

BULLETIN

AMERICAN COLLEGE OF SURGEONS



November 2001
Volume 86, Number 11



**Medical
meetings:**

The real value



Bulletin of the American College of Surgeons (ISSN 0002-8045) is published monthly by the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. It is distributed without charge to Fellows, to Associate Fellows, to participants in the Candidate Group of the American College of Surgeons, and to medical libraries. Periodicals postage paid at Chicago, IL, and additional mailing offices. POSTMASTER: Send address changes to Bulletin of the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The American College of Surgeons' headquarters is located at 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5000, fax: 312/202-5001; e-mail: postmaster@facs.org; Website: www.facs.org. Washington, DC, office is located at 1640 Wisconsin Ave., NW, Washington, DC 20007; tel. 202/337-2701, fax 202/337-4271.

Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the authors' personal observations and do not imply endorsement by nor official policy of the American College of Surgeons.

©2001 by the American College of Surgeons, all rights reserved. Contents may not be reproduced, stored in a retrieval system, or transmitted in any form by any means without prior written permission of the publisher.

Library of Congress number 45-49454. Printed in the USA. Publications Agreement No. 1564382.

NEWS

31

R. Scott Jones installed as 82nd ACS President

David L. Nahrwold receives top ACS honor

32

College names three Honorary Fellows

33

Citation for Prof. Albrecht F. W. Encke, MD, FACS
Margaret F. Longo, MD, FACS

34

Citation for Prof. Pekka Häyry
Thomas E. Starzl, MD, PhD, FACS

35

Citation for Prof. Minoru Hirano, MD, PhD
Gerald B. Healy, MD, FACS

36

2003 Travelling Fellowship available

37

Officers and staff of the American College of Surgeons

Officers

R. Scott Jones, MD, FACS, *Charlottesville, VA*
President
Kathryn D. Anderson, MD, FACS, *Los Angeles, CA*
First Vice-President
Claude H. Organ, Jr., MD, FACS, *Oakland, CA*
Second Vice-President
John O. Gage, MD, FACS, *Pensacola, FL*
Secretary
John L. Cameron, MD, FACS, *Baltimore, MD*
Treasurer
Thomas R. Russell, MD, FACS, *Chicago, IL*
Executive Director
Gay L. Vincent, CPA, *Chicago, IL*
Comptroller

Officers-Elect (take office October 2002)

C. James Carrico, MD, FACS, *Dallas, TX*
President
Richard R. Sabo, MD, FACS, *Bozeman, MT*
First Vice-President
Amilu S. Rothhammer, MD, FACS, *Colorado Springs, CO*
Second Vice-President

Board of Regents

Edward R. Laws, Jr., MD, FACS, *Charlottesville, VA*
Chair*
Jonathan L. Meakins, MD, FACS, *Montreal, PQ*
Vice-Chair*
Barbara L. Bass, MD, FACS, *Baltimore, MD*
L. D. Britt, MD, FACS, *Norfolk, VA*
William H. Coles, MD, FACS, *New Orleans, LA*
Paul E. Collicott, MD, FACS, *Chicago, IL*
Edward M. Copeland III, MD, FACS, *Gainesville, FL*
A. Brent Eastman, MD, FACS, *La Jolla, CA*
Richard J. Finley, MD, FACS, *Vancouver, BC*
Josef E. Fischer, MD, FACS, *Boston, MA*
Alden H. Harken, MD, FACS, *Denver, CO**
Gerald B. Healy, MD, FACS, *Boston, MA**
R. Scott Jones, MD, FACS, *Charlottesville, VA**
Margaret F. Longo, MD, FACS, *Hot Springs, AR*
Jack W. McAninch, MD, FACS, *San Francisco, CA**
Mary H. McGrath, MD, FACS, *Maywood, IL*
John T. Preskitt, MD, FACS, *Dallas, TX*
Ronald E. Rosenthal, MD, FACS, *Wayland, MA*
Maurice J. Webb, MD, FACS, *Rochester, MN*
*Executive Committee

Board of Governors/Executive Committee

J. Patrick O'Leary, MD, FACS, *New Orleans, LA*
Chair
Sylvia D. Campbell, MD, FACS, *Tampa, FL*
Vice-Chair
Timothy C. Fabian, MD, FACS, *Memphis, TN*
Secretary
Julie A. Freischlag, MD, FACS, *Los Angeles, CA*

Steven W. Guyton, MD, FACS, *Seattle, WA*
Rene Lafreniere, MD, FACS, *Calgary, AB*
Courtney M. Townsend, Jr., MD, FACS, *Galveston, TX*

Advisory Council to the Board of Regents (Past-Presidents)

W. Gerald Austen, MD, FACS, *Boston, MA*
Henry T. Bahnson, MD, FACS, *Pittsburgh, PA*
Oliver H. Beahrs, MD, FACS, *Rochester, MN*
John M. Beal, MD, FACS, *Valdosta, GA*
Harvey W. Bender, Jr., MD, FACS, *Nashville, TN*
George R. Dunlop, MD, FACS, *Worcester, MA*
C. Rollins Hanlon, MD, FACS, *Chicago, IL*
James D. Hardy, MD, FACS, *Madison, MS*
M. J. Jurkiewicz, MD, FACS, *Atlanta, GA*
LaSalle D. Leffall, Jr., MD, FACS, *Washington, DC*
William P. Longmire, Jr., MD, FACS, *Los Angeles, CA*
Lloyd D. MacLean, MD, FACS, *Montreal, PQ*
William H. Muller, Jr., MD, FACS, *Charlottesville, VA*
David G. Murray, MD, FACS, *Syracuse, NY*
Jonathan E. Rhoads, MD, FACS, *Philadelphia, PA*
David C. Sabiston, Jr., MD, FACS, *Durham, NC*
Seymour I. Schwartz, MD, FACS, *Rochester, NY*
George F. Sheldon, MD, FACS, *Chapel Hill, NC*
G. Tom Shires, MD, FACS, *Las Vegas, NV*
Frank C. Spencer, MD, FACS, *New York, NY*
Ralph A. Straffon, MD, FACS, *Shaker Heights, OH*
James C. Thompson, MD, FACS, *Galveston, TX*

Executive Staff

Executive Director: Thomas R. Russell, MD, FACS
Division of Advocacy and Health Policy:
Cynthia A. Brown, Director
American College of Surgeons Oncology Group:
Samuel A. Wells, Jr., MD, FACS, Group Chair
Communications: Linn Meyer, Director
Division of Education:
Ajit K. Sachdeva, MD, FACS, FRCSC, Director
Executive Services: Barbara L. Dean, Director
Finance and Facilities: Gay L. Vincent, CPA, Director
Human Resources: Jean DeYoung, Director
Information Services: Howard Tanzman, Director
Journal of the American College of Surgeons:
Wendy Cowles Husser, Executive Editor
Division of Member Services:
Paul E. Collicott, MD, FACS, Director
Organization: John P. Lynch, Director
Division of Research and Optimal Patient Care:
Cancer:
David P. Winchester, MD, FACS, Medical Director
JoAnne Sylvester, Associate Director
Office of Evidence-Based Surgery:
Margaret Mooney, MD, Interim Director
Trauma:
Gerald O. Strauch, MD, FACS, Director
Executive Consultants:
C. Rollins Hanlon, MD, FACS
Olga Jonasson, MD, FACS

2002
*Young
Surgical
Investigators'
Conference*

The Surgical Research and Education Committee of the American College of Surgeons has organized the Sixth Biennial Young Surgical Investigators' Conference to assist surgeon-scientists who are entering the process of obtaining extramural, peer-reviewed grant support for their work. The goal of these conferences, held with staff members of the National Institutes of Health (NIH) in attendance, is to introduce young surgeons to the process, the content, the style, and the people involved in successful grant-writing and interactions with the NIH.

The program will include intensive exposure to:

- NIH programs and policies
- Information from NIH Institutes
- What programs are best and available for your research project and how to apply
- Workshops in hypothesis testing, methodology, background, and preliminary results
- Grant-writing strategies
- Mock study sections reviewing model grants

The program and registration form are available online at <http://www.facs.org/dept/serd/srec/youngsurg.html>. For further information, contact Ms. Donna Coulombe, Education and Surgical Services Dept., American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; phone 312/202-5488; fax 312/202-5013; e-mail dcoulombe@facs.org

March 8-10, 2002

*Lansdowne Resort
Conference Center
Leesburg, VA*

*Sponsored by the
Surgical Research and Education Committee of the
American College of Surgeons*

From my perspective

As I write this column, the events of the 87th annual Clinical Congress are fresh in my mind. By all accounts, I believe it was a very successful meeting. There were superb presentations by the volunteers of the American College of Surgeons, and the sessions offered opportunities for interactive dialogue. As always, the College is most appreciative of everyone's efforts, both staff and Fellows.

Throughout the five days of the meeting, an overarching issue was clearly on everyone's mind—the events of September 11 and the potential for further acts of civilian terrorism. I am pleased to report that in response to these concerns, we were able to offer a special session during the Clinical Congress that addressed “Unconventional Civilian Disasters: What the Surgeon Should Know.” The session was presented on Thursday, October 12, by David B. Hoyt, MD, FACS, Chair of the ACS Committee on Trauma, and Donald Fry, MD, FACS, Chair of the Board of Governors' Committee on Blood-Borne Infection and Environmental Risk. It clearly gave everyone a lot to think about.

Time to act

Our world is very different now, and the College, as well as individual surgeons, must respond appropriately in these turbulent times. We must be prepared to deal with bioterrorism. At press time, it was reported that there have been four deaths from the inhalation form of anthrax, four people had inhalation infection, and thousands of people, particularly in Washington, DC, were being treated for possible anthrax exposure. Clearly, this is a problem that is not going to go away.

In the past, many of us were perhaps reasonably complacent about disaster planning or the potential for bioterrorism. Like most people, we simply couldn't fathom these horrible events happening, and, as a result, many of us (including myself) were not particularly involved in the process of planning for natural or manmade disasters. Well, we can no longer afford to be passive, having actually experienced our worst nightmare on September 11 and now having accepted the fact that someone is using bioterrorism to attack our people and our sense of well-being. We now need to listen and learn about bioterrorism, lead the profession and the public, and realize that these



“Surgeons are uniquely qualified to learn about bioterrorism and to eventually lead and participate in disaster planning.”

kinds of attacks are liable to happen again. We cannot be apathetic and reactive; rather, we must face these issues as an organization and as individuals in a much more proactive way.

The College prepares

The College has long had an interest in trauma care and an active trauma network. During this year's Clinical Congress, we took steps toward dealing with the new face of trauma and issued two statements that reflect our willingness to become involved in the battle against biological and chemical terrorism. These statements, which were presented during the special session on unconventional civilian disasters during the Clinical Congress, may be found on pages 8-12 of this issue of the *Bulletin*. The first position paper, *Disasters from Biological and Chemical Terrorism—What Should the Individual Surgeon Do?*, is a report from the Committee on Trauma; the other—*Statement on Unconventional Acts of Civilian Terrorism*—is a report from the Board of Governors. To

summarize, these reports call on the College and individual surgeons to take immediate action to become more responsive to the likelihood of future terrorism.

First, the documents indicate that we will need to improve and change our trauma system. The papers note that chemical and biological disasters cannot be addressed through traditional trauma systems planning in the local community, and that trauma centers will have to be modified if they are to be able to respond to chemical and biological attacks. Additionally, the statements recommend that each hospital be integrated with the county or state disaster plan and with the government agencies that would be involved in such a plan. The reports also suggest that the College itself develop formal relationships with the National Disaster Medical System (NDMS), the military, and other federal, state, and private disaster response units.

As a result, I believe we need to establish a network of related regional trauma agencies. I also believe the College should formally establish liaisons with the Centers for Disease Control and Prevention, the Department of Defense, and other federal, state, and local government agencies, and should be a real participant in the NDMS. To that end, we will approach the appropriate agencies and indicate our willingness to offer the services of our existing trauma network.

Individual involvement

The College's reports also emphasize the importance of the individual surgeon's involvement in efforts to combat bioterrorism. Surgeons are uniquely qualified to learn about bioterrorism and to eventually lead and participate in disaster planning. As trauma surgeons and as burn specialists, we have background and expertise in critical care. Perhaps equally important, we can process much of the information and prioritize the potential effects of these acts. We can do much to educate the public and establish meaningful policies at our hospitals.

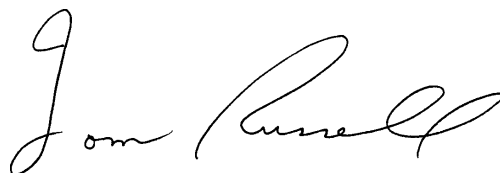
The ACS documents call upon all surgeons to actively participate in developing a disaster response system within their institutions, local communities, and geographic regions and to learn more about how the NDMS and local trauma and disaster response systems operate. Further, they

recommend that surgeons educate themselves about biologic and chemical agents, and participate in training about the pathogenesis, diagnosis, prevention, and treatment of diseases and conditions caused by acts of civilian terrorism. Similarly, surgeons should help to educate their colleagues about these issues, and the College should be a leader in this educational process. To achieve this goal, I believe we will need to offer educational activities that bring surgeons of all backgrounds to a higher level of understanding about the realities of bioterrorism and the methods terrorists use to accomplish their egregious ends.

