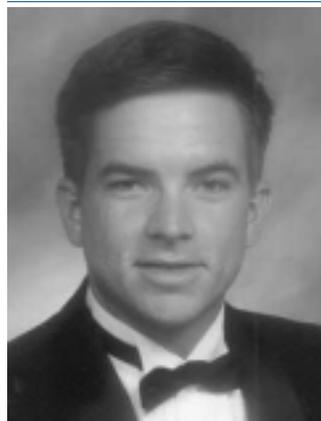
opened the door to combined laparoscopic and endoscopic procedures. Procedures such as the laparoscopic Heller myotomy and laparoscopic transgastric cyst-gastrostomy are performed with the combination of endoscopy and laparoscopy. Residents who are involved in the CAST rotation have significant interaction with the surgical ERCP fellows,¹¹ allowing an increase in the scope of advanced endoscopic experience for both. We believe it is our commitment to both endoscopy and laparoscopy that permits the evolution of these truly minimally invasive techniques. During this rotation, surgical residents also participate in advanced endoscopic ultrasound procedures, an opportunity provided to them by our gastroenterology faculty.

Extensive opportunities are also presented for resident involvement with sentinel node biopsy for melanoma, breast cancer, and other sites, as well as radioguided minimal access parathyroidectomy. Concentrated experience in stereotactic and ultrasound-guided breast biopsy, instruction in the interpretation of noninvasive vascular testing, and exposure to advanced techniques using photodynamic therapy and yttrium-aluminum-ganet (YAG) laser are obtained. The endovascular graft effort was suspended temporarily when CAST was initiated because of technical problems with a specific brand of graft being used, but this training has since resumed. Endorectal ultrasound for both prostate and rectal disorders occurs during this rotation, but supplements a vast experience with ultrasound for trauma and emergency surgery at our level I trauma center.

This broader view of new technologies has been extremely attractive to trainees and offers them an understanding of surgical advances in the broadest possible perspective. It also provides them with an initiation in new concepts as well as new techniques across the whole domain of surgery. For example, CAST includes thoracoscopy as a substantial improvement in the management of blunt chest trauma and surgeon-performed and formally interpreted ultrasound examination in the management of the trauma victim. Experiences with these diverse procedures are accomplished as a separate rotation in the fourth and/or fifth clinical year of



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the residency. The greatest advantage of this program is an opportunity to sample these and many other new concepts as part of the regular trainee program, providing a basis for further skills if a surgical resident chooses to pursue any of them in-depth.

Ensuring competitiveness

These experiences in advanced surgical techniques (see Table 4, p. 13) have allowed residents at the University of Louisville to offer established practices the knowledge of new and effective procedures that are in high demand. The combination of broad-based surgical training and advanced skills in minimal access surgery and sentinel node biopsy allows these emerging surgeons to compete at the highest level and, at the same time, enhance the currency of ideas and forward thinking of the practice group that they join.

Certain technologies have led to an occasional blurring of margins between the disciplines.⁷ This can pose a significant obstacle and, in some institutions, has led to such contention and disagreement that there is outright civil war. We have been fortunate because the departments of radiology and surgery and the gastrointestinal division in internal medicine have been willing to cooperate and foster the immense success of this budding joint venture. The CAST rotation is unique to general surgery training programs, and we believe it is among the first of its kind to emphasize exposure to the new techniques that are now permeating the surgical field.*

Surgical educators are faced with a vast array of new surgical techniques that are in demand. Relying on laparoscopic fellowships and other post-residency training is not the answer for the next generation of surgeons. Exposing surgical residents to advanced minimal access and new techniques during their residencies will allow them to master these skills while they complete their surgical training.

Surgical training programs need to be at the

forefront of advanced training and not at the back. The painful lessons learned from laparoscopic cholecystectomy a decade ago should not be repeated with each new surgical advance. Specialized rotations in advanced surgical techniques during residency are needed and can be formulated even in the busiest of surgical residencies. If not, training programs will fail in their ultimate goal of training residents completely. 

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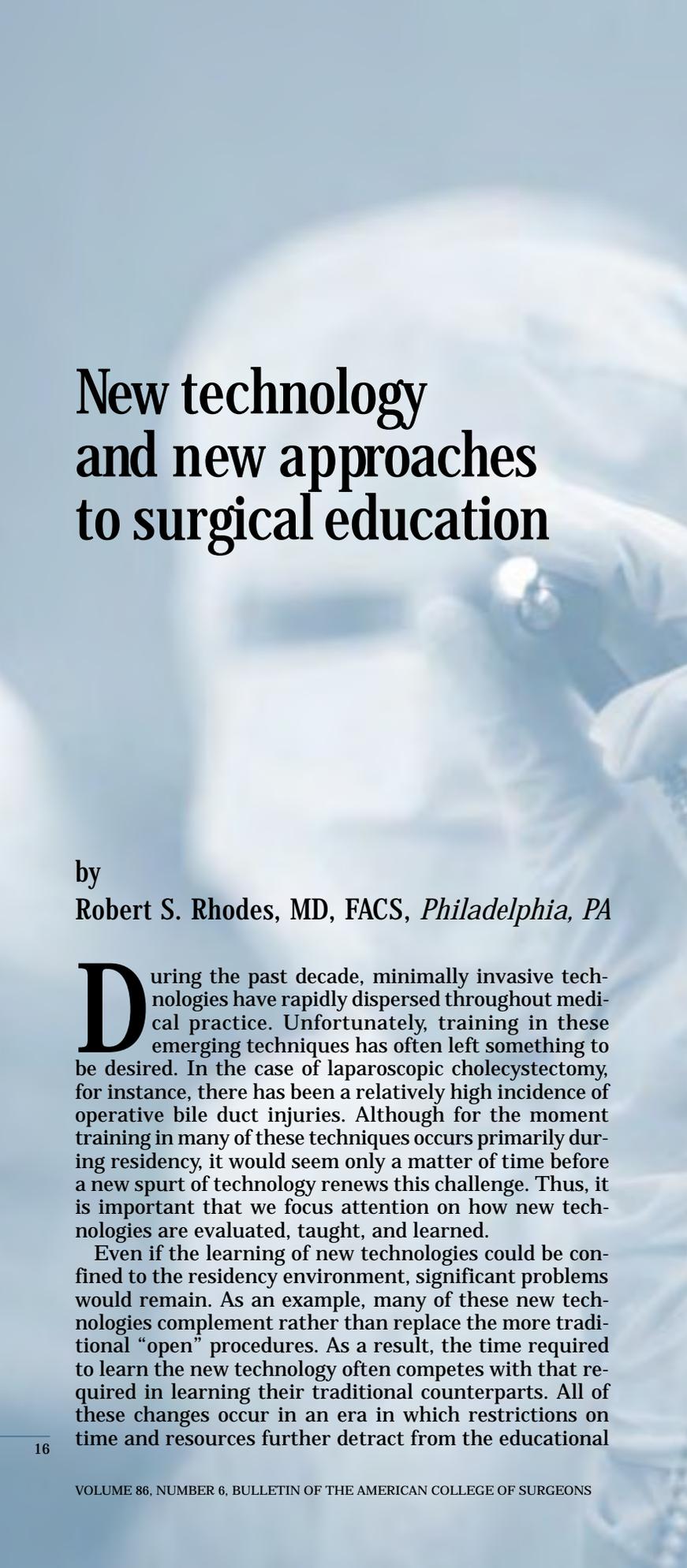
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*We have recently become aware of a similar highly focused program at Indiana University in nearby Indianapolis, IN, directed by Jay Grosfeld, MD, FACS, and David A. Canal, MD, FACS.



