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From my perspective

All of our perspectives have changed dramatically since the events of the morning of September 11, 2001. Topics that once seemed important and that I had written about previously for this month's *Bulletin* are now of little consequence. The attacks on the World Trade Center in New York City and the Pentagon in Washington, DC, have changed all of our lives and have clearly altered the priority we place on certain issues.

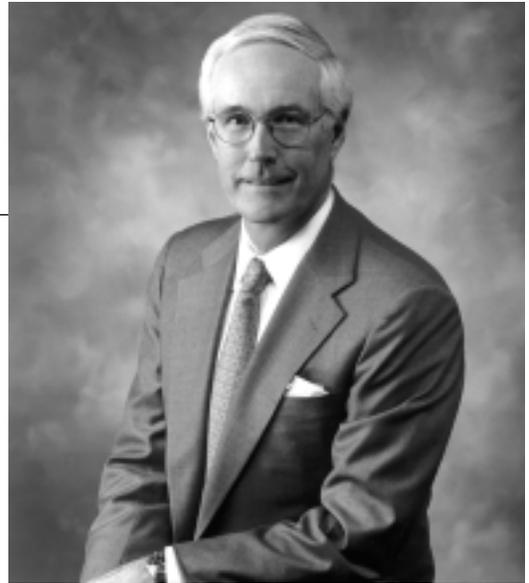
On that infamous day, we all experienced both the worst and the best of humanity. The terrorist acts were of unbelievable proportion, of a magnitude never before witnessed in this country. As a nation, as individuals, as professionals, we have experienced wars, but other than the Civil War and the bombing of Pearl Harbor, none of them was launched so close to home.

Heroes emerge

For every demon and villain to surface on September 11, thousands of heroes emerged. Among these champions were the individuals on the hijacked aircrafts, the victims on the ground, and the multitude of individuals who participated in the salvage operations, including firefighters, police, volunteers, and medical personnel. Responding from the medical community were paramedics, transport specialists, and trauma teams from hospitals consisting of surgeons, nurses, burn specialists, emergency room physicians, and a host of other caregivers who actively participated in helping the injured.

The American College of Surgeons attempted to quickly monitor the activities in New York through our trauma network and the Committee on Trauma. We were in contact with surgeons close to ground zero and were aware of activities carried out by the trauma units at all of the surrounding hospitals, particularly St. Vincent's Hospital, which treated many of the victims. All of the trauma units hoped for more survivors. Initially many patients were rushed to the hospitals, but the number quickly tapered off as few—and then no—survivors were found in the ensuing days.

It became clear early on in the process that ad-



“For every demon and villain to surface on September 11, thousands of heroes emerged.”

ditional outside assistance probably would not be needed. The College sent an e-mail on the morning of September 12 to our Fellows announcing that we were monitoring the situation and that, at that particular time, there did not seem to be a need to mobilize volunteers from other parts of the country.

I was moved by the outpouring from our members who responded to the e-mail. Surgeons from different locations and of different specialties wanted to volunteer if the need arose. We all felt helpless during that vulnerable period, but clearly this expression of volunteerism was touching and profound.

We, as individuals and as a nation, are only in the beginning phases of responding to this crisis. Things will never be the same. We will all experience changes and challenges unimaginable in the past. Along with the remaining threats of further terrorism, there is the potential for biological, chemical, and nuclear destruction. We will need to brace ourselves for addressing those possible future hazards.

Words of thanks

The American College of Surgeons not only wants to express our deeply felt sorrow for the victims of these horrendous acts, but also our appreciation for the hard and dedicated work of the relief teams who worked tirelessly and selflessly. The response of the trauma community in New York City and the surrounding areas and in Washington, DC, has been astonishing, and our heartfelt gratitude goes out to all who participated. I thank all the members of this College who actively participated in the care of the victims and also the rest of you who so admirably responded and were willing to volunteer additional support and help. This altruism is in the true spirit of being a physician and represents the very best of our profession.

To end this piece, I thought it would be best to let some of the many surgeons who responded to our e-mail notification speak for themselves in their own humanitarian voices about the cataclysmic events that unfolded last month.

“I would be honored to volunteer in any capacity.”

“Please let me know and I can be available at any time.”

“Make the call and I’ll be there or accept transfers here.”

“Thanks for the support of the College and the COT... Unfortunately, there are very few survivors from the buildings themselves. The city has triaged approximately 1,000 patients who had minimal injuries. We set up a MASH unit at Chelsea Piers with over 100 OR tables. In a 12-hour period, we did not treat a single case. At ground zero, my worst fears were realized as I could not imagine anyone surviving the initial impact, the building collapses, or the inferno that followed. Presently, we have more surgeons than patients requiring their services.”

“Please count me in if a team is mobilized from

Chicago...I am a plastic surgeon with 25 years’ experience in cranio-maxillofacial surgery, trauma, and previous experience with burn care...Please keep me in mind.”

“Our Burn/Trauma Service is available any time for mobilization if desired.”

“I am available. However, judging by the magnitude of the blasts, it looks like more perished than survived.”

“I’d be honored to help in any way possible.”

“All of the attending and resident otolaryngologists and ophthalmologists are ready, able, and willing. Simply give the word, and we will respond immediately.”

“I will help however I can with time or money.”

“We were at Kings County Hospital all day Tuesday until Wednesday. The number of wounded was extremely small, although the hospital was completely mobilized. We all fear that the number of dead will be much greater than the wounded and potentially salvageable. Thank you for the College’s most generous offer.”

“I will volunteer if my services could be of any use. Please keep me listed and contact me as necessary.”

“I know with certainty that surgeons of all specialties would be honored to travel...to Washington or New York to care for the wounded. Please let us know how we may serve.”

“I’m proud that ACS is ready to act as needed...anytime and any place.”

“We went to the VAMC yesterday and unfortunately we did not get casualties last night. The staff there is on full alert, but I have news that NYC is a real problem and that they have run out of body bags.”

“Thank you for coordinating this. It is precisely what is on our mind as surgeons.”

“If there is any help needed, I will consider it a privilege to assist.”

“I am currently on alert for the Air Force reserve, but if you need this trauma surgeon, let me know.”

“Thankfully my family is safe, but should you need resident volunteers and my program allows, I am more than willing.”

“I wish to offer my services for emergency care and for future repair of injuries—offering this to patients at no charge. Please add me to your list.”

“Actually, we have plenty of surgeons. Unfortunately, most of the victims were buried and are presumed dead in the rubble.”

“I am in a group of four neurosurgeons in Annapolis, MD. We all have extensive training in trauma. If we can help, please let us know.”

“I am a retired general surgeon in North Dakota and would be glad to help even if it means changing dressings or starting IVs. Let me know if they need any help.”

“While I am just a urologist, if there is something I can do, please contact me.”

“This is our duty as physicians to the United States. I commend the College and Dr. Russell for attending to these matters in a concerted and expeditious manner.”

“Please receive our sympathy and our deepest condolences in this tragic hour for all mankind, not just the U.S.A. (By this hour, 11 Mexican citizens already are confirmed dead and 500 more are missing in the twin towers, since more than 150,000 of our nationals live in the New York City area.) Unfortunately, our experience in the 1985

earthquakes in Mexico City tells us that, unlike a battlefield where there is a steady flow of wounded as long as the actions continue, in this kind of event a large wave of injured people are followed by a sudden stop and only the recovery of bodies and a few miraculous events occur in the following days. Let’s hope this time there will be many of these, and we are with you in every effort that you do for the quick recovery of our U.S. friends.”

“I would be happy to volunteer immediately for any and all needs in the disaster areas.”

“All of our staff is ready for any help, any time you think necessary. All of us are horrified by this ominous attack.”



Thomas R. Russell, MD, FACS

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

FYI: *STAT*

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



The College's **Health Policy Steering Committee** met via conference call on September 20 to review issues that will be included on the College's legislative and regulatory agenda for the next session of the 107th Congress. Details of that meeting will be reported on in future issues of the *Bulletin* and *ACS NewsScope*.



The **first annual report of the National Trauma Data Bank™** has been published and is now available on the College's Web site at <http://www.facs.org/ntdbreport2001/index.html>. A timely profile of hospital trauma care nationwide, *National Trauma Data Bank Report 2001* serves to inform trauma care professionals and the public about the current state of care for injured persons in hospitals that serve their communities as trauma centers, with an emphasis on the causes, costs, and complexion of trauma in our society.



The American College of Surgeons is offering Faculty Research Fellowships for surgeons entering academic careers in surgery or a surgical specialty. Funded through the generosity of Fellows, chapters, and friends of the College, the fellowships will assist surgeons in the establishment of new and independent research programs. In addition, the College and the American Head and Neck Society are offering a faculty career development award to head and neck surgeons to support clinical, basic science, or translational research in the study of neoplastic disease of the head and neck. Both the **Faculty Research Fellowships and the Faculty Career Development Award** are in the amount of \$40,000 per year for each of two years. The deadline for submission of applications for both awards is November 1, 2001. Requirements and application forms are available online at <http://www.facs.org/dept/fellowship/research.html>.



The Office of Continuing Medical Education of the American College of Surgeons has implemented a **CME Joint Sponsorship Program**. The program is being conducted by the College as a national accrediting organization under the Accreditation Council for Continuing Medical Education and offers cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for their CME programs and meetings. In the initial phase of the program, CME accreditation is being offered for meetings and educational programs that are scheduled to be held after July 1, 2001. Further information and application materials are available from JSP@facs.org or online at http://www.facs.org/meetings_events/cme_events.html.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

ACS comments on supervision of CRNAs

The College submitted comments on September 4 in response to a proposed rule issued on July 5 by the Centers for Medicare and Medicaid Services (CMS). That draft regulation addressed the conditions for hospitals' participation in Medicare and Medicaid that pertain to physician supervision of certified registered nurse anesthetists (CRNAs). Under the proposal, "the current physician supervision requirements would be maintained, unless the Governor of a State, in consultation with the State's Boards of Medicine and Nursing, exercises the option of exemption from this requirement, consistent with State law."

Governors would be required to submit a letter of exemption testifying that it is in their citizens' best interest to "opt-out" of the supervision requirement. The rule also directs the Agency for Healthcare Research and Quality (AHRQ), with input from CMS and other stakeholders, to conduct a study to assess the impact of CRNAs' practice without physician supervision.