Difficult days

These are moving and trying days! I believe the position papers developed by the Committee on Trauma and the Board of Governors do much to frame the College's evolving role and our individual obligations during this unsettling period in our nation's history. Our response will include involvement in public policy, communications, and education at both the national and local levels.

All of us must be willing to accept responsibility for helping our nation get through this difficult time, and clearly, your ideas and thoughts will be valuable to the College as we prepare to take on our new obligations. As always, I solicit your views on how the College and our Fellows can help to meet the health care needs of our country.



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.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

College submits comments on 2002 fee schedule

On September 30, the College submitted comments to the Centers for Medicare & Medicaid Services (CMS) regarding the group's August 6 proposed rule on the 2002 Medicare fee schedule. The proposed rule includes the CMS's plans for continuing to refine the resource-based practice expense relative value units and other payment policy changes for 2002, none of which is expected to have a significant impact on surgical services.

As reported in the October 2001 *Bulletin*, the CMS has requested information pertaining to payments for co-surgeons, which could be used to decide whether a policy change for 2003 is necessary. The College expressed concern that the notice raises a number of questions about the distinction between a "co-surgeon" and an "assistant at surgery" and about how to value the work performed by co-surgeons. In its comments, the College outlined the differences between the two types of services and urged the CMS to consult the American Medical Association/Specialty Society RVS Update Committee should the agency decide to proceed with more work on the subject.

In addition, the College expressed concern to the agency regarding the lack of information pertaining to the physician payment update for calendar year 2002. Given the appearance of dramatic growth in utilization during 2000, the College stressed that the CMS should have issued a request for comments to consider important changes in clinical practice and other factors that could lead to errors in the calculations of the sustainable growth rate and Medicare Economic Index—two key elements of the physician payment update. Failure to address these issues could result in a reduction in the conversion factor for next year that would negate many of the gains surgeons have made as a result of the five-year review of the work component of the fee schedule.

GAO criticizes Medicare provider communications

On September 25, the House Ways and Means Health Subcommittee held a hearing regarding Medicare regulatory and contracting reform. The hearing included testimony from the CMS and the General Accounting Office (GAO). In the GAO's testimony, the agency outlined several problem areas within the Medicare program, including reliable contractor communications between physicians and carriers.

In studying this issue, the GAO found that "physicians often do not receive complete, accurate, clear, and timely guidance on Medicare billing and payment policies." For example, when the GAO staff contacted local carrier call centers with questions that were selected from the "frequently asked questions" on their Web sites, staff found that only 15 percent of the carriers' answers were complete and accurate, while 53 percent were incomplete and 32 percent were entirely incorrect. To rectify this problem, the GAO recommended that the CMS develop a "more centralized and coordinated approach" for responding to physician and other health care provider questions and concerns.

In an effort to correct a number of these concerns, both the House Ways and Means and Energy and Commerce Committees have developed Medicare regulatory and contractor reform legislation, which both committees planned to "mark up" during early October. Both bills ad-

CMS releases proposed rule on CRNAs

dress a number of serious problems with the claims auditing and recovery process.

On September 5, the College submitted comments to the CMS in response to a July 5 proposed rule regarding physician supervision of certified registered nurse anesthetists (CRNAs). Currently, Medicare's hospital conditions of participation require that physicians supervise CRNAs. Under the proposed rule, these requirements would be maintained unless a state's governor, in consultation with the boards of medicine and nursing, exercises an exemption option that is consistent with state law. In those cases, governors would submit a letter of exemption testifying that it is in the best interests of the state's citizens to "opt out" of the physician supervision requirement. The proposal also directs the Agency for Healthcare Research and Quality (AHRQ), with input from the CMS and others, to assess the impact of CRNAs practicing without physician supervision. In its September 5 comments, the College supported the CMS's decision to restore the longstanding requirement that CRNAs be supervised by physicians while allowing flexibility to account for local resources and needs. The College also supported the CMS's proposal for a comprehensive AHRQ outcome study on this issue. The College cautioned, however, that applications to opt out of the supervision requirement should be carefully reviewed and evaluated before they are granted.

College comments on hospital OPPS rule

On October 3, the College submitted comments to the CMS regarding the agency's August 24 proposed rule on the hospital outpatient prospective payment system (OPPS). Among other concerns, the College noted that: the CMS needs to clarify whether postsurgical observation care is reflected in hospital OPPS payment; problems are being created by retention of the "inpatient list" of procedures for which outpatient department payments have not been calculated; and proposals for hospital coding for evaluation and management services need to be reevaluated. In addition, the College urged the CMS to move forward expeditiously in terms of both accounting for all new procedures in the final hospital OPPS rule and updating the current ambulatory surgical center list.

OIG releases work plan for 2002

During September, the Department of Health and Human Services's (HHS's) Office of the Inspector General (OIG) released its work plan for various projects to be addressed during fiscal year 2002. The OIG's mission is to work with the department both to ensure effective and efficient HHS programs and operations and to minimize fraud, waste, and abuse in department programs. Among other issues, the OIG will be examining physicians at teaching hospitals, billing for residents' services, physician evaluation and management codes, use of advance beneficiary notices, hospital privileging activities, medical education payments, and procedure coding of outpatient and physician services.

Unconventional civilian disasters: What the surgeon should know

One of the high points during this year's Clinical Congress, which was held October 7-12 in New Orleans, LA, was a special session on Unconventional Civilian Disasters: What the Surgeon Should Know. The presenters at the session were David B. Hoyt, MD, FACS, Chair of the Committee on Trauma, and Donald Fry, MD, FACS, Chair of the Board of Governors' Committee on Blood-Borne Infection and Environmental Risk. Two documents were prepared as handouts for that special session:

- Disasters from Biological and Chemical Terrorism—What Should the Individual Surgeon Do?: A Report from the Committee on Trauma.
- Statement on Unconventional Acts of Civilian Terrorism: A Report from the Board of Governors.

These documents provide information on biological and chemical terrorism and offer guidance as to how individual surgeons can actively participate in the disaster planning processes of their local communities and geographic region. They also emphasize why surgeons must be agents for change in community disaster awareness and planning.

The College believes the information in these two documents is vitally important and encour-

ages each and every Fellow to become familiar with the recommendations of the Committee on Trauma and the Board of Governors. Because of our training in trauma and critical care, surgeons will play a major role in our health care community's response to any unconventional acts of civilian terrorism. As a result, we urge you to assume a leadership role in your local community. Please review these documents carefully and watch for updates and educational information in future editions of *ACS NewsScope* and the *Bulletin*.



Thomas R. Russell, MD, FACS
Executive Director
American College of Surgeons

Disasters from biological and chemical terrorism— What should the individual surgeon do?

A report from the Committee on Trauma

In the weeks following the September 11 disaster, we have all been asking how we can prepare for a homeland disaster response to acts of biological and/or chemical terrorism and how we as individual surgeons can get involved.

The exact answer to these questions is not yet clear. Increasingly, we are beginning to identify the approach that we should each take in our communities. Following are some concepts and recommendations to guide each Fellow as we proceed toward developing a definitive answer to these questions.

An organized response

A trauma and EMS system is designed to be an organized response to injury. As such, it has many of the elements needed for a disaster response, including identification of injury, transport of the injured, a communications network, designation of receiving facilities or hospitals, and specific details of medical care that would be appropriate at the point of injury and at receiving hospitals.

The response required for a biological or chemical disaster may be proportionally different but, in principle, is still an organized response to injury. Differences would include: the magnitude and types of injury, the number of injured, and the risk to providers of exposure and personal injury. Chemical and biological disasters may not be addressed by trauma systems planning in a local community, and a disaster response will differ from a traditional trauma/EMS system in four ways.

- First, the traditional hospital-based trauma program will need to be modified to include a chemical or biological response ability. Such capability will require involvement of various different elements within the hospital in addition to the traditional trauma program.

- Second, at the local/regional level, each hospital needs to be integrated with the county or

state disaster plan and the government agencies that would be involved in such a plan. The details of the biological and chemical disaster plans will differ from conventional trauma/EMS disaster plans.

- Third, a disaster of significant proportion may require the participation of the National Disaster Medical System (NDMS) and the military. How this system is activated and interfaced with the local/regional response should also be clear to everyone involved.

- Finally, the uniqueness of biological and chemical injuries may exceed a practitioner's current knowledge, which may include deficiencies in knowledge regarding techniques of surveillance and detection, the need for specific procedures to protect prehospital and hospital providers, the signs and symptoms of disease, and treatment.

As we respond to this challenge we all must:

1. Expand our current trauma/EMS systems to respond to biochemical disasters.
2. Increase specific knowledge at an individual practitioner level.

The surgeon's role

Surgeons are natural leaders. We should lead this effort in our communities. The following are specific recommendations for surgeons to consider:

1. Within each hospital, surgeons should participate in defining and developing the internal response capabilities of their hospitals for biological and chemical injury. A guide for accomplishing this goal has been developed by the Office of Emergency Preparedness of the U.S. Department of Health and Human Services and the American Hospital Association. This guide can be accessed at www.bt.cdc.gov. The internal response system of each hospital should include procedures to increase surveillance of infectious disease in coordination with the state and local health agencies. The surgeon needs to work as or with the local hospital trauma director, the hospital director, infectious disease and critical care colleagues, toxicologists, and pharmacists to ensure that the internal response is operational. An additional resource to help with hospital disaster plan development is Chapter 20 in the American College of Surgeons' manual, *Resources for Optimal Care of the Injured Patient: 1999*.*

2. The surgeon must understand how the local trauma and EMS system and disaster plan function. They should work with the local trauma/EMS system to determine what mechanism exists and how responses need to be modified or expanded to deal with chemical and biological threats. You can identify the appropriate individuals to contact by linking to your state or local EMS agency from the National Association of Emergency Medical Directors at www.nasemsd.org.


3. The surgeon should know and understand the NDMS and how it works. This system is activated through local, state, and federal agencies. The NDMS complements local/regional resources and can mobilize them through a mutual aid agreement with other government agencies. Examples of some of the multiple resources that are available include search and rescue teams, medical response specialty teams (specialty DMAT), the National Pharmaceutical Stockpile, and evacuation capabilities offered by the Air Force. Details regarding the NDMS can be obtained at www.ndms.dhhs.gov.

4. The individual surgeon needs to expand his or her own knowledge of biologic and chemical agents by learning: (1) agents that are most likely

to be used, (2) the appropriate initial injury control and risk reduction procedures, (3) what the presenting signs and symptoms are and the natural history of exposure, and (4) definitive treatment. A primary resource for didactic information is available on the CDC Web site at www.bt.cdc.gov.

5. The surgeon should participate in the education of colleagues, hospital staff, and administration. He or she should partner with local public health officials to educate the public regarding the thoroughness of the local disaster response, the need for specific prevention measures, and the comprehensiveness of our national systems for disaster response and management.

Beyond participating in their local hospital and community plans, surgeons are asking how they might participate at the national or international level in either a homeland disaster or war. The American College of Surgeons Committee on Trauma will continue to provide information with regard to these opportunities as they are clarified. Currently, participation in the NDMS by joining a local DMAT team is one possibility. Further information can be accessed at www.ndms.dhhs.gov.

The College will continue to use *ACS NewsScope*, its Web site (www.facs.org), and the Trauma Office to provide answers to questions regarding available resources for all Fellows. 

*For information on obtaining a copy of the manual, visit the Publications and Services section of the ACS Web site (www.facs.org), or contact ACS Customer Service at 312/202-5474.

Statement on unconventional acts of civilian terrorism

A report from the Board of Governors

Recent events have increased the public's sensitivity to acts of civilian terrorism. Terrorist acts with conventional explosive devices can result in mass casualties secondary to kinetic and thermal energy that require surgeons for their treatment. Unconventional Acts of Civilian Terrorism (ACTs) have the potential to kill and injure hundreds of thousands of individuals while destroying the health care infrastructure necessary for care of survivors. As a result, they require a new level of preparedness. By virtue of their training in trauma and critical care, surgeons will play a major role in our health care community's response to any unconventional ACTs.

Three types of ACTs

There are three major categories of unconventional ACTs:

1. *Nuclear/radiation events:* Radiation terrorism can be activated through three major routes. Nuclear detonation is one. Radioactive material placed into a conventional explosive is a second. A third would be direct efforts to disseminate radioactive contamination through food, water, or direct environmental spread.

In a nuclear detonation, injuries sustained outside of the lethal perimeter of the explosion due to kinetic and thermal energy will require treatment; such injuries will also be characterized by severe acute radiation exposure. Irradiation injury does not make the patient radioactive, but surface radioactive contamination requires decontamination through removal of all clothing and tepid bathing of the skin surfaces, preferably before the patients are transported to hospital facilities for management of physical injuries. Patients with minimal or no injury should be transported to designated (by the community disaster plan) non-health care facilities (for example, gymnasiums, arenas, convention centers, and so on) where showering or temporary decontamination activities can be conducted. The use of private

transportation will result in patients arriving at health care facilities prior to decontamination, thus posing potential risks to health care workers. Injured patients will require decontamination at the health care facility. Uninjured or minimally injured patients should be triaged to the non-hospital decontamination site.