New technology and new approaches to surgical education

by
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During the past decade, minimally invasive technologies have rapidly dispersed throughout medical practice. Unfortunately, training in these emerging techniques has often left something to be desired. In the case of laparoscopic cholecystectomy, for instance, there has been a relatively high incidence of operative bile duct injuries. Although for the moment training in many of these techniques occurs primarily during residency, it would seem only a matter of time before a new spurt of technology renews this challenge. Thus, it is important that we focus attention on how new technologies are evaluated, taught, and learned.

Even if the learning of new technologies could be confined to the residency environment, significant problems would remain. As an example, many of these new technologies complement rather than replace the more traditional “open” procedures. As a result, the time required to learn the new technology often competes with that required in learning their traditional counterparts. All of these changes occur in an era in which restrictions on time and resources further detract from the educational

environment. The result, as Charles T. Klodell, MD, and his colleagues note in this issue (p. 11-15), has been to accelerate the tendency for specialization and to encourage post-residency fellowships.

In considering these authors' approach, it is important to reflect on the fact that there have been relatively few efforts to re-examine the “efficiency” of current residency education. Indeed, there appears to be an increasing sense that the problems facing our health care system and the traditional residency model are sufficiently severe to warrant exploratory alternative approaches. This lack of educational innovation seems overdue since the current Halstedian-based model has been extant for roughly 100 years and was developed in a very different era of medical practice. Concentrating experience is a relevant and well-established principle of surgical experience. The University of Louisville's (KY) efforts (and those at Indiana University, as well) to address teaching new technology in residency training appear to go beyond tradition, and, therefore, are very welcome.

Important considerations

Several features of the authors' model are particularly worthy of comment. The primary consideration is the value of broadening surgical skills within the context of current residency education in general surgery. “See, do, teach” is another hallmark of surgical education and also remains a valid principle. Every procedure has a learning curve, and the shape of this curve varies among individuals and by procedure. However, we lack uniform criteria or reproducible methods by which to assess when a

surgeon has achieved “competence” in a given technique. Thus, current accreditation and certification depend on acquiring at least a minimal defined experience with specific procedures. Again, due to difficulties in measurement, relatively little emphasis has been placed on aspects of the structure and the context of the educational process that are critical to its outcomes. The enhanced availability of supervision and feedback on performance implied in the Louisville model should greatly facilitate learning.

Another consideration relates to the fact that our current health care system is extremely disjointed. The solution to this problem involves creating a system that enhances (or simplifies) communication and coordination. By expanding the capabilities of a given surgeon, the authors’ approach facilitates the ability of both patients and managed care organizations to be referred to an appropriate surgeon in a timely fashion. Patient satisfaction as well as other outcomes are also likely to be improved by enhancing collegiality (and thus communication) among specialists with overlapping turf. The Louisville approach, by increasing the collegial atmosphere of learning among relevant specialists, could address both of these issues.

A related consideration is the trend toward increasing specialization. It is hard to argue against the idea that more training and experience is better. Specialization, per se, is not bad, and the forces driving it make it seemingly inexorable. However, we should be cautious of such specialization if it is tied to technique rather than to the fundamental knowledge of given disease systems and the principles of their treatment. Specialization related to technique alone makes one vulnerable to being outdated by the emergence of even newer technologies.

What works?

The key question about the Louisville approach is, of course, whether these types of experiences accomplish what they say they do. The emerging paradigm of quality assessment in health care identifies three measurable elements of quality: structure, process, and outcome. Regardless of the teaching structure that students of surgery may have at their disposal, the context of the process will always be critical to the outcomes. The Louisville

program is clearly the beneficiary of the resources to create the structure. Hopefully, this new approach will further improve the processes and the outcomes by improving the context within which teaching occurs.

It should be noted that this is a time of significant changes in some of the forces that affect surgical education. To name a few: (1) the Residency Review Committee for Surgery, through a joint initiative of the Accreditation Council for Graduate Medical Education and the respective specialty boards, has recently begun to sharpen the focus on outcome measures for specific competencies; (2) the evolution of virtual reality also holds great promise for enhancing the teaching of surgical technique and for creating objective criteria for measuring technical ability; (3) there is increasing uncertainty about the future funding of graduate medical education; and (4) there are concerns about the attractiveness of the surgical lifestyle. The result of these interactions cannot be predicted, but only through continued active participation in the process can we hope for the best possible outcome. □

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Save the charts:

For whom and for what?

by Robert Kerin, MD, FACS,
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The “Socioeconomic tips of the month” column regarding retirement (*Bulletin*, February 2001, p. 31-32) provides an opportunity for comment from a recent retiree. Actually, several of the author’s comments call for a response.

One comment in the column pertains to the fate of the charts still in the hands of the retiring surgeon. As the article states, it is true that “simply by getting another surgeon to take custody of these charts. . .” costs inherent in storing them could be avoided. It is equally true that an old maid simply needs to get married to change her status. And if she is out of work and driving an old jalopy, she simply needs to get a job and buy a new car. Reality has a way of interfering with all of these recommendations. It is prudent to bear in mind that one’s traverse in life may collide with a wish rather than coincide with it.