The College supports the supervision requirements and was generally satisfied with the proposed rule. Concern was expressed, however, about granting opt-out requests automatically upon application to CMS. In its comments, the College stated that both the governors and the agency should provide public notice with ample opportunity to comment before any exemption becomes effective. The full text of the College's letter may be viewed on the ACS Web site, at <http://www.facs.org/dept/hpa/views/scope.html>.

Massachusetts General hosts Day in Surgery

The College hosted a Day in Surgery program in partnership with the Massachusetts General Hospital (MGH) in Boston, MA, on August 13-15 (see related article, p. 25). The program allows staff from government offices and federal agencies to spend a day with surgeons and residents to learn firsthand about surgical patient care, residency training, the operating room environment, and the daily routine of surgeons in the hospital setting.

The Day in Surgery at MGH was hosted by Andrew Warshaw, MD, FACS, and the program's activities were coordinated by chief resident Steven Abbate, MD. Six congressional health care staff participated in the program: Sonya Sotak from Sen. John McCain's (R-AZ) office; Lisa Meyer from Sen. Pat Roberts' (R-KS) office; Sohini Gupta Jindal from Sen. Evan Bayh's (D-IN) office; Sarah Bianchi from Sen. Edward Kennedy's (D-MA) office; Lee Stevens from Governor Mike Easley's (D-NC) office; and Kevin Hayes from the Medicare Payment Advisory Commission (MedPAC).

Specialties comment on critical care issues

In a joint letter sent to CMS on August 6, 30 specialty societies objected to provisions pertaining to critical care services that were set forth in the agency's proposed rule on the five-year review of the Medicare fee schedule. The controversy centered on the inclusion of critical care in the process used to assess relative values for certain global surgical services in which critical care is a routine part of postoperative care. CMS questioned whether Medicare might be making dupli-

Medicare issues proposal for outpatient PPS

cate payments for critical care—once to the surgeon and once to another physician assigned to the intensive care unit. The agency made clear that it will not change Medicare's critical care payment policy in 2002, but asked for comments on various changes that could be made for 2003.

The letter, which was coordinated by the College and the American Medical Association, in cooperation with societies representing surgical and critical care specialists, objected strongly to the proposals and urged that no policy or payment changes be made. The coalition's letter, along with the College's individual comments, can be viewed at: <http://www.facs.org/dept/hpa/views/fiveyear.html>.

On August 24, CMS published a proposed rule for the hospital outpatient prospective payment system (PPS) for 2002. Under this system, Medicare payment for hospital outpatient services is made at a predetermined, specific rate according to a list of ambulatory payment classifications (APCs). The draft regulation sets forth proposed revisions to payment rates for all the APCs, as well as structural changes to the approximately 160 APCs. In addition, it includes proposals regarding outlier payments, observation services, and beneficiary coinsurance. The policy of maintaining a specific list of procedures that can be performed only on an inpatient basis is continued, with no changes contemplated.

One controversial aspect of the proposed rule relates to the extra payments that currently are made for certain drugs (for example, orphan drugs, chemotherapy, and radiopharmaceuticals) and devices (such as pacemakers, stents, and infusion pumps). CMS suggests that a significant, but unspecified, reduction in these pass-through payments could be required for 2002 in order to meet statutory limits. The proposed rule can be accessed at http://www.access.gpo.gov/su_docs/fedreg/a010824c.html

Congressional "casualties" mount

As the first session of the 107th Congress draws to a close, announcements about planned career changes are being made with increasing frequency by federal legislators who are up for reelection in 2002.

Three well-known senators have announced plans to retire from politics: Phil Gramm (R-TX), Jesse Helms (R-NC), and Strom Thurmond (R-SC). At least three members of the House hope to become senators when the 108th Congress is sworn in: John Cooksey, MD, FACS (R-LA), Greg Ganske, MD, FACS (R-IA), and Lindsey Graham (R-SC).

Other representatives have announced plans to run for governor: John Baldacci (D-ME), Tom Barrett (D-WI), and David Bonior (D-MI). Five congressmen have announced that they will retire from politics: Porter Goss (R-FL), Steve Horn (R-CA), Dan Miller (R-FL), Tim Roemer (D-IN), and John Thune (R-SD). Finally, two Representatives have resigned—Joe Scarborough (R-FL), and Bud Shuster (R-PA)—and four who were elected last fall are now deceased: Julian Dixon (D-CA), Joe Moakley (D-MA), Norman Sisisky (D-VA), and Floyd Spence (R-SC).

What surgeons should know about...

Uniform standards for electronic claims

by Jean A. Harris, Associate Director, Division of Advocacy and Health Policy

Virtually all health insurers have to come into compliance with new industrywide electronic standards for claims and other transactions. The implementation date is now mid-October 2002, although at press time legislation to delay the effective date was pending in Congress. Standardization is certainly welcome news for physicians' offices, which often must deal with multiple formats. But massive changes are required to achieve standardization. Health insurers will initiate these changes, so the timing and other aspects of the conversion to the new standards are largely out of the control of physicians and their office staffs. Nevertheless, surgeons and their office staffs should benefit from some basic information about the new standards.

Q. What brought this standardization about?

A. The current lack of electronic standardization means that physicians' offices must submit claims to different payors in different formats and, in many instances, with variations in procedural and diagnostic coding. The Department of Health and Human Services (HHS) estimates that there are 400 formats now being used to file claims of all types. Developing and maintaining software in this environment is very costly, especially for physicians or providers and their billing agents.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided for HHS to establish standard transactions. Although HHS is responsible for selecting the standards, generally it is private groups which have responsibility for actually maintaining the standards. When finally

effective, physicians will be able to submit the same electronic transaction to any health insurer in the country, and the health insurer will have to accept it. Health plans will be able to send standard electronic remittance advices and other transactions to any physician. Patients, however, will continue to receive communications such as explanations of benefits and premium bills just as they do today.

Q. Who has to use the standardized formats? When are they effective?

A. The standardized formats apply to health insurers and health care providers who are exchanging electronic data. After the effective date, all electronic transactions must be in the standard formats and use the standard diagnostic and procedural coding sets. There is an exception, however, for an Employee Retirement Income Security Act (ERISA) plan that has fewer than 50 participants or is self-administered; self-administered plans can, of course, be quite large.

As of press time, insurers may adopt the standards any time before October 16, 2002. (Small health insurers—with \$5 million or less in annual receipts—have an additional year, until October 2003, to come into compliance.) However, legislation has been introduced to delay the implementation about two years; we will keep you informed of the status of this and any other changes that are made between now and mid-October 2002.

The standardized formats apply only to electronic transactions. The fact that a physician submits some electronic transactions does not mean that all transactions must be submitted electroni-

Table 1

Standard formats under HIPPA

| Standard format | What is transmitted* | Who is transmitting |
|---|--|--|
| Health care claims or equivalent encounter data | Claim or encounter data | Physician to payor |
| Health care claim payment and remittance advice | Payment to physician's bank; remittance advice to physician | Payor to physician's bank and to physician (There is no payment or remittance advice in response to encounter data.) |
| Health care claim status | Request for status of claim at payor | Physician to payor and back |
| Coordination of benefits | Request for determining relevant payment information | Physician or another payor to payor and back |
| Referral certification and authorization | Request authorization or referral for health care | Physician to payor and back |
| Eligibility for health plan | Request eligibility, coverage, or benefits | Physician or another health plan to payor and back |
| Claims attachment (not released yet) | Supplemental claim information that would normally be sent on paper rather than electronically | Physician to payor |
| First report of injury (not released yet) | Report an injury so special benefits are paid | Physician to payor |

*An acknowledgement of all transactions is sent to the physician's office.

cally. For example, a physician may submit a claim on one patient to a health plan electronically and submit a claim on a different patient to the same plan on paper. Or the physician may submit most claims electronically to one plan and all claims on paper to another plan.

Paper claims will still be processed as they are today, using either the industry-standard health insurance claim form or a plan's proprietary form, and paper remittance advices will also still be prepared. Those physicians' offices that are prepar-

ing only paper claims will not be affected by the standardized formats.

Q. Can you describe the transactions that are standardized under HIPAA? I understand that they are quite extensive.

A. In addition to claims and remittance advices, which are frequently transmitted electronically, the HIPAA standards cover five other transactions, such as claim status and re-

Table 2

Code sets designated under HIPAA

| Type of Code | Name | Comments |
|---|---|--|
| Diagnostic | International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) | Must be complete (that is, have the maximum number of digits). |
| Procedure: physician services | Current Procedural Terminology, Fourth Edition (CPT-4) | All codes and modifiers must be accepted, although payor does not have to pay for all. Surgery codes not to be used for general or regional anesthesia services. |
| Procedure: physician services, DME, orthotics and prosthetics, supplies | Level II of Health Care Financing Administration Common Procedure System (HCPCS) | All codes and modifiers must be accepted, although payor does not have to pay for all. Local codes (beginning with W-Z) to be replaced by national codes before January 2004. |
| Procedure: drugs and biologicals | National Drug Codes (NDC) | Apparently HHS will rescind the NDC for physician claims. See story for details. |

quests for authorization or referral for care (see Table 1, p. 10). Those five additional items are not highly automated partly because of the absence of standardized formats. However, with all payors using the same standards, there is the potential for the health care industry to become largely electronic within a relatively brief period of time.

Two additional standards for payment of premiums and enrollment/disenrollment in a health plan are of primary interest to employers rather than the health care community. Although the statute does not require employers to comply, they probably will be more interested in communicating electronically if there is a single, uniform standard that they can use to deal with all plans.

Q. Is it important to distinguish between formats for claims and remittance advices and code sets for diagnostic and procedural coding?

A. It is important to draw a distinction between the formats and code sets. The format identifies the data content of a transaction. For example, the format for a physician claim specifies the way the date, procedure code, diagnostic code, charges, and many other things are to be arrayed. The code sets identify which procedural and diagnostic codes must be used as well as details such as what constitutes a complete code. Changes can be made independently

Quick implementation guide

Decide how much work your practice will have to do:

- How many health plans are you now communicating with electronically?
- With how many are you already using the national standard?
- What payors is it essential that you continue to communicate with electronically? Is a fallback position to revert to paper for a while with some payors? (If so, be sure to plan for more paper claims.)
- Do any payors refuse to accept CPT modifiers or the full diagnostic code? How many local and non-standard HCPCS codes do you use?

Assuming the software is not compliant, decide what you will do:

- Ask your software vendor, billing agent, or clearinghouse what they are going to do and when. How satisfactory is their response? How much help will they be?
- If you change your claims filing arrangements, do you want to obtain software that prepares claims in the standard format? Or does a clearinghouse concept appeal to you? Exactly what would you have to do differently with each?
- What beyond the basic claims filing transactions are your payors going to support? Are you also interested in those electronic transactions? How does that fit into your plans?