2. *Chemical events:* Typical chemicals that potentially could be used in ACTs include cyanide, nerve gases (such as sarin), pulmonary toxicants (for example, phosgene), vesicants (nitrogen mustard), and others. Cyanide and nerve gas exposures require prompt recognition and specific antidote administration. Pulmonary toxicants require ventilator supportive care for severe lung inflammation. Vesicants require rapid decontamination and management of the chemical burns. All chemical agents preferably require in-the-field decontamination to protect against continued patient exposure and to protect health care providers from exposure. There is the potential that chemical agents will be used with conventional explosives, and exposure may not be appreciated until chemical injuries, independent of physical trauma from the primary explosion, are recognized.

3. *Biological events:* Biological ACTs include bacteria, viruses, and biological products. Anthrax, brucellosis, *Yersinia pestis* (plague), and cholera are the more commonly

identified potential bacteria in unconventional ACTs. Smallpox and numerous hemorrhagic fever viruses are the viral strains of interest. Botulinum toxin, enterotoxins, ricin, and mycotoxins are biological products recognized as agents of bioterrorism. Other agents will likely be identified with time. Airborne delivery of biological ACTs may be used, or they could be delivered via food and/or water. Some biological ACTs are rapidly fatal infections (for example, untreated and inhalation anthrax) while others are severely incapacitating. All ACTs have a delay from the time of exposure until clinical symptoms—such as flu-like syndromes—occur. Thus, extensive exposure could occur before the primary event is appreciated. Airborne biological ACTs will likely be delivered with conventional explosives.

Recommended actions


The threats posed by unconventional ACTs require a new level of disaster preparedness, and a new level of knowledge by surgeons who care for patients who are casualties as a result of these events. To meet the challenge of these new issues, the following recommendations are being made:

- Fellows of the American College of Surgeons should actively participate in the disaster-planning processes in their local communities and geographic region. Old disaster plans that address bygone conventional threats do not apply to unconventional ACTs. The threats and consequences of this new era require that surgeons be agents for change in community disaster awareness and planning.

- Fellows of the College will require extensive education and training in the pathogenesis, diagnosis, prevention, and treatment of the likely agents of unconventional ACTs. Education in the development of disaster plans in this new era also is required. The College will take a leadership role and will disseminate educational information through *ACS News-Scope*, the *Bulletin of the American College of Surgeons*, the *Journal of the American College of Surgeons*, state chapter meetings, and the Spring Meeting and the Clinical Congress in the fall. A plan for educational activities about unconventional ACTs will be jointly coordinated through the Governors' Committee on Blood-Borne Infection and Environmental Risk, the Committee on Trauma, the Division of Education, and other pertinent groups within the College.

- Fellows of the College should be leaders in community education of other health care providers and of the nonmedical community through structured programs created through the College. Such education can be facilitated with the development of audiovisual materials, manuals, and an organizational structure that will be a supplement to existing resuscitation courses (for example, the Advanced Trauma Life Support® course). The community that is best prepared may best minimize the consequences of a terrorist event. The community with an open and clearly present public effort to prepare and deal with this problem may be less attractive to those who perpetrate ACTs.

- The College should accept a policy of universal standards for the response to all *potential* terrorist events. The true nature of any explosion event may not be defined until well after it has occurred. First responders to such events should have appropriate protective gowns, NP-95 respirator masks, and so on. In-field decontamination is desirable before injured patients are evacuated to health care facilities. Noninjured, or minimally injured, individuals should be evacuated to designated non-health care facilities for the decontamination process. Individuals who are privately conveyed to the health care facility should be triaged in terms of the severity of their injuries, and either decontaminated at the health care facility or sent to the decontamination facility.

- The College should rapidly develop formal relationships with federal, state, and private disaster planning and response units to facilitate education, training, and research. 



Medical meetings: *The real value*



by William H. Baker, MD, FACS, Maywood, IL

Editor's note: This article is adapted from comments Dr. Baker made on May 10 during his presidential address to the Chicago Surgical Society.

Not all surgeons have a sense of history or tradition, nor have they all a devotion to organized medicine. The American College of Surgeons, like many other regional and national medical and surgical societies, is facing decreasing participation by younger members of the surgical community. Since I have always thought it important to be a joiner and to participate in surgical affairs, I wonder why this should be the case. Why do I derive pleasure and satisfaction from my societies while others disdain and avoid them? What is the real or hidden value of belonging? Is there something special behind the external facade?

In an attempt to find solutions to these questions, I first went to the literature and found precious little. Next, I canvassed many of the members of the Chicago-area surgical community for their opinions and vignettes regarding what they have garnered by belonging to surgical organizations.*

Feeling disaffected

The apathy of younger surgeons might be summed up in a December 2000 *Bulletin* article by Chad Rubin, MD, FACS. He states, "I became involved as a young surgeon when my partner, the then-president of our state chapter, nominated me to attend the College's Young Surgeon Representatives meeting. Frankly, I was not a fan of the College at the time and wasn't really sure what it had done for me. I was not familiar with the services the College offered and felt that it merely represented the chairs of the large academic centers. Despite these feelings, I decided to attend the meeting."¹

Similarly, William Laney, writing in the *International Journal of Oral and Maxillofacial Implants*, states, "If there is no immediate opportunity to realize personal satisfaction or monetary gain, joining a professional organization has apparently become a lesser priority."² William O. McCormack, writing from the department of psychiatry at Dalhousie University in

Halifax, NS, recounts giving a paper at a specialty society meeting, which had an "audience" of 10: one chair, four presenters, two loyal wives, one coauthor, and two other listeners.³

Why then should we attend such meetings? Are they really needed? Why don't we stay at home, subscribe to two more journals, perhaps turn on the computer and scroll through some new articles, rather than traipse across town or across the country to attend surgical meetings? There must be a hidden but very real value.

The hidden value

My friend Tom Pratt, a retired engineer for Electromotive, says, "The purpose of an organization is to facilitate the communication between individuals of a common profession with the express purpose of advancing their knowledge through the free interchange of their mutual experiences, observations, philosophies, and conclusions." To have this interchange we cannot merely read at home, but need face-to-face contact.

For an article in *Military Medicine*, Maj. Gary A. Wheeler, MD, surveyed the attendees at the annual meeting of the Army Chapter of the American College of Physicians (ACP).⁴ These attendees ranked networking as the number one reason for attending the meeting. This reason was followed by those of attaining medical knowledge, meeting the Army brass, listening to presentations, meeting prospects, earning continued medical education credits, learning about research, and finally, getting away. When Dr. Wheeler offered the attendees the opportunity to view select portions of the Army ACP meeting via live telemedicine links at their home medical treatment facilities, 75 percent indicated that such a broadcast would not affect their desire to attend. Thus, there must be a hidden value in attending that meeting.

Knowledge sharing

Regardless, the scientific papers form the basis of many of our meetings. Quality papers are the sine qua non for a successful meeting, and the quality of the presentations depends upon the effort exerted by the members of the organization. However, many of the nuances and details of the papers come out only in discussion. Obviously, while reading a journal at home, one cannot be privy to the give and take of the presenter and the discus-

*The author would like to thank all of the surgeons who provided their valuable suggestions and entertaining vignettes.

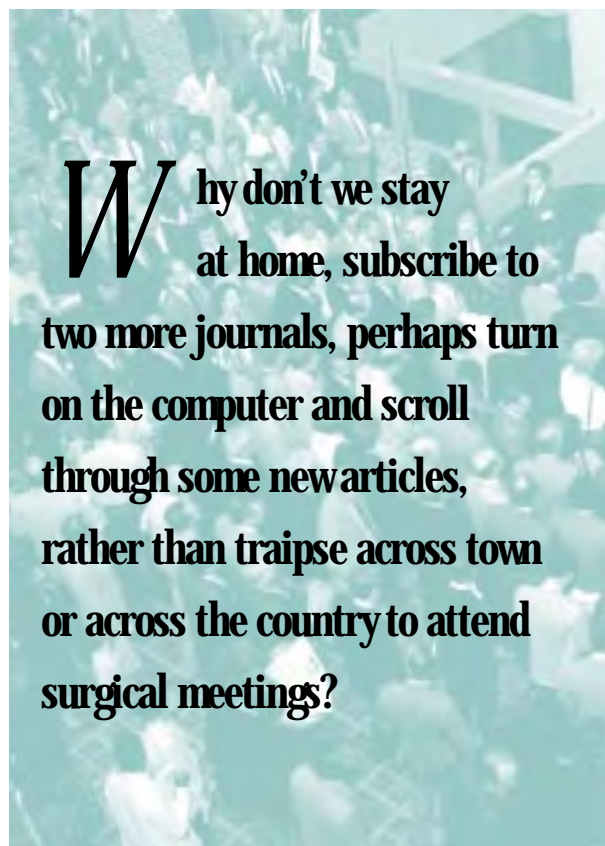
sants, which to me is an important, if not the most important, part of any presentation. At last year's Society for Vascular Surgery meeting there was a presentation regarding the cost of endografts.⁵ The ensuing acrimonious discussion clearly spiced the meeting, adding emphasis to my bias that open discussion is one of the true values of listening to medical presentation. Discussion does not stop at the podium. Kenneth Leighton, writing in the *Canadian Medical Association Journal*, states, "The great value of a gathering lies in the personal contact and in coffee table debate. Here one learns of the true position and hears the doubts and uncertainties revealed as never can be done in a public forum at a formal address. The convivial gathering provides the milieu for this exchange."⁶

Penn Faber, MD, FACS, remembers having lunch with Richard Peters, MD, FACS, and John Benfield, MD, FACS, during a thoracic society meeting, at which time Dick Peters told him about epidural techniques for controlling pain following thoracotomy. As a result of that informal discussion, epidural analgesia became the routine for the thoracotomy patients at Rush-Presbyterian St. Luke's Medical Center in Chicago.

On a similar note, John White, MD, FACS, remembers a conversation over lunch with a professor from the east coast considering a complicated aortic reconstruction. As the discussants were envisioning the procedure that the professor was describing, it became evident that the professor placed his knots inside the aorta. The professor did not even realize that this was not the common practice. Thus, we can learn both positively and negatively from these "convivial gatherings."

James Yao, MD, FACS, states that not only can one learn about new surgical techniques, but one can learn about administrative shortcuts and techniques for managing people. Dr. Yao, who recently was a temporary chair for several years, undoubtedly needed this exchange. From my personal perspective as a surgical program director, I've learned about numerous other training programs and their nuances from very informal discussions.

At the recent American Surgical Association meeting, Bob Rhodes, MD, FACS, of the American Board of Surgery (ABS) gave me some great insights into the potential uses of the ABS's in-service examination. Quentin Stiles, MD, FACS, in his presidential address to the Western Thoracic



Why don't we stay at home, subscribe to two more journals, perhaps turn on the computer and scroll through some new articles, rather than traipse across town or across the country to attend surgical meetings?

Surgical Association in 1989, tells of attending a meeting of the American Association of Thoracic Surgery with his mentor, John Jones, MD, FACS.⁷ He says, "I would dutifully sit through each delivery and take notes as the authors spoke. John missed many of the talks and never took notes. Afterward, back in Los Angeles, he would tell me what was going on at places like the Cleveland Clinic or the Mayo Clinic. The information he obtained was what we would be hearing delivered in the papers at the following year's meeting. He was a master at obtaining information from his friends on an informal basis."

Dr. Stiles then relates talking to Jerry Buckberg, MD, FACS, in a dark basement room in the old convention center in San Francisco, where they discussed stone heart and myocardial protection. This was a year or so before Dr. Buckberg's publi-

cations on this same subject. Dr. Stiles states, “There is an entirely different layer of information that one can get from one’s friends on an informal basis that cannot be obtained from reading the journals.”

I remember after a vascular meeting many years ago the late Tim String, MD, FACS, and I were lamenting the preeminence given to diagnosis using ultrasound at the expense of the physical examination. After at least two libations, we agreed upon a cooperative study to test the relative merits of ultrasound and physical examination, which was completed, presented, and published within two years.⁸ Richard Gamelli, MD, FACS, agrees that meetings “also provide many [surgeons] with the opportunity to develop creative interactive projects. Certainly, many of the opportunities that I have had in terms of publication of books and book chapters have grown out of these relationships. It certainly has proven to move forward my professional career.”

Friendships

The role of friendship and face-to-face contact cannot be emphasized enough. Richard Byrne, MD, FACS, takes great pride in having met Vijay Maker, MD, FACS, at the Illinois Surgical Society and, recognizing that Dr. Maker was a good surgeon and fair man, bringing him into the Chicago Surgical Society.

Jack Pickleman, MD, FACS, tells me that the bonds made at meetings are “personal rather than professional.” Dr. Pickleman relates that he was traveling up in an elevator with the late Robert Zollinger, MD, FACS, of Ohio State University. Dr. Zollinger told Dr. and Mrs. Pickleman that money and philandering were the two surest ways to destroy a surgical career. Whereas I have changed the exact verbiage of the colorful Dr. Zollinger, the message certainly has stayed with Dr. and Mrs. Pickleman.

Richard Prinz, MD, FACS, tells about his friends at the American Surgical Society when it met in Palm Desert. At that time, his daughter was accompanying him to look at potential colleges on the west coast. One of the schools was Redlands University, not far from the Marriott Resort in Palm Desert. Dr. Prinz’s “friends” told his daughter Kara that if she went to school in California her father would put her up at the

Marriott Resort. Although Kara was not quite that gullible, the milieu of good friends, warm sun, and a cool pool led Kara to a career at Redlands and a migration to the state of California. Dr. Prinz says, “Whenever the topic is brought up by my wife, my mother, and anyone else who is disheartened by Kara being so far away, the finger of blame is always pointed toward me.”