The article also points out that in the retirement process, patients, their records, the employees, the space, and the equipment all need to be addressed. There is a crucial sentence tucked away in this article that lends itself to amplification, and that is, “In a solo practice. . .all of these issues must be handled independently.”

My personal experience as a solo orthopaedic surgeon who retired almost three years ago indicates that some of these issues may not be that difficult

to resolve. The following are suggestions to the solo surgeon contemplating retirement. Each of the issues raised in the column is discussed, but not in equal amounts, nor to the same degree. Particular emphasis is placed on what to do with patient charts.

It is for the solo surgeon about to retire that these words are primarily intended, if any remain in this era of managed care. Those surgeons who are in group practice or who are planning to leave surgery but have replacements on hand may find these words superfluous.

Space and staff

The space problem evaporates if the retirement dovetails with a lease termination. This is a tenant-landlord issue and, once resolved, is behind the retiree. Owning your building helps considerably.

With regard to employees, the longer the lead time prior to closure of the office, the easier the transference for the office staff. My entire team was aware that the office would be closing for one year before the event. It proved to be an easy transition for them. A certified public accountant hired one of the staff, another staff member went back to school, and the third retired. Meanwhile, the physical therapist, after several decades of service, decided to spend more time with me, her husband.

Weeding out equipment

The pieces of equipment faced one of three fates: some of it we sold, some we donated, and the rest we carted to the dump. One of our sons was opening a law practice, so old tables, chairs, and sofas readily found a new home. The old X-ray unit required more time to reach its destination. Tried, true, and dependable day in and day out, it was by far the most valuable of the capital goods. Internet inquiries yielded a clinic in Katmandu, Nepal, that needed an X-ray machine, but the reality of shipping so much weight and so many components argued against that prospect. In the end, the unit found a home in a nearby college that was offering X-ray technician training, and I was able to use this donation advantageously at tax time.

Patients and their charts

According to the column to which this article responds, "Surgical practices must maintain patient records and have them available to patients and physicians who need them. This could mean storing them for years...." The author then projects the cost of storage over the first five years to be \$10,000 or more.

In the first several weeks after closing the office doors, I received many cards, notes, and letters thanking me and wishing me well. Within the first six months, no more than three dozen patients requested their charts. Since then, there have been no more requests from patients and none from physicians.

While few patients requested their charts, many sought my advice as to whom they should consult to manage their conditions. With advances made in orthopaedics over the last several decades, my options for referral had enlarged. While still in practice, I could make appropriate referrals to a myriad of physicians with expertise in the area matching a patient's need—joint replacement, spinal stenosis, and sports medicine, to name a few. Though no longer in practice, former patients would seek me out by phone or personally to obtain my ongoing recommendations. While no one ever has asked me to personally provide a service since I retired, I continue to encounter former patients who ask to be pointed in the right direction for treatment of their current problems, orthopaedic or otherwise.

One big problem that I faced was finding physi-

cians who would just listen to the patient. That is a luxury most patients don't have even though long ago Sir William Osler drew attention to the importance of listening to patients to reach a diagnosis. A family practitioner in town listens well, but he is booked to near capacity. Over the past half-century, the referral pattern in my office took a 180-degree turn. Back when I first opened my practice, family practitioners were sending their patients to me, but toward the end of my career I found myself referring patients to them because they would listen to my patients. I also have referred patients to a naturopathic physician who impressed me both with her speech to our local medical society and the subsequent care of my wife.

Indeed, my experience has been that patients' overwhelming concern is not their charts but themselves. In the epilogue to my retirement, I have found that old charts have not been critical in making suggestions to those patients asking for them. Often I only have needed to discern whether the patient has experienced a new problem or another chapter in an ongoing condition. The patients themselves have been quite adept at providing information in that vein.

Learning the legal standards

While only a handful of patients requested their charts and no physicians did, requests did come from attorneys who were interested in chart content only. These requests were predominantly from attorneys representing insurance companies seeking information on previous patients of mine who might be under the care of another physician. My care now constituted a "past history." Any information in that category becomes excellent grounds for an attorney on a "fishing expedition." The requests typically would call for the entire record and the attorney would reference a Connecticut Statute allowing 45 cents per page for each page of the chart copied plus first-class postage. While the requests were certainly legitimate, I had little desire or interest in funding fishing trips, especially those not my own.

It became apparent to me that I needed some definition of how long to store the charts. It also was important to differentiate between what was desired and what was required and by whom.

Each state has laws and regulations defining how long charts should be retained and the statute of

limitations for bringing a malpractice action. In Connecticut, where I practiced, there are multiple regulations addressing medical records. Section 19A, 14-42, provides that all parts of a medical record must be retained for seven years from the last date of treatment. The same section of the rule states that a record must be retained for three years after the patient's death. X rays also must be kept for three years.

Section 19A, 14-44, addresses the discontinuance of practice in the event of a practitioner's death or retirement. The last sentence in this section states, "Medical records of all patients must be retained for at least 60 days following both the public and the private notice to patients." Our focus is on what is required upon retirement; the requirement in Connecticut is clearly 60 days.

This knowledge paved the way to another conclusion. Simple mathematics would argue against the wisdom of maintaining a record library at an estimated cost of \$10,000 over five years at a reimbursement rate of 45 cents per page.

Section 52-584 defines malpractice vulnerability. An action must be brought within two years of the date that injury is first sustained or discovered. In cases in which there is a delay in recognizing the problem, the plaintiff has up to three years to file a claim. Additionally, children's charts should be preserved for one year after they turn 18.

This information about state mandates provided some parameters as to what was required of me as a retiring solo surgeons.

When to dispose of the chart

All of us in medicine have been inculcated with the inviolate chart doctrine. It is the repository of what was ordered for and done to each patient. Every chart is at least a short story; some are sagas. There is dual authorship—the patient and physician each contributing respective parts. Each chart contributes to a rich source of medical data and is a literary treasure of human experience. But in the world of the solo retiree, as jolting and disquieting as it sounds, and in spite of all the time, effort, and cost deployed in their assemblage, the vast majority of records stored in the chart library have little value beyond perhaps a trip down memory lane.

In retirement, these charts actually constitute a liability inasmuch as each contains privileged in-

formation. And the patient who serves as the genesis of each chart has every right to expect that the confidentiality of the information in the records be respected. If, for whatever reason, a chart falls into unauthorized hands, the physician may be vulnerable to legal action from the patient.