Develop a firm plan for doing the work:

- Clearly assign responsibility for doing the work and follow-up to be sure it is done.
- Be sure to start early enough that you won't be bothered by major setbacks (for example, delays in software becoming available).

Finally, a few words about testing:

- Be sure to allow plenty of time for submitting test claims once a payor allows it.
- Test using a variety of claims, both "good" claims and claims with errors in them.
- Be sure you and the payor can process a file as big as you will submit.
- Look at your results carefully to be sure you identify and correct every error. Remember that the payor may be at fault.

in the formats and in the code sets.

Q. **Submitting a claim is key to running physician offices. How can we tell whether we are in compliance with the new standards?**

A. All Medicare carriers are in compliance with the new format for submitting claims and generating remittance advices. However, they may also still be using an older non-

standard format; if they accept more than one format, you need to check whether the format you are using is in compliance. As discussed in the following paragraphs, Medicare is going to have to eliminate local and nonstandard procedure codes and perhaps change the procedure code set for drug and biologicals.

Q. **When are changes made in the formats? Changes are made annually in the code sets, but what kind of a grace**

period is there? What are the rules if a claim is submitted late, well after the diagnostic and/or procedural codes have changed?

A. Changes in the standard formats cannot be made more frequently than once every 12 months, and there will be at least six months of lead time. Although the regulations do not spell it out, there will certainly be a period of time when payors have to deal with both the old and the new formats. That gives physicians a “window” of time to make the corresponding change.

Diagnostic coding changes are made on October 1 of each year, and procedural coding changes for physician services are made on January 1. For both systems, physicians have three months to actually make the change. For procedure codes, for example, physicians can use the old or new codes for services rendered during January, February, and March. Those rules have been in effect in the Medicare program for some time.

The diagnostic and procedural codes must be from the code sets that were valid at the time the service was furnished, and payors must be able to make payment based on old code sets. The rest of the claim must use the standard format in effect at the time the transaction is submitted.

Q. What are the diagnostic and procedural coding requirements?

A. Table 2 on page 11 lists the sets for diagnostic coding and various procedural coding systems surgeons use. The column on the right contains items that surgeons and their staffs should be aware of as implementation proceeds. Medicare is already in full compliance with the ICD-9-CM rules for diagnostic coding and the CPT-4 and Level II of Health Care Financing Administration Common Procedure System (HCPCS) rules for procedural coding. Of course, local and HCPCS codes

(those with a first character of W through Z) have to be eliminated between now and January 2004.

In August 2000, the National Drug Code (NDC) was announced as the code set for drug and biologicals. However, at the end of May 2001, HHS said that it will publish an additional regulation in the “near future” proposing to retract the NDC for all transactions except those for retail pharmacies. There is speculation that the existing HCPCS codes that begin with a J could continue to be used or a new code set will be developed. The NDC is an 11-digit number appearing on the drug or biological packaging that identifies the vendor or labeler, product, and trade package size.

Q. Will some changes actually be made after the deadline to come into compliance with the new standards?

A. That is correct. Although some local codes probably will be eliminated this January and next, they will not be completely eliminated until January 2004. Of course, if the legislation to delay implementation is passed, the local codes probably will be completely eliminated before implementation.

Q. Can you explain what a “health care clearinghouse” is?

A. A clearinghouse provides a translation service—translating data back and forth between formats. That function is already offered by a number of billing services, which take data from a physician’s office and translate it into the many different formats used today by different payors. Under HIPAA, their role will be limited to translating between the nonstandard physician office format and the standard format.

The clearinghouse concept may become popular with payors as a way to avoid the expense of dramatically altering their claims processing system

under HIPAA. Software on the front end of their system would translate from the new standard format to the old nonstandard format they have always used. Additional software on the back end of their system would translate from the old nonstandard format to the new standard format that would be sent to the physician's office.

Q. Coming into compliance with HIPAA sounds like a significant undertaking. What should I be doing now?

A. The quick implementation guide on page 12 gives some key tips for small practices that have to do the entire job of selecting software or a clearinghouse. Your practice may be a part of a large group, so you will not be responsible for selecting a vendor. However, you should ask about the plans that are being made, focusing on the questions that will have an impact on the portions of the claims process for which you and your staff are responsible.

Q. How will the standards be enforced?

A. No procedures have been announced yet, but HIPAA gives the Secretary of HHS authority to enforce the standards. He may impose penalties of up to \$100 per violation not to exceed \$25,000 for violations of one requirement.

Q. What is the expected cost and benefit of all of these changes?

A. The total implementation cost to physician practices from 2002 to 2011 is \$402 million dollars. HHS estimates a 17 percent increase in the volume of electronic claims from physicians in 2003, from 55 percent if HIPAA had not been enacted to 63 percent with HIPAA. Compa-

rable figures for 2011 are 73 percent of claims if HIPAA had not been enacted and 94 percent of claims with HIPAA.

Q. Where can I get more information about HIPAA?

A. We will keep you informed of any new requirements that are issued by HHS, either through a feature article or in the "Socioeconomic tips of the month" column in the *Bulletin*. Watch for notices from your Medicare carrier and from other payors. For those individuals who have access to the Internet, a great deal of information is available at <http://aspe.hhs.gov/admsimp/Index.htm>. Finally, software vendors or billing agencies can be a good source of information. [Q]



Physicians and the war on drugs



Physicians and the war on drugs: The case for legalization

by Benson B. Roe, MD, FACS, San Francisco, CA

The massive bureaucratic endeavor to interdict the enormous importation and marketing of recreational substances is not only futile and extravagant, but has no justification as a protective measure. This article provides clear inferential evidence to demonstrate that outlawed narcotics are less dangerous than their legal counterparts, a fact of which the public is largely unaware.

Although decriminalization would significantly benefit society, the only prospect of achieving that objective is via organized medicine. Both adversaries in the “drug war” would be disenfranchised by decriminalization and have huge resources to oppose any legislation that might conclude the “war.” This article is intended to initiate the profession’s potential role in that objective.

Drug war a fraud

When examined carefully, it becomes apparent that the war on drugs is a monumental fraud. The medical profession is in a pivotal position to expose the deception, and we have neglected our moral and social responsibility to exercise this role.

The government’s effort to obliterate these drugs is based on a false premise. Its demonstrable failure was totally predictable, and the war’s cost to society is enormous and growing. And, if the outlawed drugs were to be used legally, everyone would benefit, except for criminals, the lawyers, and the bureaucracies of the Drug Enforcement Administration (DEA), the Federal Bureau of Investigation (FBI), and the prison system. Those statements may seem extravagant, so let’s examine them.

Deception

The public, the judiciary, law enforcement agencies, and perhaps a major segment of our profession have been deceived into subscribing to a mind set that cocaine, heroin, and marijuana are toxic

and demonic substances so dangerous that society must be rigidly protected from them. Yes, it is true that they may have detrimental or even lethal consequences if indulged in abusively or inappropriately. But it is equally true that those same consequences are applicable to alcohol, nicotine, caffeine, sunshine, guns, airplanes, automobiles, boats, and a host of other potentially dangerous elements in our environment. The public is provided with some protection through educational measures and regulations on their use, but no one has suggested that any of these other ubiquitous hazards be outlawed. Why not? What is the evidence to justify making some possibly dangerous materials illegal and not others? Folklore, propaganda, and legends are abundantly applied to substantiate the government’s decisions about these serious measures, but there are simply no conclusive studies to justify these actions.

Even if heroin and cocaine were proven harmful (marijuana probably isn’t) the only hope for curtailing their detrimental consequences is not by prohibition but rather through a realistic acceptance of their presence, efforts to monitor purity and strength, and controlled distribution through licensing, as we do with alcohol and pharmaceuticals.

Our responsibility

It should be our profession’s responsibility to help the public understand the actual and comparative hazards of illegal substances so they can address the issue rationally. Pathologists should be more outspoken about their knowledge that with perhaps a few rare exceptions these “drugs”—which have been widely used for centuries—have never been identified with a serious or fatal disease process. Certainly the same cannot be said about tobacco, alcohol, or even caffeine, which account for hundreds of thousands of deaths per year.



Physicians and the war on drugs: The case against legalization

by Charles D. Mabry, MD, FACS, Pine Bluff, AR

Dr. Benson Roe has proposed an interesting and controversial approach to the topic of illegal drugs and the “Drug War.” In his article, he espouses the following novel ideas:

- Legalization of currently illegal drugs (heroin, cocaine, crack, methamphetamines, and so on) would benefit everyone, except for criminals, lawyers, and the government bureaucracies.
- Legal and medical organizations “have been deceived...that cocaine, heroin, and marijuana are ...substances so dangerous that society must be rigidly protected from them.”
- Illicit drugs have never been identified with a serious or fatal disease process. Users of illegal drugs are at risk only because the substances are illegal and uncontrolled.
- There is little evidence that making drugs illegal decreases their use.

To summarize, Dr. Roe calls upon society to: legalize all illegal drugs, mainstream drug production to ensure a supply of quality drugs, fire the police officers and lawyers who are in collusion with the drug kingpins, and tax the drugs. If we take all these actions, he says, everybody will be happy down at the old ranch.

To these assertions I say, get a grip on reality, Dr. Roe. While he certainly is entitled to his opinion, the vast majority of scientists and physicians who have studied the problems of drug abuse and addiction would find exception to much of what he has opined. Let’s apply science to this complex and difficult subject, and review some objective evidence about what we do know.

Illegal drugs are dangerous

First, illegal drugs are dangerous and cause a host of medical and societal problems. The use and abuse of drugs (including alcohol, as well as prescription and nonprescription medicines)

has been ranked as “the nation’s number one health problem” by the respected Schneider Institute for Health Policy and by the Robert Wood Johnson Foundation.¹ More than 20 million Americans are addicted to alcohol and drugs. Those addictions cause about 130,000 deaths annually.