Recruiting faculty

Recruiting new faculty or new partners clearly depends on one’s friends. Bob Baker, MD, FACS, states that not only do meetings provide a real opportunity to get information regarding potential recruits, but they are a great place to initially screen potential candidates. My old boss, Bob Freemark, MD, FACS, fondly remembers one of our neurosurgeons, John Shea, MD, FACS, at a meeting when they were both on the same program. Dr. Freemark was so impressed with Dr. Shea that he almost hired him on the spot. It is noteworthy that Dr. Shea received one of the coveted teaching awards at Loyola University Medical Center this spring. On the other hand, Dr. Freemark was given a bum steer by one of his so-called friends regarding another potential faculty. This faculty fell flat on his face—attesting to the fact that friends aren’t everything.

Dr. Yao also mentioned that a meeting is an excellent place to gain more personal knowledge about the candidates you’re going to recruit. Although some individuals may claim that one phone call would yield the same information, Dr. Yao believes that the body language in a face-to-face situation is certainly more telling. During an *Oprah* show, Dr. Phil, Oprah’s favorite psychologist, said that communication was perhaps 7 percent verbal but 93 percent nonverbal. Clearly, the great communicator Jimmy Yao understands this very well.

Meeting mentors

Meetings are a great place for young surgeons to connect with professors and other notable presenters. For a resident, this experience may be an anxious one. Staff for the societies tells of residents who approach the meeting registration desk, believe they are not dressed correctly or mumble some lame excuse, and quickly leave in fright before anyone sees them.

Bill Hopkins, MD, FACS, remembers being ner-

vous at his first Chicago Surgical Society meeting. A waiter dropped a shrimp cocktail on his only sport coat, making him truly embarrassed. But Jim Schuler, MD, FACS, remembers meeting the professors during a surgical society meeting when he was a resident and discovering quickly that they were upstanding and moral gentlemen. He says it gave much more meaning to their proclamations and surgical talents.

Dr. Gamelli remembers, "The first medical meeting I attended was as a third-year resident. At that meeting there were luncheon sessions, where over the days I became exposed to Joe Fischer, MD, FACS, and George Sheldon, MD, FACS, and in the panel sessions there were individuals such as Larry Way, MD, FACS, and John Rombeau, MD, FACS. Certainly, Fischer and Sheldon were just absolutely outstanding individuals, and the view of what a surgeon could be, beyond simply being someone who did cutting and tying, began to become a very exciting opportunity. A meeting at the NIH [National Institutes of Health] a year later exposed me to the likes of Charles Baxter, MD, FACS, and Basil Pruitt, MD, FACS, where any loss of enthusiasm I had as a fourth-year surgical resident was, once again, reinvigorated. Getting introduced at a young age to people like Bill Drucker, Alex Walt, Art Baue, Bill Abbott, Bill Holden, Jack Burke, Tom Shires, Lloyd MacLean [all ACS Fellows], as well as many others provided a never-ending group of role models to keep the focus of academic interest alive."

Jim Schuler, after listing an equally impressive array of giants in surgery, said, "I can also remember very clearly being overcome by an almost uncontrollable urge to be 'just like them.'" Haven't the rest of us had similar feelings? These testimonials should encourage all members to invite favorite residents and younger colleagues to these hallowed halls.

The thrill of meeting a luminary continues to this day. Jim DeBord, MD, FACS, has lectured about Tom Throckmorton, MD, FACS, and his contributions to hernia repair for several decades. In his presentation, Dr. DeBord shows a slide with a quote by Dr. Throckmorton from 1947, the year of Dr. DeBord's birth. In 1997, at a meeting of the Western Surgical Association, Dr. DeBord sat down at a table next to a very distinguished gentle-

man and his female companion. He found he was sitting next to Dr. Throckmorton, then 94 years old. Jim states he had a "memorable evening that enriched my life and my connection to surgical history."

Insights into peers

Meeting our colleagues gives us a sixth sense of whom we can trust. Who among us has not enjoyed meeting the younger associates of a presenter or fellow surgeon who then either lavishes praise or presents an aura of caution regarding their boss? We then see that surgeon in an entirely different light. And who among us has not utilized the networking of the ACS for referrals? Bill Hopkins, MD, FACS, like most of us, relies on the surgeons whom he has met at local surgical meetings and whom he trusts to ask about physicians in their hospital. He then recommends these "unknown" physicians to his friends and relatives based entirely on the trust of his comrades. I have done the same thing.

"In the end, it's the friendships," notes Ken Printen, MD, FACS. All topics—professional, economic, malpractice hassles, or personal problems—are enhanced by our friendship. Even gossip, a topic mentioned by a majority of respondents to my inquiry, is a great part of these meetings. Who was fired, why they were fired, who was divorced, why they were divorced, and like questions always enter into the conversation. I will not quote specific vignettes regarding these subjects.

These friendships and networking characteristics are present at all gatherings, not just surgical meetings. Mac McDowell, president of Exectech Microsystems, states in discussing a national society of business CEOs, "It's a peer group.... The vast majority of members are entrepreneurs and principals in the organizations they're representing. Several people are sounding boards for me. There's also the intangible reward of associating with similar professionals."⁹

Margaret Beleckis of Oppenheimer and Co. says a good group "helps you grow and develop."¹⁰ But you have to have the right frame of mind to benefit. "If you go there with the attitude that you just want to get business, you won't get much from the organization."

This attitude is underscored by Baber and Waymon, who write, "Get ready to give. The biggest misconception about networking is that it's

about getting. But that's not the main point. Yes, networking can be extremely beneficial, but giving comes before getting."¹¹

For example, Hass writes about George Segal, the CEO of Crate and Barrel, "It wasn't until he (Segal) joined the Young President's Organization that he realized the true value of networking. He had emerged from a management cocoon that he had built as the Crate and Barrel founder, entrepreneur, and CEO. It wasn't until he met other chief executives that he realized that they too had problems similar to his own. Problems he felt were unique. He no longer felt isolated."¹² How many of us have also found a sympathetic listener at the ACS who had a similar patient, a like problem in nursing, or a twin of your wonderful yet exasperating resident?

Overt and covert exchange

In closing, I hope I have underscored that medical meetings are more than listening to mere scientific presentations. There is an overt and covert exchange of scientific, social, and personal information. Dr. Gamelli notes, "The continuously refreshing thing is that people are not afraid to share their problems, talk about their solutions, and give you some legitimate insights on how you might proceed."

This benefit comes at a price: that is, we must actively participate in and devote our energies to the success of such meetings. Dr. Rubin, the ACS young surgeon mentioned at the beginning of this article, observes that "there is a real concern about the future of organized medicine. Without members there are no leaders, and without leadership there is no voice."

The Hon. Tip O'Neill once said, "All politics is local." Paraphrasing Mr. O'Neill, I should like to add that all of organized medicine begins locally. The College chapters are among those local organizations that with a modicum of effort can benefit us all. Our efforts to participate in and support the College locally and nationally will be rewarded by an even greater personal and professional growth. We owe it to ourselves. We owe it to medicine. As stated in the modern Hippocratic Oath, "I do solemnly swear by whatever I hold most sacred that I will be loyal to the profession of medicine and just and generous to its members." It is all of the above, from the professional to the per-

sonal, that is the real value of meetings and belonging to the American College of Surgeons. 

References

1. Rubin C: Why young surgeons must get involved. *Bull Am Coll Surg*, 85(12):25-27, 2000.
2. Laney W: What's in it for me? *Intl J Oral & Maxil Imp*, 15:777, 2000.
3. McCormack WO: Trivial pursuit at major medical conferences? *Can Med Assoc J*, 139: 479-80, 1989.
4. Wheeler G: The Army American College of Physicians annual scientific meeting: Attendee motivation and educational value. *Military Med*, 165:211-13, 2000.
5. Sternbergh C, Sterberg WC, Money SR, et al: Hospital cost of endovascular versus open repair of abdominal aortic aneurysms: A multicenter study. *J Vasc Surg*, Feb. 2000; 237-244.
6. Leighton K: Of meetings. *Can Med Assoc J*, 111:304, 1974.
7. Stiles Q: Scientific surgical meetings: Why do we need them? *J Thorac and Cardiovasc Surg*, 9(4):577-580, 1990.
8. Baker WH, String ST, Hayes AC, Turner, D: Diagnosis of peripheral occlusive disease, comparison of clinical evaluation and noninvasive laboratory. *Arch Surg*, 113:1308-1310, 1978.
9. MacDowell M, in Baker WE (ed): *Networking Smart: How to Build Relationships for Personal and Organizational Success*. New York, NY: McGraw Hill Publishing, 1994, chapter 13.
10. Beleckis M, in Baker WE (ed): *Networking Smart: How to Build Relationships for Personal and Organizational Success*. New York, NY: McGraw Hill Publishing, 1994, chapter 13.
11. Baber A, Waymon L: Use your networking skills to connect at conferences. *Biomed Inst and Technol*, May/June:227-228, 2000.
12. Hass H, Tamarkin B: *The Leader Within*. New York, NY: Harper Business, 1992, p. 91.

Dr. Baker is professor of surgery and head, division of vascular surgery, Loyola University Medical Center, Maywood, IL.





State legislatures 2001: *The year in review*

—

The famous bank robber, Willie Sutton, when asked why he robbed banks, replied, “I rob banks because that’s where the money is.” The not-so-famous author of this article (absolutely no relation to Willie!), when asked why it is so important to focus on activity in the state legislatures, replied, “Because that’s where all the action is.”

Indeed, the majority of legislation affecting the daily practice of surgeons is passed in the state legislatures because states regulate health and professional liability insurers, license physicians and other health care practitioners, protect the health and welfare of the general citizenry, and administer the Medicaid program. As such, it is important to not only be involved in grassroots advocacy at the state level, but to be knowledgeable about what has been passed and signed into law.

State activity in 2001

Every state legislature met in 2001, most adjourning for the year by the end of May. With each legislature considering anywhere from 2,000 to 5,000 pieces of legislation covering a broad range of issues, legislators and their staffs were very busy.

Of course, not all of these bills related to health care, but, thanks to the wonders of information technology, the College was able to cull those bills that may be of most interest to surgeons.

External review

By the end of 2000, 40 states already had passed external review laws.¹ Generally speaking, if a health maintenance organization (HMO) or other managed care plan denies a claim based on medical necessity or other benefit coverage reason, these laws require that the insured be permitted to request a review of the denial by an external panel of physicians. In many cases, the decision of the external review panel is binding.

At the beginning of 2001, the 10 states without an external review statute included **Arkansas, Idaho, Mississippi, Nebraska, Nevada, North Dakota, Oregon, South Dakota, West Virginia, and Wyoming**. During 2001, two of these states—**Oregon and West Virginia**—passed external review laws, and **South Dakota** passed a law requiring development of internal grievance procedures with the option of impartial mediation.

by Jon Sutton,
State Affairs Associate, Division of Advocacy and Health Policy

Health plan liability

The issue of holding health plans, HMOs, and other managed care plans liable for damages for failing to exercise ordinary care when making a health care treatment decision was a major issue in the state legislatures this year. This interest was heightened due to congressional debate on the health plan liability provisions included in federal patient protection bills. At least 18 state legislatures considered health plan liability bills in 2001. Of these, **New Jersey, Oregon, and West Virginia** saw bills signed into law, thereby joining **Arizona, California, Georgia, Maine, Oklahoma, Texas, and Washington** in allowing patients to sue their health plans.

The **New Jersey** law gives patients the right to sue their HMO or health plan for denial or delay in providing medically necessary, covered services and, as a result, causing serious or significant harm, including death, loss or serious impairment of a bodily part or function, and exacerbation of a serious health condition. Patients with the most serious conditions may bypass the state's appeals program and go directly to court. Those patients with a less serious problem must go through the appeals process before filing a lawsuit.

Part of a more comprehensive patient protection law, the new **Oregon** statute provides an enrollee who is the subject of a decision by an independent review organization with a private right of action against the insurer for damages arising from an adverse decision by the insurer that is subject to external review. This applies if: (1) the insurer states in the health benefit plan in which the patient is enrolled that it is not bound by the decisions of an independent review organization; and (2) the insurer fails to comply with the decision.

The **West Virginia** law was also included as part of a comprehensive patient protection bill. Under provisions of this law, managed care plans must comply with the decision of the external review board, or be held civilly liable for all damages proximately caused to the patient.

Mandated benefits

State legislatures traditionally deal with large numbers of bills relating to mandated insurance benefits. These mandates cover all types of benefits, including mental health parity, screening for

cancer, payment for clinical trials, optometry services, surgical procedures, and so on. The 2001 legislative session was no different, and a couple of states passed legislation of particular interest.

- *Clinical trials.* **California, Connecticut, Delaware, New Mexico, and Vermont** joined nine other states in requiring reimbursement for clinical trials. Most of these bills mandate insurance coverage for routine costs associated with clinical trials, and are usually limited to cancer clinical trial phases II-IV for treatment of cancer, although sometimes all phases are covered.²

- *Colorectal cancer screening.* **Maryland and Texas** passed laws requiring coverage for colorectal cancer screening based on American Cancer Society guidelines. They join **Delaware, Illinois, Indiana, Missouri, New Jersey, Rhode Island, Virginia, and West Virginia** in mandating such coverage.¹

- *Morbid obesity.* Three states—**Louisiana, Maryland, and Virginia**—considered legislation requiring insurance coverage for the surgical treatment of morbid obesity, with **Maryland and Virginia** passing legislation. Both statutes indicate that coverage for the treatment of morbid obesity will be for gastric bypass surgery or other methods recognized by the National Institutes of Health.