It is painful to destroy the charts amassed over an entire career—to dispose of thousands (yes, thousands) of records. Yet, if the physician does not dispose of charts sooner, then his estate will be obligated to do it later. And with disposal goes the priceless follow-up on every patient.

Conclusion

It is sad enough that all of us in medicine have become captives of mundane requirements, such as paperwork and precertification mandated by managed care plans and other insurers. We should do nothing that allows or encourages further intrusion into our activities.

Retirement is a time to relieve oneself of outside demands and not to become encumbered with fixed obligations or expenses. Maintaining an obsolete chart library is a shining example of the latter. The retiring solo surgeon should not believe that records must be stored for "many years." Indeed, in Connecticut all that's required is 60 days. □

Editor's note: This month's "Socioeconomic tips of the month" column (p. 23) gives additional information on the subject of record retention.

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Keeping current

Using *ACS Surgery*: Online tips and tools

by Adrienne M. Stoller, New York, NY

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Socioeconomic tips of the month

Record retention

As a practicing surgeon, you understand the importance of maintaining a patient's medical record. However, if you decide to close your surgical practice, are you aware of the proper retention and storage requirements for the patient's health information?

This is an important consideration, as the surgeon needs to ensure that patients, health care providers, and other legitimate users have access to health information, while maintaining patient confidentiality.

Recommendations

First, the surgeon should complete the patients' medical records in order to maintain future continuity of care. The surgeon should ensure that all dictated operative notes, laboratory and pathology results, referrals, radiology results, and so on are filed within the patient's medical record. The surgeon should accomplish this task before transferring or storing the medical records.

Second, the surgeon should notify patients of the decision to close the practice. This can be accomplished through a simple letter or by placing an announcement in the local newspaper informing patients of the decision to close. This provides patients with the opportunity to obtain copies of their medical record before the surgeon transfers records to a storage facility or, if feasible, to another surgeon. When a surgeon closes a practice, he or she does not have to retain medical records outside of the parameters specified by law. Therefore, it is important to first review current state retention requirements. Other retention requirement articles may be referenced; however, keep in mind that some of the data may be outdated. It is advisable that the surgeon become familiar with state retention requirements.

As a surgeon remains liable for disclosure of health information, whether the disclosure is accidental or not, during or after closure of a practice, medical records should be transferred or stored by knowledgeable and reputable resources for the required retention time. There-

fore, it is helpful to become familiar with the agencies that provide retention criteria. There are federal retention requirements, state laws or regulations, accreditation agency retention standards (for example, the Joint Commission on Accreditation of Healthcare Organizations) and the American Health Information Management Association's (AHIMA) recommendations. As retention standards vary by state, it is too difficult to list each state retention requirement individually. It is advisable to first check your state's current laws regarding record retention. Individual state regulations can be obtained by accessing the Web site: www.alllaw.com/state_resources/. For additional retention advice, the *Journal of AHIMA* published an article listing the various guidelines and individual state laws for patient health information retention. This article, "Practice Brief: Protecting Patient Information after a Facility Closure," published March 1999, may be obtained by contacting AHIMA at www.ahima.org/journal/pb/99.03.html.¹ Also available from AHIMA is "Practice brief: Retention of health information," at www.ahima.org/journal/pb/99.06.html.²

Retention schedule

The majority of states have specific record retention requirements; however, in the absence of state retention requirements, patient health information should be retained for at least the period specified by a state's statute of limitations, if not longer, for both minors and adults. In the absence of specific state retention requirements, AHIMA created recommendations regarding established minimum time periods for retaining patient health information (see table, next page).

Closure of a practice with a sale

If the decision is made to sell the practice to another surgeon, then the medical records may be considered assets. In this instance, the medical records can be included in the practice valuation. As part of the agreement to sell, the surgeon should include the right to access the

Retention schedule

Health information	Recommended retention period
Diagnostic images (e.g., X rays)	Five years
Disease index	10 years
Fetal heart monitor records	10 years after the infant reaches age of majority
Master patient/person index	Permanently
Operative index	10 years
Patient health/medical records (adults)	10 years after most recent encounter
Patient health/medical records (minors)	Age of majority plus statute of limitations
Physician index	10 years
Register of births	Permanently
Register of deaths	Permanently
Register of surgical procedures	Permanently

records and retrieve copies, if needed, for any reasonable purpose. If a surgeon requests copies of medical records, a fee for retrieval and copying of records may be charged.

Closure of a practice without a sale

If the decision is made to dissolve the practice without selling to another surgeon, then either the medical records can be transferred to another surgeon who has agreed to maintain responsibility for the records, or they can be archived. If the decision is made to transfer the medical records to another surgeon, a written agreement should specifically outline terms and obligations. The new surgeon should agree to maintain the medical records according to specific retention requirements and permit access by authorized persons. It is recommended that, if another surgeon can maintain the records, this method be used, as the expense of storage and retrieval of records can be costly.

If the decision is made to archive or store the records, the surgeon should remember the need to maintain patient confidentiality and the need to assure future access of a patient's health information by patients, health care providers, physicians, and other legitimate users.

Additionally, a surgeon may wish to check with

state archives or health departments, as some may store medical records from a dissolved practice. A directory of state health officials in state health departments may be obtained by referring to the Web site www.health.gov/hpcomments/Guide/state_PH.htm. If this option is unavailable, then records should be stored with a reputable storage firm if a surgeon has not agreed to maintain the records. Before placing records with a storage firm, the surgeon should verify the firm's experience in maintaining patient confidentiality and the ability of legitimate users to access the information. Prior to archiving or storing records, the surgeon should create a written contract specifically outlining the terms and obligations of using a storage facility. The surgeon should be aware that there will be fees for copying or reproducing the records. This amount should be specified in the contract.

Helpful tips

Before closing a practice, the surgeon may wish to contact professional organizations such as the state licensure board for guidelines and recommendations. Also, it is advisable to obtain legal counsel to help assure compliance with state laws. In larger practices and managed care systems, it

continued on page 33

College news

Philip Sandblom, MD, PhD, FACS, dies

by C. Rollins Hanlon, MD, FACS, ACS Executive Consultant

On Ash Wednesday, a phenomenal career ended when Philip Sandblom was fatally stricken in the Lausanne airport as he prepared to travel to Lund, Sweden. Dr. Sandblom had been professor of surgery and departmental chief at Lund Hospital from 1950 to 1970. From 1957 to 1968, he had also served in challenging times as president of Lund University, where he brilliantly accomplished both a radical democratization of higher education and a restoration of ancient academic traditions.