Additionally, a study by the Lewin Group for the National Institute on Drug Abuse estimated the total economic cost of alcohol and drug abuse to be \$244.7 billion for 1992. Of that cost, \$97.7 billion was due to drug abuse alone, including lost wages, health care costs, and crime associated with drug usage. The Lewin Group also found that employed drug abusers cost their employers twice as much in medical and worker compensation claims as their drug-free coworkers.²

Despite Dr. Roe’s assertions that these drugs have not been identified with fatal disease processes, the facts are that medical (and surgical) problems associated with drug abuse and addiction are well documented. Most Fellows who have taken trauma call in any major emergency room within the past 10 years don’t need a rendition of national statistics to fully appreciate the cause-and-effect relationship between drug abuse and traumatic injury. In 1994, 431,800 visits to emergency rooms were drug-related, nearly 143,000 due to cocaine abuse alone.³ Further, a 1993 National Highway Traffic Safety Administration study reported that 18 percent of 2,000 fatally injured drivers from seven states had drugs other than alcohol in their systems when they died.³

Finally, as only one example of how drug abuse is associated with active crime, the New York City Arrestee Drug Abuse Monitoring Program found that 74 percent of male adults arrested for committing violent crime tested positive for drug use. Similar data were also reported out of Albuquerque, NM, and Ft. Lauderdale, FL.³

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The relatively few deaths caused by these outlawed substances are solely attributable to contamination from their unhygienic use or to overdosing from misusing an unrecognized or high concentration of the intoxicant (comparable to quaffing a stiff Martini innocently made with 95 percent alcohol instead of the 40 percent you are used to), but not from any inherent toxic properties of the substances themselves.

The “demonizers” have focused the public’s attention on the small minority of abusers whose conspicuous behavior and disabling complications have serious consequences, while conveniently ignoring the millions of drug users who are leading normal, unimpaired, productive lives, as are the majority of those millions who indulge in alcoholic beverages. Although specific numbers are lacking to prove the widespread use, common sense tells us that the relatively few but conspicuous “junkies” could consume only a tiny fraction of the enormous drug trade, the bulk of which must be going to a huge population of unrecognized users who are showing no harm or impediment from the drugs. These users are at risk only because the substances are illegal and uncontrolled. Their alleged harm is legendary but never documented other than publicizing lurid images of the severely addicted. Why has our profession been so silent about this important misinformation?

Addiction issue

Addiction has been an excuse for alarm about these drugs, but that issue too is misleading. Addictions to various substances and activities are numerous. Each has a different degree of addictive severity and individuals differ in their susceptibility to a given compulsion. And, certainly addiction is not limited to illegal drugs. Much of the world’s population is firmly addicted to caffeine in the form of coffee and tea. Tobacco is known to be more addictive than heroin, and marijuana is minimally addictive, if at all. Why should heroin and cocaine addicts be treated with less tolerance, understanding, and support than we provide to cigarette, alcohol, chocolate, and gambling addicts? Our profession should play a larger role in clarifying this paradox and helping the public recognize that the illegal substances are not as addictive as many legal substances. The entrenched impression to the contrary will be difficult to dis-

pel and will need the authority of our profession to accomplish it.

Futile, costly efforts

Even if the contention that the drugs are harmless were to be erroneous, it is nevertheless obvious that the war against them has been a miserable failure, as any sensible historian could have predicted. Prohibition has never worked, as we learned in the futile attempt to enforce the 18th Amendment (1919) and the Volstead Act (1920), which outlawed alcohol. Economic forces dictate that any product that has a large demand will inevitably be supplied. It simply cannot be prevented, as this failed effort has proven once again. The futility of the interdiction effort is epitomized by the fact that illegal drugs are readily available even in most prisons. Highly publicized “drug busts” (even those that yield literally tons of a substance) represent only a tiny fraction of the huge market, which continues to operate with little or no evidence of slowing down. And, of course, the war (which both sides would hate to see end) provides a huge bonanza for the enforcement system, for the legal system, for the prison system, and especially for the drug marketers who are bleeding hundreds of billions of untaxed dollars out of our economy.

The monetary cost of this futile exercise is enormous, and its consequences to society are a national disgrace. The annual financial expenditure is difficult to ascertain, but let’s look at the extent to which it is easily evident in the public record: In fiscal 1998-99 the DEA spent more than \$1.4 billion on the drug war, not including: (a) the \$285 million spent on prosecuting narcotics cases by the 94 U.S. Attorney Offices; (b) the \$749 million spent on drug enforcement by the FBI; (c) the costs of the Coast Guard and other federal agencies involved in enforcement (not separately itemized); (d) the budgets of state and local enforcement agencies; and (e) the legal defense costs, some of which are sustained by public defenders. The biggest item is the horrendous cost of incarcerating the large number (but a small percentage of) traffickers who are caught, prosecuted, and convicted. The Justice Policy Institute estimates that in March 2000 more than one million nonviolent offenders were incarcerated chiefly for drug charges at a cost of more than \$23.7 billion for the entire year. Moreover,

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Legalization would increase use

Legalizing or decriminalizing drugs that are now illegal will only increase their usage and subsequently the numbers of patients addicted to those drugs. Most of the illegal drugs we are talking about have, at one time or another, been legal. They are now illegal for good reason. Society has repeatedly made the collective judgment that these drugs just shouldn't be freely available because their side effects are so horrible. An excellent objective review of the history and policy approaches to addictive drugs has been written recently by DuPont and Voth.⁴ The conclusions of this comprehensive article are clear: making addictive drugs legal and available will assuredly increase the numbers of citizens addicted.

Does making addictive drugs illegal work? Cocaine and potent narcotics were freely sold in America until the first two decades of the 20th century, and the number of patients addicted dropped sharply once availability was curtailed.^{4,5} Addiction rates have dropped for several other drugs once availability was decreased and penalties for trading them were established.^{3,4,5}

More recently, several European countries have experimented with various attempts to legalize or decriminalize some illegal drugs. These experiments have resulted in a rise in the number of drug-addicted patients and a corresponding increase in the crime rate.^{3,4,5} Of substantial note: these European experiments were such a failure that in 1994 a group of major European cities (including London, Berlin, Paris, Madrid, Stockholm, and others) banded together and signed the "European Cities Against Drugs" resolution, which called for a rejection of "demands for legalizing illicit drugs...."³

The National Center on Addiction and Substance Abuse has stated the situation concerning illicit drugs in this country most eloquently: "Drugs are not a threat to American society because they are illegal; they are illegal because they are a threat to American society."^{6,7}

Two important aims

Proper medical management of addiction and use of the law of the land to contain and decrease the supply of addicting drugs are both important goals and are not mutually exclusive. Dr. Roe disingenuously implies that the National Coalition

for Drug Policy Change stands for legalizing addicting drugs. As one of the original signatories of the group's 1993 resolution, Dr. Roe should know that document reads: "WHEREAS, the overall situation regarding the use of drugs in our society and the crime and misery that accompanies it has continued to deteriorate for several decades ...THEREFORE BE IT RESOLVED, that our society must recognize drug use and abuse as the medical and social problems that they are and that they must be treated with medical and social solutions...."⁸ The coalition's main thrust was to ask the President to appoint a special commission to study how Congress should change existing drug laws—not to legalize illicit drugs.

The Robert Wood Johnson Foundation has published an excellent monograph that covers the subject of substance abuse and current approaches for policy and treatment, for those interested in reading more about this subject.¹ Addiction is a disease and should be treated like all other chronic relapsing diseases. Modern research has shown that addiction is, in many instances, inherited. The tendency to become addicted when exposed to addicting drugs is therefore not under the control of a given person. Increasing the availability of extremely addicting narcotics increases the likelihood of susceptible people coming in contact with these drugs and, thus, becoming addicted. As history has shown us on several occasions, changing social mores (and laws) does not repeal inherited physiology or its consequences.^{1,4,5} The more addicting drugs become available, the more likely it is that people will become addicted, and the more that society will suffer. It is tragic but simple math.

There is another stark reality: In some cases, the only thing that forces someone who is addicted to drugs and spiraling out of control into therapy is the threat (or reality) of incarceration. Do away with laws prohibiting sale of these drugs, and you do away with the only hope of help for so many people who are addicted but just can't stop themselves.

Of course, simply incarcerating addicted patients does nothing to help them overcome their disease. Clearly, we need to expend much more effort on the treatment and prevention of this medical problem. We need to not just talk about but to ensure that proper treatment for this chronic, relapsing disease is available for all of our citizens,

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these data do not take into account the cost of superimposed theft crime to which addicts are driven by the necessity to pay inflated “street” prices for their drugs.

Added to the actual costs are significant lost revenues. The market for illegal drugs in the U.S. is estimated to be between \$200 billion and \$300 billion, almost none of which has been subject to either income tax or sales tax. It is too complex to factor the tax brackets of various suppliers and distributors and the sales taxes of different states, but it is fair to say that a legal market would yield several billion tax dollars to society’s profit.

Added to the huge monetary costs of the war is the untold destruction of the otherwise productive lives of those individuals in prison for an infraction whose harm to society is no greater and perhaps less than that of those who purvey liquor and cigarettes. Our current prison population of more than two million people—now the world’s largest number of incarcerated individuals—is becoming predominantly composed of those men and women arrested for drug-related offenses.

Advantages of legalization

To those individuals who have espoused the “party line” that legalization would result in an increased drug usage it should be pointed out: (1) that the present marketplace for illegal drugs is so huge and so ubiquitous that there is little evidence of restraint resulting from prohibition—indeed, it is now easier in many places for children to obtain illegal drugs than to buy beer; (2) that the criminal “pushers” of illegal drugs are continuously expanding their market by getting kids “hooked,” whereas legal distributors would be required to keep drugs away from children and would ultimately reduce total consumption by putting the criminal marketers out of business; (3) that legal drugs are subject to regulatory controls on distribution, labeling, purity, and advertising, which would eliminate the contamination and overdosing associated with the currently outlawed drugs; and (4) that if only a fraction of the more than \$20 billion enforcement effort were transferred to public education, we could expect to see drug usage follow the recent dramatic pattern of declining consumption of tobacco and alcohol. Education works; prohibition doesn’t.

The depth of prejudice and the impact of misin-

formation on this sensitive issue is so great that the only hope of reversing it is with an authoritative body taking a stand and promoting that position. A small but a significant start has been made by the Drug Policy Foundation, supported by philanthropist George Soros and other groups of concerned citizens. But these efforts have been and will remain ineffectual against the enormous resources of the drug enforcement bureaucracy and the drug cartels of organized crime, both of which would vigorously oppose any attempts at decriminalization. The only realistic possibility of mounting a successful campaign to disseminate the truth lies in the moral, intellectual, and numerical strength of the medical profession. With our initiative to dispel the misleading information, we can expect to be joined by other professions and perhaps even by the judiciary. Both our profession and the public need to be more aware of the National Coalition for Drug Policy Change, which encompasses several hundred individuals, including 95 public officials, 142 physicians, and 82 attorneys. There is also growing outspoken support from prominent individuals such as Milton Friedman and Joseph McNamara of the Hoover Institute, former U.S. Secretary of State George Schultz, and Governor Gary E. Johnson of New Mexico.