- *Reconstructive surgery.* HMOs and other health insurers in **Illinois** are now required to provide coverage for reconstructive procedures following a mastectomy. In addition to including reconstruction of the breast on which the mastectomy was performed, coverage must include surgery performed on the other breast to produce a symmetrical appearance. Protheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas, must be covered.

Office surgery

Based on legislative activity in 2000 and general concern about patient safety issues, many surgical specialty societies predicted that state legislatures would actively address the issue of regulating office-based surgery. However, 2001 was a relatively quiet year, and only two states actually implemented regulations in this regard.

The **Illinois** Department of Professional Regulation adopted rules to implement the

Nursing and Advanced Practice Nursing Act. Part of these rules dealt with the delivery of anesthesia services by a certified registered nurse anesthetist (CRNA) and supervision requirements. Under the rules, a CRNA may only provide anesthesia services in a physician's office if the physician has training and experience in the delivery of anesthesia services. This may include the physician maintaining clinical privileges to administer anesthesia services in a hospital or completing continuing medical education courses for conscious sedation, deep sedation, regional anesthesia and/or general anesthesia. In addition, the physician and CRNA must be certified in advanced cardiac life support.

Under legislation signed by the governor, **Connecticut** is implementing standards for patient safety through accreditation of physician offices or other unlicensed health care facilities where certain levels of anesthesia are administered. As defined, these levels include moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia. To comply with the accreditation requirements, physician offices may obtain accreditation through the Medicare program, the American Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., or the Joint Commission on Accreditation of Healthcare Organizations, as appropriate.³

Prompt payment

Requiring managed care and other insurers to pay claims in a timely manner has become an annual issue in the state legislatures. In 2001, more than 15 states dealt with the issue of prompt payment with many of them focusing on improving their existing statutes. In fact, according to the American Medical Association's Advocacy Resource Center, 47 states now require prompt payment for health insurance claims, 44 of them through legislation, and three through insurance regulation.⁴ Only three states (**Idaho, Nebraska, and South Carolina**) have no rules pertaining to prompt payment of claims.

New laws were enacted in **Iowa, Oregon, Rhode Island, and West Virginia**. Those states improving their statutes with tougher enforcement provisions and shorter time frames for pay-

ment of clean claims included **Alabama, Alaska, Arkansas, Indiana, Missouri, Ohio, and Oklahoma**. Bills to tighten prompt payment statutes in **Michigan** and **Texas** were vetoed by their respective governors, much to the dismay of physicians in those states.

Under **Iowa's** new law, insurers and managed care organizations are required to pay clean claims promptly, and failure to do so will result in an interest payment of 10 percent per year and the assessment of a civil monetary penalty. Specific time frames for payment are not yet available, as the insurance commissioner has been charged with developing rules to implement the statute, hopefully by the end of the year.

The **Oregon** prompt payment legislation was signed into law on July 5. The new statute, which went into effect immediately, requires insurers to pay clean claims within 30 days of receipt. If denied, the provider must be notified no later than 30 days after receipt of the claim and must be given an explanation of the additional information required to complete the transaction. Simple interest of 12 percent per year must be paid by insurers who fail to pay claims within the required time frame, and is applied only to the unpaid portion of the claim.

In **Rhode Island**, HMOs, health insurers, and other entities that operate health plans are required to pay complete claims within 40 calendar days of receipt. If filed electronically, complete claims must be paid within 30 calendar days. In those cases where further information is required or the claim is denied, the health care entity must notify the health care provider within 30 calendar days. Any health care entity that fails to pay a complete claim within the required time frame is required to not only reimburse for the amount of the claim but also pay interest at a rate of 12 percent per year.

Effective August 1, 2001, provider contracts in **West Virginia** must contain specific provisions requiring insurers to promptly pay clean claims within 30 days for electronic claims and 40 days for paper claims. If a claim is denied, the insurer must notify the provider within 30 days with its request for further information. Failure to pay a claim within the required time frame will result in interest payments of 10 percent per year on the unpaid portion of the claim.

What the future holds

Making predictions about future activity in state legislatures can be very dicey. Quite often, a local tragedy will spur a legislator to introduce legislation to deal with what may have caused the tragedy, and if there is nationwide reporting of the incident, legislators in other states may decide to do the same. In other cases, release of a government report on an issue, such as the federal report on medical errors, can result in an immediate response by numerous legislators in various states. However, a few potential trends are apparent for 2002.

Many states will be forced to address the problem of prescription benefit plans, especially for senior citizens, if Congress does not develop a plan of its own for Medicare. Currently, all state Medicaid programs provide prescription drug benefits for senior citizens and others who qualify for Medicaid. In many cases, this will involve the state's Medicaid program, and may result in the reallocation of Medicaid funds from one area to pay for expanded prescription benefits to low-income seniors who would not normally qualify for Medicaid (that is, reimbursement for other services could conceivably be cut to pay for the increase in prescription benefits). Those states with additional types of plans in place (**California, Delaware, Florida, Indiana, Maine, Maryland, Massachusetts, Nevada, New Jersey, Virginia, and West Virginia**)⁵ will likely end up needing to dramatically increase funding for these programs to keep up with the escalating cost of prescription drugs and ever-increasing use by an aging population.

Because very few states currently regulate office surgery, it is anticipated this issue also will become more prominent. In fact, other medical organizations, such as the American Society of Anesthesiologists, are working with their state societies to become active in this issue and to encourage them to advocate with state legislators to implement appropriate regulation. Some of this advocacy may also take the form of guideline development (often coordinated by the state medical society at the request of the state) that does not carry the weight of law, but can be used by state regulators to encourage voluntary compliance. **South Carolina** and **New York** already have guidelines, and the **North Carolina** legislature is working with the

2002 legislative sessions

State	Begins	Ends
Alabama	January 8	April 22
Alaska	January 14	May 14
Arizona	January 14	Late April
California	January 7	August 31
Colorado	January 9	May 8
Connecticut	February 6	May 8
Delaware	January 8	June 30
Florida	January 22	March 22
Georgia	January 14	Mid March
Hawaii	January 16	Early May
Idaho	January 7	Late March
Illinois	January 9	Late May
Indiana	January 14	March 14
Iowa	January 14	Late April
Kansas	January 14	Early May
Kentucky	January 8	April 15
Louisiana	April 29	June 12
Maine	January 2	April 17
Maryland	January 9	April 8
Massachusetts	January 2	July 31
Michigan	January 9	Meets throughout year
Minnesota	January 29	May 20
Mississippi	January 8	April 7
Missouri	January 9	May 30
Nebraska	January 9	Mid April
New Hampshire	January 2	July 1
New Jersey	January 8	Meets throughout year
New Mexico	January 15	February 13
New York	January 9	Meets throughout year
North Carolina	May	July
Ohio	January 2	Meets throughout year
Oklahoma	February 4	May 31
Pennsylvania	January 1	Late November
Rhode Island	January 1	Late June
South Carolina	January 8	June 6
South Dakota	January 8	Mid March
Tennessee	January 8	Late April
Utah	January 21	March 6
Vermont	January 8	Early May
Virginia	January 9	March 9
Washington	January 14	March 14
West Virginia	January 9	March 9
Wisconsin	January 7	March 14, with veto session May 14
Wyoming	February 11	March 8

Source: National Conference of State Legislatures

North Carolina Medical Society to develop appropriate guidelines. In addition, the **Ohio** Medical Board is reviewing potential regulatory changes that would impact office surgery facilities similar to the Illinois anesthesia rules noted earlier. Chapters should pay close attention to see if their states are working on guidelines or planning to do so, as surgeons should be well-represented at the table.


Most states provide physician data (name, license information, disciplinary actions, and so on) to those who request it, and more than 18 of them have access to this information through Web sites. However, only two states (**Alabama** and **Massachusetts**) include malpractice information (number of lawsuits within a defined time frame, settled lawsuits, and so on). As such, attempts will be made in other states to include malpractice information.

Scope of practice for single-degree oral surgeons will likely be more prominent, after the success these professionals had this year in **Virginia** and **West Virginia** in expanding their scope of practice by redefining the practice of dentistry. This was done through a revision in the dental practice act, and was not discovered by the physician community until after passage had been assured thanks to a well-run grassroots advocacy effort. The new definition of the practice of dentistry in **Virginia** is the "evaluation, diagnosis, prevention, and treatment through surgical, nonsurgical or related procedures, of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent and associated structures and their impact on the human body." As such, single-degree oral surgeons will be able to perform cosmetic surgery of the head and neck without the benefit of a medical degree or completion of a surgical residency program. It is important that chapters be aware of legislative or regulatory revisions proposed by their respective dental licensing boards and respond appropriately.

Time for advocacy

Regardless of which issues come to the fore, now is the time for chapters to start preparing for the 2002 legislative session in their states. Is a system in place to immediately respond to legislation, such as a key contact network or an e-mail "listserv" to Fellows for distributing legislative alerts and calls to action? Has the state medical society been contacted to see if it has determined its legislative

agenda for 2002, and has the chapter been participating in a state specialty council or other venue where its voice can be heard relating to legislative and regulatory issues? What are some of the "hot" legislative issues brewing for 2002, and has the chapter's legislative committee met to discuss them? If these questions are addressed, a chapter will be well on its way to being prepared for the 2002 legislative session.

The chart on page 22 indicates when state legislatures will begin their sessions. It omits the few state legislatures not meeting at all (**Arkansas, Montana, Nevada, North Dakota, Oregon, and Texas**). Chapters seeking advice and assistance in their state legislative advocacy efforts should contact Jon Sutton, State Affairs Associate, by e-mail at jsutton@facs.org, or by phone at 312/202-5358. 

Author's note: The College uses an Internet search service called [nexis.com](http://www.nexis.com)sm. Through this service, the Division of Advocacy and Health Policy tracks the status of pertinent legislation throughout the U.S., notifying its chapters of pending legislation that may need a response at the local level. Searches cover such topics as prompt payment, medical malpractice, managed care reform, scope of practice, physician data profiling, office surgery regulation, and so on.

References

1. The Kaiser Family Foundation: State Health Facts Online, 2001. Web site: <http://www.statehealthfacts.kff.org>.
2. Health Policy Tracking Service, National Conference of State Legislatures: *Fact Sheet: Clinical Trials*, July 23, 2001. Web site: <http://www.hpts.org>.
3. American College of Surgeons: *Currents*, May 2001 and July 2001. Web site: <http://www.facs.org/hpa/pubs/pubs.html>.
4. American Medical Association Advocacy Resource Center, July 2001. Web site: <http://www.ama-assn.org>.
5. American Medical Association Advocacy Resource Center: *Access to Affordable Pharmaceuticals—State Summary*, July 2001. Web site: <http://www.ama-assn.org>.



**Surgeons offer
survival strategy *for the
new millennium***

**by Robert L. Howisey, MD, FACS,
Seattle, WA**

**and Martin B. Durtsehl, MD, FACS,
Ketchum, ID**

The survival of medical practices and access to care for patients literally depends on developing new ways of interacting with the increasingly monopolistic U.S. health insurance industry. Thomas R. Russell, MD, FACS, Executive Director of the College, accurately detailed in one of his recent columns (From my perspective, *Bulletin*, May 2001) the pressures that have led to the current situation in which medical practices are exsanguinating due to reduced reimbursement rates. The “hassle factor” involved in dealing with many health insurers contributes to early physician retirement and discourages new physicians from choosing careers in general surgery. These unusual circumstances have forced physicians to consider new strategies for survival. Dr. Russell has requested that we share the experiences of our 40-person general surgeon group in western Washington, which has successfully created an entity that helped to turn the tide with respect to improving contract reimbursement rates and contract terms for physicians in the state of Washington.

Operation “stop the bleeding”

Collective bargaining between individual competing surgical practices is not currently legal in the United States. Prospects of changing current laws in this realm remain dismal. The only safe way to bargain collectively is to create a legal entity, a professional service corporation, which can legally negotiate as a single entity with health insurers.

Our group began meeting in 1995 to evaluate the possibility of creating such an entity. By January of 1998 we had successfully created a single corporation, merging eight separate surgical practices at nine area hospitals. Since then, we have grown to 40 physicians at eleven hospitals, covering much of the population center in western Washington. Several critical success factors were important in bringing together such a large group of traditionally independent surgeons. They are outlined as follows.

Broad geographic footprint

A single surgical group practicing at a single hospital in a population center with multiple hospitals has no ability to negotiate with third-party payors. Bringing together multiple practices or care centers over a broad geographic area creates

a defined market share that becomes critical to any third-party payor network. By including less than one-third of the region’s available general surgeons we avoided antitrust prohibitions. We defined our core physician group by carefully selecting potential members based on their quality as surgeons and by requiring that they be Fellows of the College. These surgeons tended to be among the busiest in the region.

Single specialty

We chose to incorporate as a single specialty group with a single tax ID number and a single fee schedule. This action eliminates the divergent goals that multispecialty groups necessarily have and that insurers exploit. General surgeons, by virtue of their training and experience, tend to think alike when faced with decision making, whether in the operating room or at a board meeting. We found most critical decisions in forming our organization were made by unanimous consensus.