To his remarkable administrative accomplishments and his significant contributions to pediatric and biliary surgery, he added an unassuming but elegant collegiality with his younger associates and a deep concern for patients and students.

Born in Chicago, IL, and educated in Sweden, Dr. Sandblom spent an early postgraduate year with the great physiologist, Andrew Ivy, at Northwestern University; this experience underlay his pioneering introduction of experimental surgery into Scandinavia. Extensive research on wound healing taught him the importance of a rigorous scientific methodology and contributed to his gentle, meticulous surgical technique.

Facile in many languages, he lectured widely on traumatic biliary tract hemorrhage or hemobilia, an ancient but



Dr. Sandblom, pictured in 1952 upon receiving Honorary Fellowship in the American College of Surgeons.

largely unknown syndrome, which he clarified and developed as his special province. Thousands of surgeons worldwide associated him with this landmark entity and with his other contributions to the treatment of portal hypertension.

As the doyen of Honorary Fellows in the American College of Surgeons (1952), Dr. Sandblom was also an honorary fellow of three other surgical colleges and an honorary member of more than a dozen surgical organizations here and abroad. Besides

his activities in surgery and administration he was skilled in the sports of skiing and sailing and had a life-long interest in modern Swedish and French art. During 70 years of marriage, he and his charming wife Grace formed a remarkable collection of masterpieces of painting and sculpture. When he “retired” to an active visiting professorship in the department of surgery at Lausanne, Switzerland, the Sandbloms donated to the National Museum in Stockholm works by Cezanne, Courbet, Delacroix, Picasso, and Seurat.

As tangible evidence of his interest in the humanities, in 1982, he published *Creativity and Disease: How Illness Affects Literature, Art and Music*. Of this gem-like book Carl Nordenfalk, PhD, director emeritus of the Swedish National Museum, has written that it provides “...a deeper insight into many of art history’s most poignant life-stories” as set out by “...the foremost Swedish art collector of his generation.” With its incisive characterizations and its splendid color reproductions, the book has been widely acclaimed and has now passed through a dozen English and four Swedish editions to become an enduring classic.

Two days before his 97th birthday in October 2000, he lectured at the Clinical Congress of the American College of Surgeons on his signature topic of

disease and creativity as the lead speaker for the final program of the Seminar on Science and Humanism, a series that endured for 15 years. As a birthday gesture to a large, appreciative audience, he bestowed on his listeners the gift of several hundred copies of "the Book" for those who would go to a designated booth in the exhibition hall. When a negligent hotel employee failed to deliver the books promptly, he and his cheerful, resolute consort personally transported them by taxi to the designated point of distribution.

This brief note makes no pretense of capturing the long, pro-

ductive career and the buoyant spirit of this magnificent humanist and world citizen. But a quote from some "Reflections" in his 75th year* may provide some hint of the good humor so treasured by friends and associates. Speaking of Chicago as his birthplace, as well as that of his eldest son and grandson, he wrote: "Though none of us lives there, it has become a family tradition always to have a son born in Chicago. In fact, although my whole education and career have taken place in Sweden, I have

* Sandblom P: Reflections, *Contemporary Surgery*, Vol. 11, 1977.

come to the U.S. for all important events in my life: to be born, to get married, to have my eldest son, to get my master's degree, and to receive many honorary awards. As, by now, I have only one important event left in my life, you may appreciate why I hesitate to return to the U.S."

Despite this whimsically apprehensive comment, he and Grace made what I would estimate as some 50 subsequent trips to the U.S. for active participation in surgical meetings. The surgical world is enormously poorer by Philip's absence.

Fellows and facts

Haile T. Debas, MD, FRCS(C), FACS, has been elected to serve as the new President of the American Surgical Association. Dr. Debas is a general surgeon in San Francisco, CA.

The Queen of England recently knighted **Barry T. Jackson, MS, PRCS, FACS (Hon)**, for his contributions to the profession of surgery. Sir Barry, President of the Royal College of Surgeons (Eng), was the guest speaker during the Opening Ceremony of the 2000 Clinical Congress. His presentation focused on the 200-year history of the RCS(Eng), as well as its relationship with the ACS.

Gerald Marks, MD, FACS, was recently inducted as an hon-

orary member of the European Association of Endoscopic Surgery. Dr. Marks is a colon-rectal surgeon in Wynnewood, PA.

James O. Menzonian, MD, FACS, professor of surgery at Boston University School of Medicine, recently received the Association of American Medical Colleges (AAMC) Humanism in Medicine Award for 2000. Honorees are nominated by the AAMC Organization of Student Representatives.

George F. Sheldon, MD, FACS, Zack D. Owens Distinguished Professor of Surgery and chairman of the department of surgery at the University of North Carolina-Chapel Hill, recently delivered the 17th Hunterian Oration at the

Royal College of Surgeons (Eng). This lectureship is one of medicine's oldest and most distinguished. Dr. Sheldon's presentation was titled "John Hunter and the American School of Surgery." Additionally, Dr. Sheldon, a Past-President of the College, was admitted as an honorary fellow of the Hunterian Society, founded in 1819.

The National Academy of Medicine of Argentina recently presented its highest distinction, the title of Honorary President, to **Julio Vicente Uriburu, MD, FACS**, a general surgeon in Buenos Aires, Argentina. This distinction has been awarded only six times since the academy's founding in 1822.

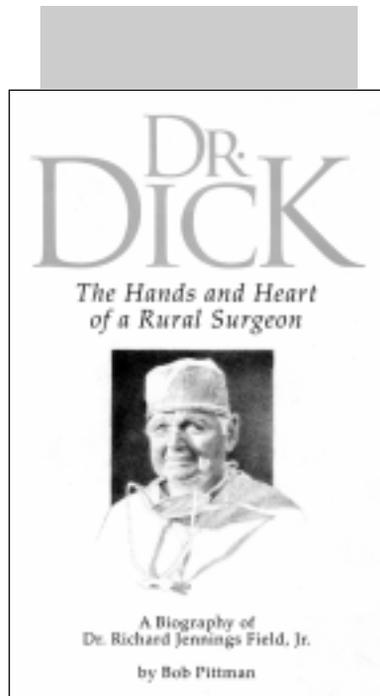
Biography of Richard J. Field, Jr., MD, FACS, published

A biography of Richard J. Field, Jr., MD, FACS, former ACS Governer and Regent, was released this spring. *Dr. Dick—The Hands and Heart of a Rural Surgeon* follows Dr. Field's life throughout his training, his military duty, his efforts to uphold his father's legacy in Centreville, MS, and his dedication to the College.