As physicians, we must start the process by persuading all of our professional organizations to remove their blinders and declare a position that will change the attitude of the public and our legislators! It will not be without powerful opposition from the richly funded drug cartels and enforcement agencies, but it will be a great service to society. □

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in and out of jail.^{7,8,9} In 1994, the RAND Corporation found that law enforcement costs 15 times more than drug treatment to achieve the same benefit for cocaine addiction. Similarly, a study published in the *Journal of Quantitative Criminology* showed that drug treatment saves about \$19,000 in crime-related costs in the year following treatment. Currently only about a third of those needing treatment for addiction receive it.⁷

Physician involvement

One of the best organizations trying to change policies for the treatment of drug addiction and to refocus the aim of the criminal justice system is the Physician Leadership on National Drug Policy (PLNDP).^{8,9} The basic premise of PLNDP is that

“drug addiction is a chronic, relapsing disease, and...that emphasis on the criminal justice approach alone is not solving drug problems in this country.” Of the 37 distinguished founding physicians, I am proud to note that three (Drs. Claude Organ, Seymour Schwartz, and Donald Trunkey) are distinguished Fellows of the College. The PLNDP believes that we need to treat drug addiction as any other disease and make sure that all physicians are educated to identify and treat this disease. Further, the PLNDP calls for increased research into drug addiction, improved insurance coverage, and for the establishment of community-based health partnerships. The PLNDP does not advocate decriminalization of illicit drugs, but instead calls for “reallocation of resources...and uti-

Educational video looks at being “Out of Control”

Substance abuse” and “surgeons” are words that not many people like to think about going together. But like any other segment of society, the surgical community has no immunity to the problems of alcohol and drug addiction.

Indeed, recent surveys have shown that alcohol and drug abuse is at least as prevalent in the medical profession as it is in the public at large, and surgeons are no exception to that rule. Recognizing that substance abuse is a serious problem for many practicing surgeons and surgical residents today, the Board of Governors’ Committee on Physicians’ Health has given itself the charge to educate surgeons and surgical residents to help them recognize substance abuse in themselves and in their colleagues, and to help affected surgeons obtain the most effective available help that will lead to recovery and rehabilitation.

To that end, the Committee on Physicians’ Health requested that an educational video on substance abuse by surgeons be developed and produced by the College’s Communications Department. The end result was the spring 1995 release of *Out of Control*, a video that is intended to help physicians, surgeons, and surgical residents understand what it means to be out of control with regard to alcohol and drug abuse, and to provide confidential resources to whom people in trouble can turn for help. The video features the real-life, personal stories of

three individuals who have dealt with the problem of substance abuse.

Initially, the video was sent to 6,200 medical directors of U.S. hospitals; 882 medical directors of Canadian hospitals; 1,700 surgical program directors; 50 state physicians’ health committees; 69 chapters of the College (U.S. and Canadian only); the surgical specialty societies; and several other groups allied to surgery. Subsequent requests for copies have brought the total distribution to 10,000.

The reaction to the video has been highly positive, with requests for additional copies or permission to duplicate the video being received from numerous state and private treatment programs, individual surgeons and physicians, state medical associations, medical staff administrators, and various individuals who indicated that they are using the video as part of their educational programs.

The Committee on Physicians’ Health encourages all Fellows of the College and other surgeons to address the problem of impairment due to substance abuse and believes that *Out of Control* is an excellent vehicle for starting an educational program that will achieve that goal. For more information about *Out of Control* or a copy of the video, please contact Linn Meyer, Director, ACS Communications Dept., at tel. 312/202-5311, or via e-mail at lmeyer@facs.org.

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lizing criminal justice procedures that are shown to be effective in reducing supply and demand....”

What can we as physicians do? We can start by educating ourselves and encouraging increased emphasis on understanding and treating drug addiction in medical school and residency training. About one of every five medical students receives no education about substance abuse, and a little over half of medical students receive only a small amount.⁷ Drug addiction affects our patients every day, and surgeons need to be able to identify its effects and know about treatment. Addiction also affects our families and ourselves. Knowing how to spot the symptoms of drug abuse can lead to early intervention and treatment. The College has produced an excellent videotape, *Out of Control* (see p. 21), which deals with the topic of substance abuse by professionals. There are also several good Web sites and organizations that gladly provide information and help on the topic of substance abuse and addiction.^{10,11,12}

Drug addiction is a disease that affects each and every one of us daily. We have the responsibility as physicians to help the fight for better treatment of that disease by our society. That fight, or “war,” is best pursued not just with improved medical therapies, but by also using the laws of our land to protect our citizens from the very real threat of illicit drugs. □

Author’s note: I first became involved with this topic when my son became addicted to alcohol and drugs. He is now in recovery and is working as a drug rehabilitation counselor here in Arkansas. Our family is grateful for his progress but realizes that his is a lifelong medical problem; relapse is just one symptom of the disease. In our case, it was only with the assistance of the courts and the legal system that we were able to first get him into therapy. Without a beneficial legal and criminal justice system in this country, many people would not be exposed to this essential treatment, especially when they are out of control and addicted. I know that our case is not unusual and, in fact, is quite typical. My hope is that we as physicians can influence the system and encourage more widespread and accessible treatment for all patients afflicted with this disease.

If you, your family, or your friends need help, please contact one of the agencies listed in the references that follow or your local chapter of Alcoholics or Narcotics Anonymous. Just remember—you are not alone, and there is a lot of help out there. Just ask.

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Physicians and the war on drugs

Dr. Roe responds

I am pleased to respond to Dr. Mabry's presentation of the case against the legalization of illicit drugs.

First, it should be noted that at no point did I assert that illegal substances are harmless, only that their harm has been exaggerated and that they are not associated with the kind of significant pathology identified with tobacco and alcohol. Indeed, there are far greater health reasons for outlawing those substances. The mere fact that Dr. Mabry refers to drugs and alcohol in the same context supports my point. This connection necessarily, but presumably unintentionally, implies that alcohol should be made illegal again. Further, Dr. Mabry's reference to the continued enormity of the drug problem is an acknowledgement that the drug war has been a futile failure as a means of addressing the nation's drug problem.

I also maintain that his reference to trauma as a consequence of drugs is a non sequitur to the issue of legality. Does he mean to imply that autos, guns, boats, and contact sports should be outlawed as a means of reducing injuries? Moreover, his correlation between drugs and violent crime actually supports my position, as the violence is a product of either illegal sales or the high cost of illicit drugs motivating theft to finance the habit. Violent crime would virtually disappear with cheap, legal drugs.

In addition, Dr. Mabry asserts that I am disingenuous in citing the position of the National Coalition for Drug Policy Change as being in support of legalization. Apparently, he doesn't recognize

that this group, along with the Drug Policy Foundation and others, privately acknowledges the failure and fallacy of prohibition but for political reasons is cautiously deferring a position on legalization so as not to appear too radical. I have simply chosen to articulate the "extreme" objective they are hesitant to seek publicly in the presence of strong public opinion generated by the government's fraudulent marketing of the drug "demon."

Nonetheless, I am encouraged by Dr. Mabry's points advocating treatment and education, which obviously imply that incarceration (the consequence of illegality) is counterproductive. This is exactly the direction I would hope would result from redirecting the effort and megabucks expended on the "drug war" toward therapy and support for those addicted.

As a final thought, I would recommend that all individuals who are concerned about this issue read the July 28-Aug. 3, 2001, issue of *The Economist* with the cannabis leaf cover and the headline, "The case for legalizing drugs." 

Physicians and the war on drugs

Dr. Mabry's rebuttal

One thing I will say about Dr. Roe, he may be wrong, but he is never in doubt. Dr. Roe's response to my counterpoint article is, as expected, replete with the same misinformation contained in his original article. Rather than respond to Dr. Roe point by point, I will simply let the readers decide for themselves what he and I actually said and meant in our articles and encourage them to check out our references. But, most importantly, let's not take our eye off the ball.

Regardless of his appreciable zeal, Dr. Roe ignores the science of genetics and physiology. The primary problem with his vision of America—dishing up a buffet line brimming with hard drugs and allowing all to partake—is that some in the crowd will have been born with a genetic tendency to become addicted. While those individuals amount to only about 10 to 15 percent of the population, they are likely to become 100 percent addicted if exposed.

Moreover, those individuals that do become addicted often lose interest in all they hold dear, and will pursue drugs at all cost, with predictably bad results. Dr. Roe believes that because the majority of the population can occasionally use addictive drugs, it's a wonder what all the fuss is about. I, conversely, argue that society should protect the minority from easy exposure to potentially lethal drugs and expand treatment for those who have succumbed. Those who professionally treat addicted patients know firsthand what is and is not important in the battle against drug abuse and addiction. Interestingly, I cannot find one drug-

rehabilitation professional who calls for increased supplies of purer and cheaper illicit drugs for our nation. Surely, they all can't be wrong.

Next, I want to re-emphasize to the readers my argument for improved education of health care professionals about the topics of drug abuse, addiction, and treatment. I want to further encourage all physicians to become involved with how society deals with these very real problems (including efforts to get needed therapy to those in trouble), to look at alternative sentencing for drug related offenses, and to increase public awareness of the overall problem of addiction.

Like Dr. Roe, I too would refer the readers to *The Economist*, but in this instance to the March 27, 1997, issue, which contains an excellent article about the newer model of justice delivered by "drug courts." This is a process in which the legal system helps with treatment for first or second offenders by backing up treatment recommendations with mandatory drug testing and the threat of jail for noncompliance. The Urban Institute has recently shown this approach to decrease the relapse rate threefold compared to the traditional court system sentences.

Finally, I would like to thank the editorial staff, the *Bulletin* advisors, and the College leadership for allowing us to discuss this controversial but important topic and for the opportunity to bring this serious matter to the attention of the Fellows. □



Making Washington work for you:



“All politics is local”



**by Christian Shalgian, Senior Government Affairs Associate,
and Erin LaFlair, Legislative Assistant, Division of Advocacy and Health Policy**

Tip O'Neill, former Speaker of the House of Representatives, once observed that "All politics is local." The validity of this expression is frequently demonstrated through efforts made by professional societies to convince members of Congress to assist in advancing certain pieces of legislation. When thinking about becoming involved in this process, it is important to recognize that every representative faces election every two years and senators are elected for six-year terms. Consequently, legislators are forced to listen to their constituents, who determine whether or not they return to Congress. Indeed, it appears to many people that the number one priority of every member of Congress is to be reelected. If, in fact, all other priorities take a back seat to reelection, obviously, legislators who fail to succeed in that regard are forced to watch Congress from the outside.