Preserve each practice

Each practice in our organization remains virtually independent in day-to-day operations, including their policies related to revenue sharing, salaries, staffing, and new partner hiring. These issues are subject to only broad quality guidelines developed by the corporation. Governance of the corporation is made up of a board of directors consisting of one representative from each care center. Decisions made at the corporate level include human resource issues, pension plan management, benefits packages, payroll and tax payments, mal-

Dr. Howisey is a surgeon in private practice for 21 years, specializing in general, vascular, and laparoscopic surgery. He is past-president of Surgical Associates of Washington and Council Member for the ACS Washington State Chapter.



practice coverage, quality improvement, and contract negotiation. Very substantial savings were achieved by negotiating group rates for health care benefits and malpractice coverage.

Sharing individual expertise and experience between care centers has been invaluable. By focusing our time and resources on contract negotiation we have been able to approach these talks from a position of strength, with accurate information developed through our own analysis. We provide an essential service in such volume and of such quality that our failure to participate within a network severely limits the viability of any insurance product offered to the public.

Quality improvement program

A medical director was chosen from the membership to spearhead quality assurance projects. So far we have evaluated colon resection and were able to implement recommendations that made significant improvement in outcomes. Future projects will assess hernia repair and breast surgery.

Commit to each other's success

Surgeons have traditionally viewed other surgeons, rather than insurers and regulators, as their primary opposition. This adversarial relationship frequently has worked to the advantage of insurance plans that exclude some practitioners and give participating physicians greater market share but, of course, at a lower rate of reimbursement.

Our commitment to mutual success as partners rather than competitors eliminates professional jealousy and creates a powerful team. When a local insurance company presented a new contract in 1999, which would result in another 6 percent reduction in payments to surgeons, our group voted unanimously to drop the contract after all efforts at negotiation failed.

Partner with patients

It is a mistake to think that patients do not support their surgeons. They do understand the important role we play in their lives and are much more likely to support us than the insurance industry. We hired a public relations firm and spent considerable time educating our community and patients about our goals and why we were unable to accept the continual deterioration of contract

terms. We did call attention to the ongoing devaluation of physicians in general and reaffirmed the fact that we treat patients regardless of ability to pay and that we must remain profitable in order to provide this service.

The outcome

After six months out of network with the state's largest insurer, a new contract offer resulted in a substantial reimbursement improvement for all physicians in our state. The financial impact of dropping the contract was less than expected, as many patients switched to different insurance companies in order to continue their care with us. By state law, all emergency services provided while we were out of network were paid at full fee. Contract negotiations with other insurers suddenly became much easier once they recognized our importance to their network. Overall, we realized a 10 percent improvement in reimbursement for the first time in 20 years.

All of this important work is impossible to do without a critical mass of surgeons with common goals, and an administrative structure directed toward those goals. Virtually no independence was sacrificed by any surgeon. The expenses of running the corporation were offset by the savings produced by operational efficiencies. The significant time requirement by board members was simply an investment in the health of our practices. Most importantly, we have taken very large steps in what will be a continuing journey to regain control over the remarkable relationship that exists between physician and patient. □

Dr. Durtschi is a general surgeon in private practice and clinical assistant professor, department of surgery, University of Washington in Seattle. He can be reached via e-mail at mdsea2sv@cox-internet.com.



Keeping current

On the fast track

by Adrienne M. Stoller, New York, NY

Fast-track surgery is a novel concept in perioperative care that combines recent advances in anesthesia and postoperative pain control, techniques to reduce postoperative stress and organ dysfunction, and the use of minimally invasive techniques to facilitate early recovery and minimize complications. Through the fast-track approach, a broad range of surgical patients are enjoying markedly shorter recovery times and a heightened sense of wellness while experiencing fewer complications.

Defining fast-track surgery

Fast-track surgery has evolved from minimally invasive techniques and better understanding of perioperative pathophysiology, including pain control and stress reduction. The approach involves several elements, including the maintenance of normal body temperature during operation, the use of regional anesthesia, and early nutrition and mobilization. "The primary aim of fast-track surgery is to reduce the stress of the operation and enhance recovery, thereby reducing complications and the need for hospital stay; by reducing the stress response to surgery, we can quickly facilitate recovery for our patients and send them home faster," explains Douglas W. Wilmore, MD, FACS, Frank Sawyer Professor of Surgery, Harvard Medical School, Boston, MA, and founding editor of *ACS Surgery: Principles and Practice*. Dr. Wilmore is coauthor with Prof. Henrik Kehlet, MD, PhD, of an upcoming chapter in *ACS Surgery on fast-track surgery*¹ as well as of a recent clinical review in the *British Medical Journal* on fast-track procedures.²

Once, the concept of fast tracking was relevant primarily to cardiac patients who underwent early extubation and were moved more quickly through recovery. In recent years, however, accelerated procedures and clinical pathways have been developed within most areas of surgery. In fact, many surgeons worldwide have introduced fast-track surgical principles with great success in gastrointestinal, gynecologic, and orthopaedic proce-

dures. "Fast track has been well established for most minor procedures, including inguinal hernia repair, arthroscopic procedures, and laparoscopic cholecystectomy, which can be managed in a day-case fast-track setting," explains Prof. Kehlet, who is chief surgeon, department of surgical gastroenterology, and professor of surgical gastroenterology at the Hvidovre University Hospital in Denmark. "However, more recent advances have shown the same approach to be successful in ambulatory mastectomy, laparoscopic adrenalectomy, laparoscopic fundoplication, short-stay (one to two days) radical prostatectomy and lung resection, and short-stay (two to four days) colonic resection."

According to Prof. Kehlet, studies have shown that procedures such as outpatient laparoscopic cholecystectomy yield positive results in terms of safety and economic benefit. In addition, several studies have documented similar benefits from the application of fast-track principles to colonic resection, radical prostatectomy, lung resection, mastectomy, fundoplication, adrenalectomy, rectal procedures, major joint replacement, coronary bypass, and other vascular procedures. Even so, more investigation remains to be done. "There is a great need for further large-scale studies. To establish safety in certain major operations and to define optimal care protocols, fast-track principles require the support of the scientific data that can only be obtained through proper randomized clinical trials," Prof. Kehlet said.

Fast track at work

Although the scientific underpinning of fast-track surgery may not be fully in place yet, the current literature contains a number of published reports that tend to support this approach. One such report comes from the Duke University Medical Center.³ The authors performed a retrospective analysis comparing 145 consecutive patients who underwent 156 breast cancer operations under paravertebral block with 100 patients who underwent comparable breast procedures under gen-

eral anesthesia. Anesthetic effectiveness and complications, inpatient experience with postoperative pain, nausea, vomiting, and length of stay were measured. In 85 percent of the cases attempted with paravertebral block alone, the operation was completed successfully without further anesthesia, and in 91 percent of the cases, the operation was completed with paravertebral block supplemented with local anesthesia. Some 20 percent of patients in the paravertebral block group required medication for nausea and vomiting, compared with 39 percent in the general anesthesia group. Narcotic analgesia was required in 98 percent of general anesthesia patients, compared with only 25 percent of paravertebral block patients. Finally, 96 percent of patients in the paravertebral block group were discharged the day of surgery, compared with 76 percent of patients in the general anesthesia group.

Another intriguing report appeared in the *European Journal of Cardiothoracic Surgery* in September 2001 under the authorship of Eduardo A. Tovar, MD, FACS, associate clinical professor, department of surgery, University of California at Irvine (Irvine Medical Center).⁴ In this study, Dr. Tovar performed major lung resections on 65 patients using a video-assisted muscle-sparing minithoracotomy. Thirty patients were 70 years of age or older, and five were octogenarians. Patient and family education, multimodal analgesia, and accelerated recovery were implemented for all patients. Discharge criteria included pain control with oral analgesics, clear lungs, independent ambulation, adequate oxygenation, and patient acceptance with home support. Once all criteria were met, patients were released from the hospital. The results were as follows: the average stay for the whole group was 1.2 days, no deaths were reported, and there were few complications. "This study and other operations I have performed using accelerated pathways demonstrate that it is absolutely feasible to create strategies to prevent or attenuate stress responses during surgery," explains Dr. Tovar. "It is critical to establish nonphysiologic factors such as determination, perseverance, and willingness to participate, which, regardless of age, have been found in my experience to promote early recovery with fewer complications.... [T]here is no doubt in my mind that quality-based fast-track surgery will have a profound effect on patient out-

comes and significant economic implications for the [health care] industry."

Fast track into the future

Planned and executed correctly, fast-track surgery offers many clinical advantages. With continued improvement in our understanding of perioperative care and postoperative rehabilitation, the trend for the future may include a modified system of traditional surgical care that will emphasize shorter recovery periods after major operations, shorter hospital stays, and less postoperative impairment and morbidity.² "The key to successful implementation of a fast-track program is revision of the entire perioperative care program on the basis of a collaboration among all levels of surgical and patient care," explains Prof. Kehlet. "All caretakers—including anesthesiologists, surgeons, nurses, and rehabilitation therapists—must agree to the principles that are established, thereby providing a rational basis for optimizing results of care," he said. This collaboration includes multidisciplinary discussions for developing a clinical pathway to guide perioperative care as well as for making subsequent necessary adjustments to the pathway as additional scientific data become available.

Advocates of fast-track surgery agree that in addition to comprehensive studies, surgical training will have to emphasize education in the principles of surgical care and pathophysiology. "Fast-track success requires organization, operative skill, and the participation of a multidisciplinary team whose members have very focused objectives on how to care for a patient," says Dr. Wilmore. "I believe that this process will lead to further substantial improvements in surgical care." □

References

1. Kehlet H, Wilmore DW: Fast-track surgery. In: Wilmore DW, Cheung LY, Harken AH, et al (eds): *ACS Surgery: Principles and Practice*. New York, NY: WebMD Corp. (in press). Web site: www.webmd.com.
2. Wilmore DW, Kehlet H: Management of patients in fast track surgery. *BMJ*, 322:473, 2001.

continued on page 38

Ms. Stoller is editor/writer, division of physician communications, WebMD, New York, NY.

Socioeconomic tips of the month

Frequently asked coding questions

Q. I am having problems coding and obtaining reimbursement for the creation and repairs of fistulas and grafts for dialysis access. According to the guidelines for vascular access, established by the Dialysis Outcomes Quality Initiative (DOQI), native fistulas (code 36821) should be attempted in most cases. If native fistulas are not possible or fail, prosthetic grafts (code 35830) or an open revision of an arteriovenous fistula, with or without thrombectomy (codes 63831-33), should be considered. In some instances, this becomes a very complex procedure. I would like guidance about how to code for such repairs.

A. We assume that Medicare is the payor for these procedures. If the first fistula fails and you must perform a second procedure, report the procedure actually performed in both instances with a modifier appended to the second code to indicate that the return to the operating room was for a related procedure (modifier -78). The modifier should generate payment for the intraoperative portion of the second procedure and start a new 90-day global period.

When the second procedure is the same as the first, but done at a different location (for example, a wrist fistula fails and a new wrist fistula is performed on the opposite side), modifier -59 (distinct procedural service) should be used to indicate that services are not normally reported together but are appropriate under the circumstances. Among other information modifier -59 gives the payor is that the same procedure was performed during different sessions or patient encounters. It is generally used when the two procedures are performed on the same day, but it is possible that a few carriers may want it used even when the same procedure is done on different days within a global period.

There is no doubt that some procedures can be very intense and time-consuming. Medicare pay-

All specific reference to CPT terminology and phraseology are CPT only © 2000 American Medical Association. All rights reserved.

Around the corner

November

- The implementation period, during which Medicare will allow claims to be submitted with the 2001 and the 2002 versions of ICD-9-CM diagnosis codes, continues.
- 2002 Medicare fee schedule scheduled for release. Medicare carriers distribute fee schedules to providers.
- CPT 2002 available.

December

- Postgraduate course on coding, compliance, and reimbursement presented by the ACS during the Society of Laparoendoscopic Surgeons' 10th International Congress and ENDO EXPO on December 5, 2001, in New York, NY. Contact Flor Tilden at 305/665-9959 for registration form.

ment policy assumes that a given case was "typical." However, Medicare will reimburse at a higher rate for services that are "significantly greater than usually required" (*Medicare Carriers Manual*, §4822). These services should be reported with modifier -22 (Unusual procedural services). Documentation, which consists of a concise statement of how the service differs from the usual and a copy of the operative report, should accompany the claim. Medicare requires that all documentation be reviewed and a manual decision made about whether to make payment beyond the usual.

Q. A carotid endarterectomy (code 35301) was performed on the patient. The procedure was successful, but two days later the patient experienced a postoperative myocardial infarction and needed central venous access (code 36489). Since the central venous line was placed well within Medicare's 90-day global period for code 35301, should I report code 36489 with modifier -79 (unrelated procedure or service by the same physician during the postoperative period)?

A. Technically, you only need to report modifier -79 when the second operation has a 10- or 90-day global period. Modifier -79 does two things: it tells the carrier to only pay for the intraoperative services of the second procedure, and it resets the global period. When the second procedure is a zero-day global, all the services are intraoperative and the length of the global period is not affected.

Q. What code should I use to report a lumpectomy?

A. Since *CPT* does not use the word “lumpectomy,” the physician who performed the procedure will need to decide which code best describes the situation. Some codes you could consider are code 19160 (Mastectomy, partial; with axillary lymphadenectomy) and code 19120 (Excision of cyst, fibroadenoma, or other benign or malignant tumor).