Dr. Field trained at Tulane University in New Orleans, LA, and the Lahey Clinic in Boston, MA. After completing his surgical training, Dr. Field served as a military surgeon at the close of the Korean War. He then returned to Centreville to work at the Field Clinic and Field Hospital, both founded by his father and his uncle, Samuel Field, MD, FACS.

The book describes the frustration Dr. Field felt in trying to bring modern surgical techniques to an antiquated facility when he went back to his home town. Nonetheless, Dr. Field stayed true to his dream of carrying on the work his father had begun in rural Mississippi, and the biography details how he resolved conflicts relating to his father, his faith, and his profession.

In the foreword of the biography, C. Rollins Hanlon, MD, FACS, ACS Executive Consultant and a former Director of the College, states, "This book is more than an account of a small hospital's survival in the face of socioeconomic tidal



waves that have swamped hundreds of similar institutions. And, it is more than the story of one young couple who put aside personal preferences to establish a center for modern medical care and teaching in a most unlikely location.

"A great faith is depicted here, joined with steely determination over three generations," Dr. Hanlon writes. The third generation is left in the hands of

Richard Jennings Field III.

Another "large component of this story is Dick Field's relationship with the American College of Surgeons," Dr. Hanlon notes. He has served as a College Governor and Regent, positions to which he brought the unique perspectives of a rural surgeon. Dr. Field also served as the Second Vice-President of the College (1994-1995).

Dr. Field continues to practice at the Field Clinic and Field Memorial Community Hospital in Centreville. He also serves on the clinical faculties of the University of Mississippi School of Medicine in Jackson, MS, the Tulane University School of Medicine, and the Louisiana State University School of Medicine in Baton Rouge, LA.

Dr. Dick—The Hands and Heart of a Rural Surgeon was written by Bob Pittman and is available for \$26.70, including tax, through the Field Memorial Community Hospital. To order the book, contact Leanne Jenkins, director of marketing and public relations, Field Memorial Community Hospital, P.O. Box 639, Centreville, MS 39631-0639; tel. 601/645-5221; fax 601/645-5842.

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Letters...

The following comments were received via e-mail regarding "From my perspective" columns written by ACS Executive Director Thomas R. Russell, MD, FACS. The columns were published in: (1) the December 2000 issue of the *Bulletin* and focused on the current debate regarding residency work hours (see www.facs.org/fellows_info/bulletin/dec00bullet.html), and (2) the March 2001 issue and focused on the residency review committee for dermatology seeking to establish a subspecialty in dermatological surgery (see www.facs.org/fellows_info/bulletin/mar01bullet.html).

Thank you for adding "Letters" to the *Bulletin*. It is a much appreciated and needed forum. I particularly enjoyed hearing from a recent chief resident about his hours and from my own mentor, Dr. Blaisdell, on his concept of responsibility. It was over 30 years ago, while interviewing a candidate for Fellowship, that I said, "Tell me about this death following a portacaval shunt." The individual replied, "Oh, I don't know how that happened. I was the surgeon, but became 'off duty' and had left the hospital before the case was over."

I believe that this is what we are talking about and agree completely that the term "responsibility" goes hand-in-hand with the privilege of operating on a living human being. Unfortunately, the responsibility concept starts in kindergarten and requires parenting, personal dedication, honesty, and stamina. SATs, MCATs, and recertification programs do not always pre-

dict the men and women that we would wish for our own surgeons, as well illustrated by Dr. Ritchie's article in the April *Bulletin*. Continued success from a once-busy surgeon who has now become a potential (shivers...) surgical patient.

**John N. Baldwin,
MD, FACS**

Letters in response to "From my perspective" were a bit surprising to me in that they commented very little on the issue of the value of residency work hours to future performance as a practicing surgeon. No doubt a less demanding residency schedule may seem to enhance the performance of the surgical resident. As one from the old days of 33 hours on call, 15 hours off, then repeat, for all of internship and residency, I thought it was excellent training in commitment for future actual practice, which may be even more demanding.

It is no excuse before a peer review body (or malpractice defense) to argue fatigue as a mitigating circumstance. Many private practitioners in all fields must respond with accurate judgment and commitment, whether for the single case in the ER or for the community medical catastrophe. One of the key lessons learned from a stressful residency's demands is to condition the mentality of the 25- to 30-year-old surgical resident so that his or her decision making and performance as an older practitioner will stand up under scrutiny and the demands of accountability. As a New York physician who testified at the hearing on limiting house staff hours,

it is my view that the issue was handled in a highly political manner, to the detriment of good surgical training.

George Lim, MD, FACS

I have continued to enjoy your "perspectives" on important issues for a number of months. You give an excellent overview of a subject and sound reasons why you have your own personal viewpoint. I read with great interest in the March 2001 issue of the *Bulletin* your perspective on the value of four years of training in surgery to achieve a broad experience in performing surgery rather than just becoming a "technician." I agree that many people can learn to perform a certain type of surgery but have little training or appreciation for the larger picture, where mature surgical judgment occurs while dealing with the patient as a whole entity. Thank you for dealing with these difficult socioeconomic issues and putting them into proper "perspective."

Jack Bruner, MD, FACS

College launches CME Joint Sponsorship Program

The Office of Continuing Medical Education of the American College of Surgeons has announced the launch of a CME Joint Sponsorship Program. Approved by the Board of Regents at its February 2001 meeting, the program will be conducted by the College as a national accrediting organiza-

tion under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for their CME programs and meetings. In the initial phase of the program, CME accreditation is being offered for educational

programs that are scheduled to be held after July 1, 2001.

Further information and applications materials are available on the ACS Web site (www.facs.org) or may be obtained by contacting the program's administrator, Kathleen Goldsmith, at e-mail JSP@facs.org, or tel. 312/202-5212.

Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its meeting held on February 9, 2001:

- The Board suspended Michael E. Freeburger, a general surgeon currently residing in Texas. In February 2000, he signed an Agreed Order with the State of Kentucky to surrender his medical license in that state for an indefinite period of time.
- The Board censured a general surgeon from Oregon. The State Licensing Board of Oregon

reprimanded the surgeon for repeated negligence in five surgical cases. The surgeon was ordered to submit quarterly written reports to the Board for a period of three years.