The College's staff in Washington, DC, plays a vital role in keeping legislators and their advisors informed about issues that are important to surgeons and their patients. Nonetheless, it is not the lobbyists who vote for these members of Congress. The message truly hits home only when a member of Congress hears from surgeons in his or her home state or district. For example, the House voted recently on an amendment that would have imposed long-sought medical liability reforms. It failed by a vote of 207-221. In speaking with certain members of Congress after the vote, it became clear to us that they had heard from lobbyists on both sides, but they had heard from constituents on only one side of the argument—the side opposed by the College. That input from constituents determined their votes.

Overleaf: Top photo, left to right: Desmond Birkett, MD, FACS, and Rep. Jim McGovern (D-MA).

Middle photo, left to right: Adrienne Roberts; Rep. Dennis Moore (D-KS); Stephen Myrick, MD, FACS; Joe Bosiljevac, MD, FACS; and Stephen Smith, MD, FACS.

Bottom photo, left to right: Andrew Warshaw, MD, FACS; Kevin Hayes, Medicare Payment Advisory Commission; Sarah Bianchi, office of Sen. Edward Kennedy (D-MA); Sohini Gupta Jindal, office of Sen. Evan Bayh (D-IN); Lee Stevens, office of Gov. Mike Easley (D-NC); Lisa Meyer, office of Sen. Pat Roberts (R-KS); and Sonya Sotak, office of Sen. John McCain (R-AZ).

In an effort to encourage more of you to participate in this process, the College has developed a variety of tools to assist surgeons in becoming involved in the legislative process.

Legislative Action Center

The methods available for communicating with members of Congress have changed dramatically in the past decade. E-mail now allows constituents to instantly send their opinions to their senators and representatives, which can be important when the normally slow pace of the legislative process picks up speed.

In an effort to provide Fellows with a means to instantly send messages to their senators and representatives, the College recently added a new section to its Web site (<http://capwiz.com/facs/home/>). The Legislative Action Center is intended to provide Fellows with information about key legislative issues being considered by Congress and, most importantly, to allow surgeons to send messages directly to their legislators about these issues. Surgeons who do not know the name of their senators or representatives can simply enter their home zip code, and the Legislative Action Center will identify the legislators and provide the appropriate e-mail addresses.

The Legislative Action Center also allows the user to access prewritten (form) letters on time-sensitive issues. In order to send such letters, users need only enter their name and home address, and the Legislative Action Center does the rest.

Members of Congress receive hundreds, sometimes thousands, of e-mail communications each day. To ensure that the e-mail from users of the Legislative Action Center are used effectively, the correspondence is automatically copied to the College's lobbyists, who take them in hand to legislators and their staffs to provide evidence of grassroots support for particular issues.

Congressional Action Program

Staff members of the Washington Office have been traveling to College chapter meetings and speaking with surgeons about the health care issues that Congress is working on and how they could affect surgical practice. These visits provide a two-way opportunity for surgeons to gain information about what is happening in Con-

gress and for the lobbyists to hear from practicing surgeons about their concerns. The visits also provide opportunities to recruit surgeons to participate in the Congressional Action Program (CAP). These surgeons have committed to communicating with their members of Congress and with College staff on a regular basis about important surgical issues on the legislative agenda. E-mails are sent to CAP members when input is needed, and legislators and their staffs have come to rely on them as resources when drafting legislation or determining whether to support or oppose a particular proposal.

Chapter Visit Program

The College launched the Chapter Visit Program in 1988, and it has proven to be one of the most successful ways to involve Fellows in the legislative process. The goal of the program is to educate Fellows about the legislative process and important issues being debated that can affect them and their patients, as well as to promote the College's legislative agenda. The program also provides an opportunity for both College staff and the legislators to hear from Fellows about issues that are of concern to surgeons in the field, as well as about possible solutions to these concerns. Issues the College and its Fellows have brought to Capitol Hill in the past few years include managed care reform, physician reimbursement, Medicare reform, regulatory reform, and trauma care funding. This year representatives from 19 ACS Chapters visited Washington to participate in this program.

Day in Surgery

The Day in Surgery Program began in 1990 in the Washington, DC, metropolitan area. This program was created to provide congressional aides with an opportunity to experience a "day in the life" of an attending surgeon and see firsthand how surgeons are trained. Congressional staff learn about patient care, the operating room environment, surgical training, and various daily routines. In 1996, the program was expanded nationally by coordinating hospital visits through state chapters and other surgical specialty societies. To date, Day in Surgery programs have been held in North Carolina, Texas, Florida, Louisiana, Washington, Minnesota, Tennessee, Michigan, and Massachusetts.

Two or three programs are scheduled during the congressional recess periods each year. Fellows also are encouraged to invite their own legislators and staff to visit their hospital. Anyone who is interested in coordinating a visit is welcome to contact the Washington Office for details.

Your involvement is very important

The importance of surgeons becoming involved in the legislative process at the federal and state levels cannot be stressed too strongly. As the health care environment continues to evolve and the regulation of health care continues to grow, legislators require constant education from those who understand the system and who are promoting optimal patient care. Lobbying for the profession is important and can lead to positive changes for both surgeons and their patients.

For more information on any of the College's grassroots programs, please contact Christian Shalgian in the College's Washington Office at 202/337-2701 or e-mail cshalgian@facs.org. 

Keeping current

Introducing *ACS Surgery: Principles and Practice*

by Adrienne M. Stoller, New York, NY

This year's Clinical Congress of the American College of Surgeons revealed many exciting innovations in surgical practice. And for those individuals seeking the latest in surgical information, WebMD® was proud to introduce to the ACS membership the newly published *ACS Surgery: Principles and Practice* (formerly *Scientific American® Surgery*).* Sponsored by the American College of Surgeons, *ACS Surgery* is a symbol of our continued partnership with the ACS in its efforts to educate members and formulate standards of patient care. And even though the text has a new name and look, readers who are familiar with *Scientific American Surgery* will still find all the important features and information they have come to appreciate.

New, convenient format

ACS Surgery skillfully fuses the explosion of new clinical information with the tools to make quick, confident surgical decisions. The loose-leaf print version of the former *Scientific American Surgery* is now superseded by a more convenient, single-bound volume, along with a free accompanying CD-ROM that contains more than 1,200 illustrations and electronic versions of decision-making treatment algorithms found in the text, live-action videos of certain surgical procedures, and links to the latest surgical news and clinical perspectives on WebMD. *ACS Surgery* is also available online on WebMD's physician site at www.webmd.com.

Modern, practical focus

Like its predecessor, *ACS Surgery* has been designed to address the urgent and crucial decisions surgeons make daily, and it helps fulfill their information needs by providing a practical surgical

reference that includes the following:

Logical organization and new content. The newly published *ACS Surgery* is logically organized to coincide with the way that surgeons practice, with presenting problems addressed first. The emphasis is on diagnostic and therapeutic decision making to help surgeons make timely and precise decisions. Divided into nine major sections comprising over 100 chapters, *ACS Surgery* features the expertise of over 180 master surgeons who guide users with their insights on current surgical practice. They reveal concise and thoughtful approaches to the workup of common clinical problems, as well as provide practical troubleshooting tips and recommendations for postoperative management. And in response to rapid advances in surgical training and practice, *ACS Surgery* has broadened its coverage to include new chapters on laparoscopic splenectomy, carotid arterial procedures, asymptomatic carotid bruit, repair of infrarenal abdominal aortic aneurysms, and more.

Evidence-based approach. Over recent years, education and developments in surgical practice have culminated in an increasing shift from tradition-based behavior to evidence-based behavior. This change in focus toward decision making based on qualified studies corresponds with the need to demonstrate how such information will benefit the way surgeons manage their patients and facilitate quality of care. *ACS Surgery* embraces this concept, as we have incorporated information derived from qualified studies reflecting current findings in modern medicine. Thousands of end-of-chapter references support the text's evidence-based approach and encourage further reading.

Treatment algorithms. With a shift toward evidence-based medicine, treatment algorithms provide a useful guide through the decision-making process, while explaining the rationale for each clinical pathway. In fact, *ACS Surgery* includes treatment algorithms throughout virtually every nontechnique-oriented chapter, providing a step-

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by-step approach for evaluating, rationalizing, and managing crucial decisions. And if you refer to the treatment algorithms featured in *ACS Surgery* online on WebMD's physician site at www.webmd.com, you will find they are designed to be interactive, including the ability to scroll up and down or left and right to bring various parts of the image into view, with further instructions and explanations provided regarding each decision-making step.

Illustrations. *ACS Surgery* features more than 1,200 drawings, graphs, and photos that work together with the text to synthesize key points and promote better understanding. What is more, the illustrations are available for personal use; whether they are being used for a presentation or for educational purposes, users can easily obtain these illustrations from the print version's accompanying CD-ROM or from *ACS Surgery* online.

Continuous updating. Like *Scientific American Surgery*, *ACS Surgery* is continuously updated, with the introduction of at least two new or revised chapters each month. This new material will be incorporated into the bound volume of *ACS Surgery* on an annual basis, and new editions will be made available to existing and future subscribers. For those individuals who are interested in immediately accessing new content, we encourage surgeons to visit the WebMD site, where they will find the new and revised chapters posted each month.

Continuing medical education needs

Modern surgical practice demands an easy and convenient way to meet continuing education requirements, and now surgeons can fulfill a significant portion of their CME needs right at their desktop with the *ACS Surgery* self-assessment program at www.webmd.com. Each month, a series of case-based self-assessment questions are published that

are worth up to 10 hours of Category 1 CME credit. And if you don't have time to complete a test in a single session, you have the option of returning to the test at a later time by simply bookmarking the page. The self-assessment program is accredited by the University of Alabama School of Medicine and requires a \$50 registration fee that covers up to 120 hours of credit or 12 months of use, whichever comes first.

Recognizing today's changing health care environment, *ACS Surgery* exemplifies the core ideals of surgical practice, including optimal patient care, scientific research, and training. So whether in print or online, the new *ACS Surgery* will carry on the tradition of providing the most up-to-date, relevant clinical information available for and by the practicing surgeon. 

ACS Surgery is available both in print and online. The online version features interactive treatment algorithms, printable illustrations, references hot-linked to MEDLINE, and monthly updates of new and revised chapters, and may be found on WebMD's physician Web site at www.webmd.com.