Q. How do I code for the removal of infected mesh from the abdominal wall? I was looking at code 49085.

A. Code 49085 (Removal of peritoneal foreign body from peritoneal cavity) is for the peritoneum and not appropriate. You have two options; you could use code 20680 (Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate) or code 49999 (Unlisted procedure, abdomen, peritoneum and omentum). If you use code 49999, you should attach the operative note.

Q. There is some confusion about how to report a stereotatic breast procedure (ABBI or mammotome). Should code 19103 be used when placing a clip, and can you report code 19125 as well? There are some private carriers that will pay for this procedure, but Medicare will not. What can I do?

A. The American Medical Association has stated that code 19103 (Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance) should be reported with the add-on code 19125

(Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion). This revision should appear in *CPT 2002*.

Q. How do we code for debridement of Fournier’s gangrene of the scrotum and perineum up to the inguinal canal?

A. For this situation we would suggest the following: use code 55150 (Resection of scrotum) and one of the following for the perineum and inguinal area: codes 11040-44 (Debridement; skin,...), depending on the depth, with modifier -22; code 11000-01 (Debridement of extensive eczematous or infected skin...), based on percentage; or code 22999 (Unlisted procedure, abdomen, musculoskeletal system). If using the unlisted code, you should send your operative note.

Q. How do I code for an EGD with dilation of the pylorus?

A. You should use code 43245 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction, any method) when the code refers to gastric outlet that would be the pylorus. Q

R. Scott Jones installed as 82nd ACS President

R. Scott Jones, MD, FACS, a general surgeon from Charlottesville, VA, was installed as the 82nd President of the American College of Surgeons (ACS) during Convocation ceremonies that concluded the College's 2001 Clinical Congress in New Orleans, LA. Dr. Jones is currently the S. Hurt Watts Professor and chairman of surgery at the University of Virginia Health System, Charlottesville.

A native of Tyler, TX, Dr. Jones attended the University of Texas, and received his medical degree in 1961 from the University of Texas Medical Branch. Dr. Jones completed an internship in surgery at the University of Texas Medical Branch (1961-1962), was an assistant resident in surgery at the Hospital of the University of Pennsylvania (1962-1967), an assistant instructor in surgery at the University of Pennsylvania School of Medicine (1962-1966), and a fellow in the Harrison Department of Surgical Research at the University of Pennsylvania (1962-1967). After serving as a basic science trainee in the Department of Physiology in the School of Medicine at the University of Pennsylvania (1964-1965), Dr. Jones served as chief resident in surgery, instructor in surgery, and as an American Cancer Society Clinical Fellow at the University of Pennsylvania (1966-1967).

Dr. Jones subsequently headed west to complete a fellowship in gastroenterology in the departments of medicine and physiology at the University of California, Los Angeles, in 1967. He then served as a research associate (1967-1968), a clinical investigator (1968-1971), and a medical investigator (1971) at the Veterans Administration Hospital in San Francisco. In addition, Dr. Jones served as an assistant professor of surgery at the University of California, San Francisco, from 1968 to 1971.

Dr. Jones continued his surgical career at Duke University Medical Center, Durham, NC, where he served as associate professor of surgery (1971-1977) and professor of surgery (1977-1981). He also served as assistant chief of surgery at the Veterans Administration Hospital in Durham from 1971 to 1981. He has held his current position as the S. Hurt Watts Professor and chairman of surgery in the department of surgery at the University of Virginia Health System since 1982.

Dr. Jones became a Fellow of the American College of Surgeons in 1975. Since then, he has been an active participant and leader in numerous College activities. He was a member of the College's Committee for the Forum on Fundamental Surgical Problems from 1979 to 1984 and served as



Dr. Jones

Chair of that committee from 1983 to 1984. Dr. Jones also served as Chair of the Medical Motion Pictures Committee (1986-1987) and Vice-Chair of the College's Program Committee (1989-1991). He served a two-term membership on the College's Board of Governors (1991-1997), and as a member (1991), Vice-Chair (1992-1994), and Chair (1994-1997) of the College's Advisory Council for General Surgery. Dr. Jones also served as Chair of the College's Nominating Committee of the Fellows in 1998. Since 1991, he has been an active member of the Committee on Applicants and the Virginia Chapter's Membership Committee.

Dr. Jones has been awarded memberships and has held leadership positions in numerous surgical organizations. He was president (1984) and chairman of the board of trustees (1985-1986) of the Society

for Surgery of the Alimentary Tract; was treasurer and a member of the board of trustees of the American Surgical Association (1995-2000); was president of the Southern Surgical Association (1992); and president of the Halsted Society (1996). He has also served as director of the American Board of Surgery (1984-1990) and a director of the American Board of Emergency Medicine (1988-1990), served on the National Institutes of Health Study Section, and served as chair (1995-1997) and held membership on the Accreditation Council for Graduate Medical Education Residency Review Committee for Surgery (1990-1997).

Throughout his distinguished career, Dr. Jones has been awarded numerous honors, including membership in Alpha Omega Alpha and the scientific research society of Sigma Xi; and honorary membership in the Singleton Surgical Society, the Texas Surgical Association, and the Muller Surgical Society. He has received the Joseph B. Kass Award for Research, the Ashbel Smith Distinguished Alumnus Award at the University of Texas Medical Branch, and the Distinguished Alumnus Award from Duke University Medical Center.

Over the course of his career, Dr. Jones has demonstrated a strong commitment to disseminating surgical knowledge. He

has authored or coauthored more than 160 articles in a wide range of medical and surgical journals and has served on the editorial boards of the *Journal of the American College of Surgeons*, the *Journal of Surgical Research*, *Viewpoints on Digestive Diseases*, the *Journal of Digestive Diseases and Sciences*, *Annals of Surgery*, *Surgical Gastroenterology*, the *Journal of Gastrointestinal Surgery*, *American Surgeon*, and *Digestive Surgery*.

Dr. Jones currently resides in Charlottesville, VA, with his wife, Carol.

David L. Nahrwold receives top ACS honor

The Distinguished Service Award—the highest honor awarded by the American College of Surgeons (ACS)—was presented to David L. Nahrwold, MD, FACS, of Chicago, IL, during the Clinical Congress last month in New Orleans, LA. Dr. Nahrwold received the award in acknowledgment of his outstanding leadership in advancing surgical training and the practice of surgery; his dedicated service to the College, his distinctive contributions to surgical education, his leadership role in various surgical societies, and his research into biliary disease.

Dr. Nahrwold has served the College in numerous capacities

since becoming a Fellow in 1971. He is a former member of numerous committees, including the Committee for the Forum on Fundamental Surgical Problems, the Program and Development Committees, the Nominating Committee of the Fellows, and the special Task Force on Accreditation. He has represented the College on the Council of Medical Specialty Societies and the American Board of Surgery. He has been a member and Chair of the Board of Governors and a member of the Board of Regents. Most recently, he served as Interim Director of the College.



Dr. Nahrwold

Dr. Nahrwold received a medical degree from Indiana University School of Medicine, Indianapolis, in 1960. In 1960, he began an internship at Indiana University Medical Center, Indianapolis, where he also completed a residency in general and cardiothoracic surgery in 1965. After residency training, Dr. Nahrwold was a postdoctoral scholar in gastrointestinal physiology at the Veterans Administration Center of the University of California at Los Angeles from 1965 to 1966. Dr. Nahrwold served in the U.S. Army from 1966 to 1968, including as chief, general surgery, General Leonard Wood Army Hospital, Fort Leonard Wood, MO. Since 1999, Dr. Nahrwold has been emeritus professor of surgery at Northwestern University, where he has served as professor of surgery (1982-1999) and executive associate dean for clinical affairs (1997-1999) for Northwestern University Medical School, and president and

chief executive officer of Northwestern Memorial Faculty Foundation (1996-1999). He has also served Northwestern University Medical School as the Loyal and Edith Davis Professor and chairman, department of surgery (1982-1997), and Northwestern Memorial Hospital as surgeon-in-chief (1982-1997).

Throughout much of his distinguished career, Dr. Nahrwold has been a leader in organized surgery. He served as director and chairman of the American Board of Surgery (ABS) and as chairman of the certification and examination committee, plans committee, and executive examination committee of the ABS. He has been: a member of the Accreditation Council for Graduate Medical Education; a member and president-elect of the American Board of Medical Specialties; treasurer of the International Federation of Surgical Colleges; and president of the Chicago Surgical Society,

the Society for Surgery of the Alimentary Tract, and the Central Surgical Association.

Dr. Nahrwold has previously served on the editorial boards for *Surgery, Surgical Gastroenterology, Archives of Surgery, Journal of Lithotripsy and Stone Disease, Current Opinion in General Surgery*, and *Postgraduate General Surgery*, and is currently on the editorial boards for the *Journal of Gastrointestinal Surgery*, the *American Journal of Surgery*, and *Digestive Surgery*. He has been a book review editor for the *Journal of the American College of Surgeons*, and editor-in-chief (1993-1997) and editor emeritus (1997-present) of the *Journal of Laparoendoscopic Surgery*.

The College's Board of Regents is pleased to recognize Dr. Nahrwold's outstanding contributions by naming him the 2001 recipient of its highest honor, the Distinguished Service Award.

College names three Honorary Fellows

Honorary Fellowship in the American College of Surgeons was awarded to three prominent surgeons from Japan, Finland, and Germany during Convocation ceremonies at last month's Clinical Congress in New Orleans, LA. The awards presentation is one of the highlights of the Clinical Con-

gress—one of the largest international meetings of surgeons in the world. The recipients were:

• **Albrecht F.W. Encke, MD, FACS.** Professor Encke is a professor of surgery at the Johann Wolfgang Goethe University of Frankfurt am Main in Frankfurt, Germany.

• **Pekka Häyry, MD, PhD.** Professor Häyry is a professor of transplantation surgery and immunology at the Haartman Institute, at the University of Helsinki in Helsinki, Finland.

• **Minoru Hirano, MD, PhD.** Professor Hirano is the current president of Kurume University in Kurume, Japan.

Fellowship in the American College of Surgeons is awarded during the ceremonies to surgeons whose education and training, professional qualifications, surgical competence, and ethical conduct have passed a rigorous evaluation and have been found to be consistent with the high standards established and demanded by the College.

During the College's Convocation ceremonies this year, 1,786 surgeons from around the world were admitted into Fellowship. With a membership of more than 60,000, the College is the largest organization of surgeons in the world.

Sir Rickman Godlee, President of the Royal College of Surgeons (England), was

awarded the first Honorary Fellowship in the College during the College's first Convocation in 1913. Since then, 374 internationally prominent surgeons, including the three chosen this year, have been named Honorary Fellows of the American College of Surgeons.

Citation for Prof. Albrecht F. W. Encke, MD, FACS

by Margaret F. Longo, MD, FACS, Hot Springs, AR

Mr. President, it is an honor, a privilege, and a pleasure to present to you Prof. Albrecht F. W. Encke of Frankfurt, Germany, for Honorary Fellowship in the American College of Surgeons. Professor Encke is no stranger to our College. He has been a Fellow of this College since 1984 and currently serves as Governor-at-Large for the German Chapter of the American College of Surgeons.

Born in Remscheid, Germany, Professor Encke received his undergraduate medical education at the Universities of Freiburg, Tübingen, Vienna, and Cologne. His thesis for a doctoral degree in medicine was Cranial Sutures in Normal Children and Those with Intracranial Pressure. After completing a rotating internship at Muhlenberg Hospital in Plainfield, NJ, he spent six months on the medical/surgical staff at Greystone State Hospital in Morristown, NJ. Upon returning to Germany, he studied blood coagulation disorders in the department of internal

medicine at the University of Heidelberg before completing his postgraduate surgical training at the department of surgery, University of Heidelberg, under the tutelage of Prof. Fritz Linder. Qualification to teach at the Medical Faculty University of Heidelberg followed his thesis, Disseminated Intervascular Coagulation in Surgery. It was not long before Professor Encke became vice-chief to his mentor and tutor Professor Linder at the University of Heidelberg. In his spare time, Professor Encke obtained special boards in vascular surgery. In 1979, he became professor of surgery and chairman of the department of surgery at the Johann Wolfgang Goethe University of Frankfurt am Main and subsequently became chairman of the department and head of the division of general surgery. Later Professor Encke was recognized by election as professor and chairman of the department of surgery at the University of Dusseldorf, but he declined the honor and



Professor Encke

has retained his position at the Johann Wolfgang Goethe University of Frankfurt.

During this illustrious academic career, Professor Encke developed special scientific and clinical focuses. These areas include the pathophysiology of coagulation and thrombosis, shock, sepsis, intensive care

medicine, surgical gastroenterology and oncology, and hepatobiliary surgery. Notably, in the field of hepatobiliary surgery, he developed a liver transplant program and then performed the first liver transplant in Frankfurt am Main. His interests and expertise extend into primary and secondary hepatic tumors, regional and systemic chemotherapy clinical trials, and gastric and colorectal surgery. Clinically, he was instrumental in the introduction of low-dose heparin and low-molecular heparin in the perioperative period as prophylaxis and followed with the development of guidelines for general use.