- The Board restored the Fellowship of a plastic surgeon from Florida who had been placed on probation. The surgeon originally was placed on probation by the College as a result of action taken by the Florida Board of Medicine alleging failure to keep written medi-

cal records and practicing medicine below the standard of care. The surgeon has successfully completed an evaluation program to determine his medical skills, regained an unrestricted license to practice medicine, and obtained full and unrestricted surgical privileges in an accredited hospital.

In addition, the Board of Regents approved the policy to publish the names of members who are expelled or suspended from the College in the *Bulletin*.

SURGICAL TECHNOLOGY, from page 15

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Faculty career development award available

Faculty Career Development Award for Oncology of the Head and Neck, July 1, 2002-June 30, 2004

The American College of Surgeons and the American Head and Neck Society are offering a two-year faculty career development award to head and neck surgeons. The award is to support clinical, basic science, or translational research in the study of neoplastic disease of the head and neck. The award is \$40,000 per year for each of two years to support the research and is not renewable thereafter.

General policies covering the granting of the Faculty Career Development Award for Oncology of the Head and Neck are:

- The award is open to surgeons who: (1) are members or candidate members in good standing of both the American College of Surgeons (ACS) and the American Head and Neck Society (AHNS); and (2) have completed specialty training within the preceding five years and have received a full-time faculty appointment at a medical school accredited by the Liaison Committee on Medical Education in the United States or by the Committee for Accreditation of Canadian Medical Schools in Canada. Applicants should provide evidence (by publication or otherwise) of productive initial efforts in laboratory research.

- The award is to be used to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient's institution.

- Applicants may not be current recipients of major research grants. Application for this award may be submitted even if comparable application to other organizations has been made. If the recipient accepts a scholarship, fellowship, or career development award from another agency or organization, the Faculty Career Development Award for Oncology of the Head and Neck will be withdrawn. It is the responsibility of the recipient to

notify the Scholarships Division of the College of competing awards.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the senior investigator (if applicable) supervising the applicant's research effort should be submitted. This approval would involve a commitment to continuance of the academic position and the availability of facilities for research.

- The applicant must submit a detailed research plan and propose a budget for the two-year period of the research, even though renewed approval by the ACS and the AHNS is required for the second year. The applicant is also required to submit a cover letter of approximately 400 words that describes the career objectives, how these career objectives will be achieved, how the research protocol furthers the applicant's career development, and, in particular, how this award will provide data for subsequent major funding.

- The awardee is expected to attend both the annual meeting of the American Head and Neck Society (August 7-11 in Washington, DC) and the Clinical Congress of the American College of Surgeons (October 10-15 in New Orleans, LA) in 2004 to present reports to the ACS Scholarships Committee and AHNS representatives.

- The American College of Surgeons and the American Head and Neck Society require a research progress report after one year, and a summary of research progress and information regarding current academic rank, sources of research support, and future plans at the conclusion of the research period.

The closing date for receipt of applications is November 1, 2001. Application forms may be obtained upon request from Scholarships Division, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or from the College's Web site at www.facs.org.

Update your information online

The College has developed a program through which Fellows can update and edit their individual listings (including addresses, telephone and fax numbers, and e-mail addresses).

Please visit the College's Web site at <http://www.facs.org/members/members.html>. Fellows will need their eight-digit identification number to input the information. Once you

have entered the information, your Fellowship record in the College membership database will automatically be updated. There is no need to notify the College offices.

SOCIOECONOMIC TIPS, from page 24

is advised that the surgeon contact the director of health information management for advice on how to proceed with record retention. 

The American College of Surgeons would like to thank Beth Hjort, RHIA, Professional Practice Manager, AHIMA, for her review and comments.

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 for easy retrieval and future access. If there are topics that you would like to see addressed

in future columns, please contact the Health Policy and Advocacy Department, tel. 202/337-2701, fax 202/337-4271; or e-mail Health Policy Advocacy @facs.org.

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#S6 Solid 14K Gold	\$200	(Indicate finger size)		#S21 Maroon	\$35
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#S8 Solid 14K Gold	\$150	NECKTIE		#S23 Maroon	\$35
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Chapter news

by Rhonda Peebles, Chapter Services Manager, Organization Department

To report your chapter's news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

Kentucky Chapter hosts annual meeting

On February 15-16, the Kentucky Chapter conducted its annual meeting at the Camberley Brown Hotel in Louisville, KY. In addition to the council, business, trauma, and cancer liaison meetings, the chapter also conducted a residents' paper competition. Two winners were announced:

- Sandra Wong, MD,* for the paper "Sentinel Lymph Node (SLN) Biopsy for Breast Cancer: Impact of the Number of Sentinel Nodes Removed on the False-Negative Rate."
- Andrew Barksdale, MD,* for the paper "TGF- β and IL-13 Induce Arginase Activity in Foam Cells."

South Texas Chapter recognizes basic sciences

At its 2001 annual meeting, March 2-3, the South Texas Chapter held its first named lecture, The William J. Porkorny Surgical Science Lectureship. Stanley J. Dudrick, MD, FACS, chairman and director of surgical education, department of surgery, Bridgeport Hospital-Yale New Haven Health System, Bridgeport, CT, presented the first Porkorny lecture. He spoke on two topics: (1) the history and clinical application of TPN, and (2) the management of short bowel syndrome. According to Kenneth R. Sirinek, MD, FACS, the chapter's Program Chair, the South Texas Chapter created the new Porkorny lectureship to reinforce the importance of basic science research to surgical residents.

Argentina Chapter announces 2001-2002 plans

Eduardo N. Saad, MD, FACS, President, and Arnoldo E. Suhl, MD, FACS, Chair of the Interna-



The Ohio Chapter delegation to the state Capitol in Columbus included (all MD, FACS) (left to right): Robert McDevitt, Jr., Warren Muth, Sidney Miller, Michael Stark, Joseph Crowe, Jr., Ali Mokhtari, Margaret Dunn, Richard Reiling, John Raaf, and David Hasl.

tional Relations Committee for the Argentina Chapter, have reported on their plans for 2001-2002 educational programming. In August, in conjunction with the Gastroenterologic Italo-Argentine Group, the chapter will present a course on hepatic surgery and advanced laparoscopic procedures. The chapter also intends to: (1) develop mechanisms for presenting scholarships to young surgeons; (2) assess the development of an education center to provide programs on telementoring, telesurgery, and training using virtual-reality technology; and (3) develop an educational program encompassing all of the College's chapters in Latin America. For more information, please contact Dr. Saad at affbpresidencia@sinectis.com.ar, or Dr. Suhl at easuhl@intramed.net.ar.