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

College establishes Office of Evidence-Based Surgery

During their June 8-10 meeting, the ACS Board of Regents approved the establishment of a new Office of Evidence-Based Surgery. This branch of the College's growing Division of Research and Optimal Patient Care is intended to support the organization's mission of promoting the highest standards of surgical care through evaluation of surgical outcomes in clinical practice. By generating information on best practices and educating surgeons on how to incorporate evidence-based information into their daily practice, the Office of Evidence-Based Surgery responds to increasing public and governmental scrutiny of quality of care and patient safety.

More specifically, the office's purview includes: (1) developing and managing new programs to provide the best evidence on surgical practice through the measurement of surgical outcomes, meta-analyses, longitudinal studies, surveys, evidence-based practice guidelines, and facilitation of clinical trials; (2) providing resources to the other operating units in the Division of Research and Optimal Patient Care; (3) collaborating with the Divisions of Education, Advocacy and Health Policy, and Member Services to provide educational programs and to promote public policy initiatives in outcomes research; and (4) forming partnerships and undertaking collaborative activities with outside groups and organiza-



Dr. Mooney



Ms. Johnson

tions involved in the evaluation of surgical outcomes, largely through grant-supported activities.

At press time, the office was in its start-up phase, but it is anticipated that all new programs in outcomes research will be managed through this office, exclusive of programs that are managed by Cancer and Trauma. Although new program ideas may be generated by other areas of the College, this office will be responsible for final development and management of new programs involving evaluation of surgical outcomes in clinical practice. Similarly, the office will generate ideas and oversee the content of educational and advocacy programs related to outcomes research, but the Divisions of Education and Advocacy and Health Policy

will be responsible for implementing those programs. For example, the Office of Evidence-Based Surgery might determine the need for an educational program for surgeons regarding the use of evidence-based information in clinical practice, but the Division of Education would be responsible for developing and presenting the course, and Communications would be charged with marketing it.

Conversely, other operating units of the College might generate ideas that the office will implement. For example, the Division of Advocacy and Health Policy might request a survey of the membership on a particular practice issue or policy recommendation, and the Office of Evidence-Based Surgery would develop the survey to ensure that it is designed, conducted, and

analyzed through the use of appropriate methodologies.

The Office of Evidence-Based Surgery also will provide resources and staff that may be shared across all operating units within the Division of Research and Optimal Patient Care. For example, grant-writing expertise is part of the office's infrastructure but will be available to the Trauma and Cancer programs.

For the short-term, though, the office is striving to meet some of the College's more immediate needs. One short-term goal is to provide grant management support for existing activities at the College, according to Margaret Mooney, MD, Interim Director of the Office of Evidence-Based Surgery. Specific objectives for the office will become more defined over time. Another short-term objective is the development and management of new initiatives, such as collaboration between the ACS and the Veterans Administration on the National Surgical

Quality Improvement Program (NSQIP), funded by the federal Agency for Healthcare Research and Quality (AHRQ). Finally, the office has also participated in the submission of two other successful requests for grants from the AHRQ, Dr. Mooney said.

Currently, the office is staffed by two individuals: Dr. Mooney and Kathy Johnson, who serves as the office's Research Manager. Dr. Mooney came to the College in the summer of 1999, serving as the Medical Officer for the American College of Surgeons Oncology Group. Dr. Mooney attended the University of Virginia, Charlottesville, where she received a bachelor of arts degree in speech communications. She subsequently attended the Massachusetts Institute of Technology in Cambridge, where she received a master of business administration degree in management, and she earned her medical degree from the University of Chicago. Just prior to coming to the College, Dr. Mooney com-

pleted a surgical oncology fellowship at the Roswell Park Cancer Institute in Buffalo, NY.

Ms. Johnson joined the College two years ago after working in San Antonio, TX, as the chief operating officer of the Institute for Drug Development, a division of the Cancer Therapy and Research Center. Ms. Johnson has worked in the health care field for more than 30 years, serving in various positions in government and the private sector. She received a bachelor of science degree in chemistry from Louisiana State University, Baton Rouge, and a master's degree in administration with a concentration in operations research from George Washington University in Washington, DC. More recently, she was awarded a juris doctorate degree from Catholic University in Washington, DC.

Other positions not yet filled at press time include two research analyst posts, a project manager position, and the job of data manager.

CAS-ACS addresses concerns of future surgeons

The Candidate and Associate Society of the American College of Surgeons (CAS-ACS) was formed in 1999 to benefit surgeons of the future through involvement in activities of the College. The mission of this organization is to: (1) familiarize residents and young surgeons in all surgical specialties with the College's programs and leader-

ship, (2) provide an avenue for participation in College affairs, (3) enable members to develop and use leadership skills in organized surgery, and (4) provide opportunities for the opinions and concerns of residents and young surgeons to be heard by College leadership.

The CAS-ACS is organized into a Council of Representa-

tives, who are nominated by ACS chapters (one general surgeon and two specialty surgeons per chapter). The Council of Representatives forms 12 surgical specialty caucuses that nominate members to the Executive Committee and working committees.

The Council of Representatives acts as a liaison between

the CAS-ACS and the local chapter, region, hospital, clinic, and university. The CAS-ACS Council of Representatives has 130 members representing 51 of the 69 ACS chapters in the U.S. and Canada. Representatives are selected by each specialty caucus as representatives to the advisory council. These members attend their respective semiannual advisory council meetings to represent CAS-ACS members in their specialty.

Committees

The CAS-ACS committees—Education, Communications/Career Opportunity, Issues, and Membership—form working groups to carry out the goals of the society.

The major initiative of the Education Committee is to review the Accreditation Council for Graduate Medical Education's general competencies for residents in all specialties, and work with the Residency Review Committees to provide the perspective of residents in achieving and measuring the following competencies: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The committee is also working to make educational and practice management tools available from the CAS-ACS home page on the College's Web site.

The Communications/Career Opportunity Committee assists in the development of a Web page for the CAS-ACS and maintenance of an electronic database of career opportunities

for residents and young surgeons. The CAS-ACS Career Opportunities Position and Resume Data Bank (<http://web.facs.org/jobs/toc.htm>) has received an average of 10,000 hits per month.

The Issues Committee considers matters of importance to residents and young surgeons, and is working to develop recommendations for dissemination to the surgical specialties as models for implementation. These issues include: family leave, moonlighting practices, work hours, ethics, and professionalism.

Resident work hour limitations have been the subject of much debate and have recently been in medical news as regulatory agencies vie for jurisdiction over this important matter. The CAS-ACS feels it is crucial to take a proactive stance regarding resident work hours, to study the available data, and to formulate a model statement that will maintain excellence in patient care while addressing the primary issues.

The CAS-ACS's Clinical Congress program, held Sunday, October 7, in New Orleans, LA, was devoted to the topic of resident working hours. The objective of the program was to produce a statement to present to the ACS Board of Regents for adoption as the College's position on this issue.

The Membership Committee is working with the ACS Taskforce on Member Benefits to recruit residents as members of the CAS-ACS and increase selection of council members from the chapters to reach full representation. The committee is

working to make known the benefits and activities of the CAS-ACS and to promote mentoring relationships for residents so they may be able to chart the challenging course of their early career and involvement in organized medicine with guidance and personal support.

The society recognizes that the interests of young surgeons may be quite different from those of surgeons who have been in practice for 10 or 20 years. The CAS-ACS offers a way for these young surgeons to participate in the College, to develop and use leadership skills, and to present their viewpoint to the College.

Membership in CAS-ACS is automatic on becoming a member of the ACS Candidate Group or an Associate Fellow. Further information on the society may be obtained on the College's Web site at www.facs.org/cas-acs, or by contacting Susan Grunwald, tel. 312/202-5231, e-mail sgrunwald@facs.org.

The ACS coding hotline has answered more than 100,000 coding questions.

Have you taken advantage of this membership service?

The College's coding hotline—800/ACS-7911 (800/227-7911)—was established over five years ago to provide Fellows with immediate access to coding specialists specifically trained in procedural coding for your specialty. These specialists have direct access to a dynamic database organized by procedural code, payor, and state. The database is updated on a regular basis.

Since the hotline's inception, calls have increased from 15 per day to more than 50 per day. Because of this growth and in order to continue the quality of service you have received in the past, it has become necessary to adopt stricter guidelines for hotline usage as follows:

- Confirmation of ACS Fellowship is required to obtain Hotline assistance. The Hotline staff will ask that Fellows give their Fellowship identification number when calling the Hotline. Hotline services are provided and measured in Consultation Units (CUs.) One CU is a period of up to 10 minutes with additional 10-minute increments or portions thereof charged at one CU per 10-minute increment. Hotline services are limited to two CUs for each tele-

phone call. Calls over 20 minutes may require private consultation. Each caller will be advised of appropriate consultation fees to conduct said review (i.e., reviewing operative notes, etc.).

- ACS Fellows are given 10 consultation units (CUs) in one 12-month period. Unused consultations will not roll over into the next 12-month period. Additional CUs are available for purchase by Fellows at the prevailing

Physician Reimbursement Systems (PRS) retail price (\$230 per 10 additional units through June 31, 2001). Operative notes are not eligible for ACS Hotline services. Coded operative notes will only be reviewed using individually purchased CUs at the prevailing PRS retail price.

- The hours of operation are from 7:00 am to 4:00 pm (MT), Monday through Friday, holidays excluded.

The CAS-ACS: Communication is the key

by Jeffrey S. Upperman, MD, Pittsburgh, PA

The Candidate and Associate Society of the American College of Surgeons (CAS-ACS), an organization within the College, was formed to benefit surgeons of the future through involvement in activities of the ACS. The mission of this organization is to:

- Familiarize residents and young surgeons in all surgical specialties with the College and its programs and leadership.
- Provide an avenue for participation in College affairs.
- Enable members to develop and use leadership skills in organized surgery.
- Provide opportunities for the opinions and concerns of residents and young surgeons to be heard by the College leadership.

Effective communication is the key to any successful organization. As a result, the Communications/Career Opportunity Committee of the CAS-ACS is actively involved in efforts to address key goals of the College by developing a coordinated communications strategy.

For instance, this past year the Communications/Career Opportunity Committee has focused on refining our Web pages and on augmenting the communications resources that are available to all Candidates and Associate Fellows. In conjunction with the College's Communications staff, we have

embarked on a wholesale revision of the current CAS-ACS Web site and are in the process of creating a Web environment that is user-friendly, interactive, colorful, and content-rich.