Professor Encke has authored over 225 published articles. He

serves on several surgical journal editorial boards. His achievements have been recognized by various international societies, fellowships, and honorary degrees. Among these many achievements, one of the most notable is as president and chairman of the executive board of the German Surgical Society (Deutsche Gesellschaft für Chirurgie). In this capacity, he has melded surgical interests of all specialties into one parent organization.

All of Professor Encke's accomplishments, only a few of which I have mentioned, could not have been achieved without the support of his family. The professor and his lovely wife, Karin, met over a heart-lung machine, he as a pump techni-

cian and she as a lab technician. They have three beautiful children: a son, Jens, and two daughters, Julia and Katrin. Each child is secure and accomplished in a different field of endeavor. Two grandchildren complete this lovely, close-knit family.

The professor enjoys sports of a wide variety. He is an enthusiastic golfer and an avid Alps downhill skier. He and Karin enjoy fine literature, theater, and music.

And so, Mr. President, it is with esteem and admiration that I present to you the physician, the educator, the leader, the clinician, the researcher, the man, Prof. Albrecht F. W. Encke, for Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Pekka Häyry

by Thomas E. Starzl, MD, PhD, FACS, Pittsburgh, PA

Mr. President, it is an honor and a privilege to present for Honorary Fellowship in the American College of Surgeons Prof. Pekka Häyry, one of Finland's leading scientists and foremost surgeons. Professor Häyry was born December 13, 1939, in a small rural community to which his mother had been evacuated during the Russian siege of Helsinki, while his father remained in the capital with the Finnish Army. The family was not restored to their home in Helsinki until the armistice in 1945.

After receiving his MD and PhD degrees in 1965 and 1966,

Professor Häyry took a three-year postdoctoral fellowship at the Wistar Institute of the University of Pennsylvania in Philadelphia, under the preceptorship of Doctors Hilary Koprowski and Vittorio Defendi. The collaboration produced an article entitled "Mixed lymphocyte cultures produce effector cells: An in vitro model for allograft rejection," which was published in *Science* in 1970 and became an instant classic in transplantation immunology.

Although this work established Professor Häyry as a high-profile scientist, becoming a reputable surgeon took longer.



Professor Häyry

During the 10 years following his return from Philadelphia, Pekka was first a general surgery resident, then a fellow in clinical surgery, and finally associate chief of surgery at the Helsinki University Hospital. At the end of that 10-year period, in 1979, he was appointed professor extraordinarius of transplantation surgery and immunology at the University, and elevated to physician-in-chief of the University Hospital. Professor extraordinarius (EO) was the most prestigious faculty designation at the University of Helsinki. At the time of Professor Häyry's appointment, only 21 EO chairs existed at the University of Finland, representing the cream of the crop in international law, political science, archeology, ideology, and all other disciplines.

Professor Häyry did not suffer by comparison with the others. He is the only surgeon ever to receive the Matti Äyräpää Prize of the Finnish Medical Association, the most esteemed scientific distinction in Finland. His special interest has been in lymphocyte immunobiology. To in-

vestigate the inflammatory events within the graft itself and the efficacy of therapy, he developed the fine needle aspiration technology that has been adopted worldwide. For these achievements, and others too numerous to cite, Professor Häyry has been rewarded with more than half a dozen knighthoods and honors from his country, other nations, and his church, and by his recent presidency of the International Transplantation Society.

Aside from his achievements in medicine and surgery, Professor Häyry also is a devoted ecologist at a hands-on level at his country estate near Helsinki, where he raises sheep and horses in the middle of forests and lakes that are meticulously preserved in a pristine state. His other hobby is history, with a particular focus on the thousand-year Byzantium Empire of the East that brought Christianity to the Eastern part of Finland, also known as Karelia. He has generated a funding and research structure to catalogue, preserve, and digitalize the famous Byzantium Library of the Patri-

archate of Alexandria, Egypt. These historical interests have escalated during the last 10 years to an aid program for the ancient but still functional Mercy Hospitals of the old Byzantine Patriarchates of Constantinople, Alexandria, Antioch, and Jerusalem, to which he has delivered more than 16 metric tons of medicines and other materials.

Only two Finnish surgeons have ever received an Honorary Fellowship in the American College of Surgeons. The first was Prof. Väinö Ilmari Seiro, more than a half century ago, who taught the second Honorary Fellow, T.M. Scheinin, who, in turn, was Pekka Häyry's teacher. By making Pekka Häyry the third, we keep intact the direct lineage of our Finnish members, while adding Pekka's unique and engaging Nordic flavor to our own roster. I take great pleasure and pride in formally presenting Prof. Pekka Häyry, an esteemed surgeon/scientist to you, sir, and to the other members of our great organization for Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Minoru Hirano, MD, PhD

by Gerald B. Healy, MD, FACS, Boston, MA

Mr. President, it is an honor, a privilege, and a very personal pleasure to present Prof. Minoru Hirano of Kurume, Japan, for Honorary Fellowship in the American College of Surgeons. This opportunity brings particular pleasure to the inter-

national community of otolaryngologists who consider Professor Hirano to be their friend and role model.

Minoru was born in Seoul, Korea, as a Japanese citizen. He received his formal education in Kyoto, receiving both his MD

and PhD degrees from Kyoto University. After completing his training in Kyoto, Minoru was appointed to the faculty in otolaryngology at Kurume University in 1961. In 1966, he was named a Fulbright exchange scholar at the University of

Southern California and the University of California, Los Angeles, where he spent two years. Returning to Kurume in 1967, he began his long and distinguished leadership roles at that university. He has served as chairman of the department of otolaryngology, dean of the school of medicine, and currently is president and chancellor of the university.

Professor Hirano's life's work has been the study of the form and function of the human larynx in health and disease. His seminal contributions to our understanding of the morphology, as well as the aerodynamics, vibratory, and acoustic function of the vocal cord have changed our understanding of the production of human voice. These contributions have led to new minimally invasive and highly effective surgical interventions for the correction of communication disorders that affect millions of people throughout the world.

In recognition of his contributions, Professor Hirano has received numerous international awards and is a distinguished member of many international societies, as well as many Ameri-

can societies, in otolaryngology. He has chaired four international meetings and has been a distinguished leader of many organizations within his own country. In addition, he has been invited to be the keynote speaker or guest lecturer in 27 countries on six continents. His publications number more than 547 articles in peer-reviewed journals. In addition, he has published four books and has contributed more than 140 book chapters in numerous languages.

From a personal standpoint, I am sorry that Professor Hirano's dear wife, Nobuko, is unable to be with us. They have three handsome sons: Yutaka, who is an engineer with Toyota Motor Company; Kaoru, who is an orthopaedic surgeon in Japan; and their youngest son, Shigero, who I am thrilled to report is an otolaryngologist working in the department of otolaryngology-head and neck surgery at Kyoto University, but who is currently spending time at the University of Wisconsin as a visiting researcher.

I am sorry that you all will not be able to enjoy Minoru's phenomenal tenor voice, which has been put to very good use at many otolaryngology functions



Professor Hirano

and meetings over the years. My dear friend was also an outstanding athlete in his earlier life, but now confines his athleticism to golf. I strongly advise you not to get into a match with him if money is put on the table.

Mr. President, it is with deep admiration and respect that I present my friend, colleague, and role model, Prof. Minoru Hirano of Kurume, Japan, for Honorary Fellowship in the American College of Surgeons.

2003 Travelling Fellowship available

The International Relations Committee of the American College of Surgeons announces the availability of a travelling fellowship, the Australia and New Zealand Chapter of the American College of Surgeons Travel-

ling Fellowship for the year 2003.

Complete details and the requirements are available upon request from the International Liaison Division, ACS, 633 N. Saint Clair St., Chicago, IL

60611-3211. They are also posted on the College's Web site, www.facs.org. The requirements will be published in their entirety in the January 2002 *Bulletin*.

KEEPING CURRENT, from page 28

3. Coveney E, Weltz CR, Greengrass R, et al: Use of paravertebral block anesthesia in the surgical management of breast cancer: Experience in 156 cases. *Ann Surg*, 227:496, 1998.
4. Tovar EA: One-day admission for major long resections in septuagenarians and octogenarians: A comparative study with a younger cohort. *Eur J Cardiothorac Surg*, 20:449, 2001.

Suggested reading

- Basse L, Hjort Jakobsen D, Billesbølle P, et al: A clinical pathway to accelerate recovery after colonic resection. *Ann Surg*, 232:51, 2000.
- Calland JF, Tanaka K, Foley E, et al: Outpatient laparoscopic cholecystectomy: Patient outcomes after implementation of a clinical pathway. *Ann Surg*, 233:704, 2001.
- Kehlet H: Acute pain control and accelerated postoperative recovery. *Surg Clin North Am*, 79:431, 1999.
- Kehlet H: Multimodal approach to control postoperative pathophysiology and rehabilitation. *Br J Anaesth*, 78:606, 1997.
- Kirsh EJ, Worwag EM, Sinner M, et al: Using outcome data and patient satisfaction surveys to develop policies regarding minimum length of hospitalization after radical prostatectomy. *Urology*, 36:101, 2000.
- Kuo PC, Johnson LB, Sitzmann JV: Laparoscopic donor nephrectomy with a 23-hour stay: a new standard for transplantation surgery. *Ann Surg*, 231:772, 2000.
- Podore PC, Throop EB: Infra-renal aortic surgery with a 3-day hospital stay: A report on success with a clinical pathway. *J Vasc Surg*, 29:787, 1999.
- Senagore AJ, Whalley D, Delaney CP, et al: Epidural anesthesia-analgesia shortens length of stay after laparoscopic segmental colectomy for benign pathology. *Surgery*, 129:672, 2001.
- Tovar E: Minimally invasive approach for pneumonectomy culminating in an outpatient procedure. *Chest*, 114:1454, 1998.
- Tovar E: One-day admission for lung lobectomy: An incidental result of a clinical pathway. *Ann Thorac Surg*, 65:803, 1998.
- Udelsman R, Donovan PI, Sokoll LJ: One hundred consecutive minimally invasive parathyroid explorations. *Ann Surg*, 232:331, 2000.
- White PF: Ambulatory anesthesia advances into the new millennium. *Anesth Analg*, 90:1234, 2000.



ACS 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. The program will be conducted by the ACS as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for the CME programs and meetings.

Further information and application materials are available from the program's administrator, Kathleen Goldsmith, at JSP@facs.org.

The *Journal* page

Message from the Editor

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

The city of Chicago, where the American College of Surgeons is based, is noted for its architecture. Louis Sullivan, the distinguished early 20th Century architect, preached “form follows function,” which became the credo of the Bauhaus and another, more modern Chicago architect, Mies van der Rohe, who designed an apartment building within a stone’s throw of the College’s offices.

The recent changes in the form of the *Journal of the American College of Surgeons* are apparent to all and have met with praise from the readership. The form of the *Journal* is a reflection of the function, namely the contents. We are pleased to report that critical analysis of the *Journal* content provides evidence of significant improvement. During the past five years the Science Citation Index of the Journal Citation Reports (JCR) Impact Factor for the *Journal*, which is based on the number of times articles

have been cited, and, consequently, reflects the importance of the articles, has risen from 1.75 to 2.805. The *Journal* has jumped from number 34 (1995) to number 11 (2001) on the list of surgery journals in the JCR and, in 2001, is second among all general surgery journals published in the U.S. And all this does not yet even reflect the immediate past two years!

Just as is true of many of the classic Chicago skyscrapers, the improvements in the editorial presentations of the *Journal* are manifest by the improvements in the physical presentation. We strive for even greater heights.

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 December lead article

Learning Curves for Breast Cancer Sentinel Lymph Node Mapping Based on Surgical Volume Analysis. Charles E Cox, MD, FACS, Christopher J Salud, BA, Alan Cantor, PhD, Siddarth S Bass, MD, Eric S Peltz, BS, Mark D Ebert, BS, Keoni Nguyen, BS, Douglas S Reintgen, MD, FACS. From the H Lee Moffitt Cancer Center and Research Institute at the University of Southern Florida, Tampa, FL.

Background: Implementation of new procedures, including lymphatic mapping for breast cancer, must be done and overseen by the medical community in a responsible way to assure that the procedures are performed correctly. This study addresses the issues of adequacy of training and certification of surgeons performing lymphatic mapping. Assuring quality in surgical care requires outcomes measures that are described in this study.

Study design: Sixteen surgeons performed lymphatic mapping in 2,278 patients with breast cancer using a combination blue dye and Tc^{99m}-labeled sulfur colloid to identify the sentinel lymph nodes (SLNs). All participants were trained in a two-day CME-accredited course.

The Cox learning curve model (total number of mapping failures/total number of mapping cases) for a consecutive series of lymphatic mapping cases is described. The relationship of the Surgical Volume Index (the cases performed in a 30-day period), to the failure rate for each surgeon was modeled as a logistic regression curve ($y = e^{a+bx} / [1 + e^{a+bx}]$).

Results: Surgeons performing fewer than three SLN biopsies per month had an average success rate of 86.23% ± 8.30%. Surgeons performing three to six SLN biopsies per month had a success rate of 88.73% ± 6.36%. And surgeons performing more than six SLN biopsies per month had a success rate of 97.81% ± 0.44%.

Conclusions: This experience defines a learning curve for lymphatic mapping in breast cancer patients. The data suggest that increased volumes lead to decreased failure rates. These data provide surgeons performing SLN biopsy with a new paradigm for assessing their skill and adequacy of training and describes the relationship between volume of cases performed and success rate of SLN detection.