Maine Chapter receives commemorative charter

The Maine Chapter observed its 50th anniversary at its annual meeting, February 16-18, at the Grand Summit Hotel at Sugarloaf/USA. To honor the occasion, Thomas R. Russell, MD, FACS, the College's Executive Director, presented the 50th Anniversary Commemorative Charter to the

*Denotes participant in the Candidate Group.



Lebanon Chapter: Dr. Abousleiman (left) presents a medallion to Dr. Karam.

ing physicians and legislators. For more information, contact Jane Treiber, Executive Director of the Ohio Chapter, at ocacs@ocacs.meinet.com, or toll-free at 877/677-FACS (3227).

Lebanon Chapter presents ninth surgical congress

In conjunction with the Lebanese Society of General Surgery, the Lebanon Chapter conducted its Ninth Surgical Congress, February 22-25, in Beirut. The educational program included presentations on colon-rectal surgery, laparoscopic surgery, liver transplantation, pain management, urology, endo-vascular surgery, and spine surgery. At a dinner, Chahine Abousleiman, MD, FRCS, FACS, presented a special medallion to His Excellency Karam Karam, MD, FACS, who serves as Lebanon's Minister of Tourism (see photo, left).

Chapter anniversaries

Month	Chapter	Years
May	Colorado	44
	Maryland	44
June	Alberta, Canada	11
	Arkansas	26
	Connecticut	34
	Metropolitan Washington (DC)	27
	Ecuador	34
	Germany	11
	Greece	15
	Idaho	51
	Ireland	18
	Israel	4
	Maine	50
	Mexico—Northeast	26
	Mexico—Nor-Occidental	30
Minnesota	30	
New Mexico	16	
Upstate New York	35	
Western New York	46	
North Dakota	45	
Oregon	36	
Philippines	31	
Spain	19	
Wisconsin	31	

Maine Chapter. The meeting's educational program featured presentations by residents and Fellows, and a coding and compliance seminar was conducted.

Ohio Chapter meets with state legislators

On April 3, members of the Ohio Chapter participated in a second trip to Columbus to meet with state legislators (see photo, p. 34). The visits were arranged in conjunction with the Ohio State Medical Society (OSMA) and several state specialty societies. In all, about 150 physicians met with their elected officials to discuss legislative priorities.

One priority in 2001 is SB 4, "The Prompt Pay Bill." In a meeting with Ohio Chapter members last year, state Sen. Larry Mumper agreed to sponsor the new prompt payment legislation. The bill would require insurers to pay claims within 30 days, prohibit insurers from contracting for payment periods greater than 30 days, and prevent insurers from conducting "take-backs" beyond one year.

The day began with a briefing session and ended with a debriefing and reception for all participat-

The *Journal* page

Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

The July issue of the *Journal of the American College of Surgeons* includes an article that addresses the adverse effects of diagnosis-related groups (DRGs) on academic health centers. The DRGs represent just one of many incursions that impact negatively on the mission of these institutions. Academic institutions, by definition, are scholastic communities with education as an integral component.

What is happening in the current environment, in which corporate medicine dominates academic health centers, brings to mind an allegoric image of St. Anthony with his body pierced by many arrows. The DRGs represent but one of many traumatic events suffered by academic health centers. Because a mentality focused on the bottom line has become pervasive, academic imperatives have become compromised.

Perhaps the third law of physics pertains: Two

objects—in this case, profit and pedagogy—cannot occupy the same place at the same time. Current financial success, however, will be offset by the compromised education of the next generation upon whom the future is dependent. The future is being disregarded. Teaching and learning, the *raison d'être* of a residency training program, is no longer a priority. Medical students are merely exposed to surgery rather than being educated in the discipline. Would that our ophthalmology colleagues could devise a keratoplastic procedure to convert the myopic vision, through which our system is currently being viewed, to one of farsightedness.

Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the Journal of the American College of Surgeons and a Past-President of the College.

INTRODUCTORY ABSTRACT from the July lead article

How DRGs Hurt Academic Health Systems. Paul A Taheri, MD, MBA, FACS, David A Butz, PhD, Ron Dechert, RRT, Lazar J Greenfield, MD, FACS. From the department of surgery, University of Michigan Health System (Taheri, Dechert, Greenfield) and the University of Michigan Business School (Butz), Ann Arbor, MI.

Background: Academic health centers continue their mission of clinical care, education, and research. This mission predisposes them to accept patients regardless of their individual clinical variation and financial risk. The purpose of this study is to assess the variation in costs and the attendant financial risk associated with these patients. In addition, we propose a new reimbursement methodology for American health centers' high-end DRGs that better aligns financial risks.

Study design: We reviewed clinical and financial data from the University of Michigan data warehouse for FY 1999 (n= 39,804). The DRGs were classified by volume (group 1, low volume to group 4, high volume). The coefficient of variation for total cost per admission was then calculated for each DRG classification. A regression analysis was also performed to assess how costs in the first three days estimated total costs. A hybrid meth-

odology to estimate costs was then determined and its accuracy benchmarked against actual Medicare and Blue Cross reimbursements.

Results: Low-volume DRGs (< 75 annual admissions) had the highest coefficient of variation relative to each of the three other DRG classifications (moderate to high volume, groups 2, 3, and 4). The regression analysis accurately estimated costs (within 25% of actual costs) in 64.7% of the patients with a length of stay ≥ 4 d (n= 16,287). This regression fared well compared to actual FY 1999 DRG-based Medicare and Blue Cross reimbursements (n= 9,085 with length of stay ≥ 4 d), which accurately reimbursed the University of Michigan Health System in only 43.9% of cases.

Conclusions: American health centers receive a disproportionate number of admissions to low-volume, high-variation DRGs. This clinical variation translates into financial risk. Traditional risk management strategies are difficult to use in health care settings. The application of our proposed reimbursement methodology better distributes risk between payers and providers, and reduces adverse selection and incentive problems ("moral hazard").