The most important feature of our new Web pages will be the delivery of content that is vitally important to Candidates and Associates. As a result, the CAS-ACS Communications/Career Opportunity Committee will be working in collaboration with the CAS-ACS Education Committee and with various committees and areas of the College to offer online access to educational and practice management tools. We envision featuring topics that are on the active agenda of our Issues Committee and providing a survey tool that will allow our organization to hear from surgical residents and Associates.

Finally, effective communication means disseminating our organized view on issues that affect young surgeons and surgeons-in-training, such as work hour rules and the Family Medical Leave Act.

Our strategy for improving communications among our constituents is straightforward. We will assemble on an annual basis as a council of representatives and set the agenda for the upcoming year. We will raise concerns about

the status quo and offer a "half/full" analysis of issues that pertain to young surgeons. The CAS-ACS is chock-full of dynamic speakers and writers who will provide a vibrant and youthful outlook on a surgical career in fiscal year 2001 and beyond. Our immediate challenge will be enhancing existing resources and placing the "CAS" touch on ACS activities.

Our Web-based overhaul is moving forward with lots of promise. We have outlined the new layout strategy for our Web pages within the College's Web site. Our "new and improved" Web pages will be extremely accessible to the average resident who has little time and great responsibility and will offer a quick and easily navigated environment that will keep the viewer focused and satisfied. The content will include membership applications and general information. New areas under development in the CAS-ACS Web neighborhood include money management tools, interactive bulletin boards, and surgical specialty links.

We have high expectations for interactivity through our Web environment. We anticipate using survey tools and chat rooms to enhance our understanding of the issues of most concern to our members. Armed with this information,

the CAS-ACS leadership can formulate an agenda that focuses on topics that residents and Associates have identified as being important.

We cannot do it all alone. Most residents surf the Web, so it is important to us that when you arrive at the CAS-ACS Web pages you can get what you need and what you want. Therefore,

we need to know what you are interested in and how you would like it delivered.

The first step is to join the CAS-ACS. We are gaining recognition on the national level, but it is just as important for residents and Associates to participate at the local and regional level and to organize local chapters of the CAS-ACS. We invite

all residents and Associates who are interested in making a difference to join the CAS and help us help you.

***Dr. Upperman** is a pediatric surgeon at the University of Pittsburgh (PA) School of Medicine and the Children's Hospital of Pittsburgh. He is Chair of the CAS-ACS Communications/Career Opportunity Committee.*

Trauma seminar to be held in Kansas City

The College's Committee on Trauma, Region VII (Iowa, Kansas, Missouri, and Nebraska) is sponsoring the 24th annual Advances in Trauma seminar at The Westin Crown Center in Kansas City, MO, November 30-December 1, 2001.

Program chairs are: Michael H. Metzler, MD, FACS, Chief, Region VII; Thomas M. Foley, MD, FACS, Iowa State Chair; R. Stephen Smith, MD, FACS, Kansas State Chair; Marc J. Shapiro, MD, FACS, Missouri State Chair; Joseph C. Stothert, Jr., MD, PhD, FACS, Nebraska State Chair; and Frank L. Mitchell, Jr., MD, FACS, Program Co-Chair.

The purpose of this continuing medical education course is to present nationally recognized faculty who will discuss timely trauma and critical care issues aimed at improving care of the acutely injured patient. Current trauma diagnostic and therapeutic techniques will provide the audience with the most up-to-date information available.

The Friday program will include presentations on: Contemporary Neurosurgical Approach

to "Minor" Head Trauma: The McGill Concussion Protocol; Telemedicine: The Next Trauma Frontier?; Prehospital Care: When to Stop; Use of CT Scan in Clearing the Cervical Spine; Priorities in Management of Profound Shock; CT As a Predictor of Failure of Nonoperative Management of Solid Organ Injury; Adventures of the Verification Review Committee: Why Trauma Centers Fail Review; Traumatic Aortic Disruption: Diagnose How? Fix When?; Alternative Surgery in Trauma Management; Kinematics of Blunt and Penetrating Trauma; and Problem Cases in Trauma.

Saturday's program continues with: Medicine As an Industry: An Ethical Dilemma; Alcohol Abuse and Impact on Injured Patients; Prevention to Basic Science; Giving Bad News; Diagnosis of Shock: Is ATLS® Correct?; Management of Penetrating Thoracic Trauma; ARDS Update: Etiology and Treatment; Evidence-Based Trauma Care: What Do We Have and What Do We Need?; The Injured Heart; Is the Pulmonary Artery

Catheter Useful in Trauma Patients?; and Region VII Problem Cases.

Optional sunrise sessions on Friday and Saturday mornings include: Percutaneous Tracheostomy Course; and Forming Community Partnerships, Trauma Education, and Prevention.

Faculty members include: LD Britt, MD, FACS; Elizabeth Carlton, RN, MS, CCRN; Robert L. Coscia, MD, FACS; David V. Feliciano, MD, FACS; Thomas M. Foley, MD, FACS; Karen M. Johnston, MD, PhD, FRCSC; Gregory J. Jurkovich, MD, FACS; Ronald V. Maier, MD, FACS; F.A. Mann, MD; Kenneth L. Mattox, MD, FACS; Norman E. McSwain, Jr., MD, FACS; Michael H. Metzler, MD, FACS; Frank L. Mitchell, Jr., MD, FACS; Wallace N. Patrick, RN; R. Lawrence Reed II, MD, FACS; Marc J. Shapiro, MD, FACS; R. Stephen Smith, MD, FACS; Joseph C. Stothert, Jr., MD, PhD, FACS; and Donald D. Trunkey, MD, FACS.

Further information may be obtained on the ACS Web site at www.facs.org.

American College of Surgeons

CAREER OPPORTUNITIES POSITION AND RESUME DATA BANK NOW ONLINE

A Career Opportunities Position and Resume Data Bank is now online on the American College of Surgeons' Web site at <http://web.facs.org/jobs/toc.htm>. The data bank is available to Fellows and resident and young surgeon members of the Candidate and Associate Society (CAS-ACS) and is being provided at no cost. It provides Fellows with a location for listing employment and fellowship openings, and with the ability to search a list of surgeons seeking employment or practice opportunities. CAS-ACS members seeking employment or fellowships can post their resumes and interests at no cost and can access the employment opportunity listings. All that is needed to use the data bank is an ACS membership identification number. For more information about this service or the CAS-ACS, contact Susan Grunwald at the ACS via e-mail at sgrunwald@facs.org or tel. 312/202-5231.

AWS Foundaton announces Visiting Professor Program

The Association of Women Surgeons (AWS) Foundation has announced the initiation of the AWS Foundation Visiting Professor Program. The intent of this program is to heighten the visibility of women surgeons and to encourage women medical students to pursue similar careers. This year's host site is the University of Louisville, and the visiting professor is Julie

Ann Freischlag, MD, FACS.

The AWS Foundation Visiting Professor participates in a two-day program, which typically involves lectures, discussion groups, patient evaluations, patient rounds, and possibly operative procedures. The AWS Foundation selects the visiting professor and the host site, which facilitates the visit and provides opportunities for inter-

action between the visiting professor and local women surgical faculty, residents, and students.

Information about the program or about becoming a host site or a visiting professor is available from the Association of Women Surgeons, 414 Plaza Dr., Ste. 209, Westmont, IL 60559; tel. 630/655-0392, fax 630/655-0391, Internet <http://www.womensurgeons.org>.



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.



Letters...

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

What surgeons can/can't do

I read Dr. Josef Fischer's article in the August 2001 *Bulletin* and every point he described hit home. When I graduated from the University of Cincinnati in 1990, who would have thought our medical system would be like it is today?

Dr. Fischer is correct in describing the depression we young surgeons have in trying to maintain viable independent practices. Imagine being 37 years old and in your fifth year of solo practice and noting that your overhead is going to increase another \$5,000 per month, while reimbursements are continuing to shrink. Insurance companies have targeted us for fraud because they can't believe we're still in practice, since they figured they'd put us out of business by now.

To this point, I've survived by sheer guts and working seven days a week and being on call 24 hours a day while taking maybe a week off per year. I've been lucky in that the cosmetic surgery I do has allowed me to survive, but it only makes up less than 25 percent of my practice.

Dr. Fischer is also correct in that, given the choice, I, too, will quit medicine before 60 years of age. I, too, have cut down on my emergency room call because not only does it cause an unbelievable burden on my family life, it has affected my health. In

some hospitals a significant amount of emergency room care I did was gratis. Now, I take call in only two hospitals instead of six. Though we are altruistic as physicians, it can't come at the expense of our families and personal well-being. I, too, will do my best for the indigent when I am on call, but I'm starting to limit those opportunities because it has not addressed the issue of how I am going to pay my expenses each month.

I've been guilty of "hamster health care" in the first four years of practice as was described in Dr. Fischer's article. I've seen 2,300 new patients the first years of practice and still feel I've provided quality care. I slowed down this year because I realized that I couldn't continue the quality of care my patients deserve if I stayed on the current pace. My family life has also improved. I am no longer leaving the house every other night after dinner to answer an emergency room call. My biggest fear is that as my overhead again increases, I will be forced on that treadmill again.

I appreciate Dr. Fischer's enlightening article as it truly depicts the predicament young surgeons are in. I wish other surgeons could voice their concern and understanding of the struggles we all currently face. I hope to stay off that treadmill. But, what can we do about it?

**Raymond Seballos,
MD, FACS**

Dr. Fischer enumerates in detail many of the complaints from many surgeons leading to early retirement for those who can afford to. Briefly summarizing, the

complaints revolve around declining reimbursements, increased overhead, the hassle factor, and a lack of appreciation and respect for surgeons in general by society.

On the other hand, in the same issue of the *Bulletin*, Dr. William R. Greene writes about the incredibly rewarding experience of a team of surgeons traveling to Haiti at their own expense to provide life-saving care to a group of patients who would otherwise suffer and die. I would think that Dr. Greene and his team also have declining reimbursements, increasing overhead, and the hassle factor to deal with, but instead of self-pity and materialism, this group of dedicated physicians found incredible satisfaction from the practice of medicine without financial reward.

Furthermore, Dr. Fischer recommends that surgeons and organized medicine should leave the problem of the uninsured to society since physicians can't solve this problem.

Dr. Fischer, who is more qualified to lead society on this issue than physicians? We are in this predicament because organized medicine has opposed universal health care since its initial proposal right up to today. We created the mess—it's our responsibility to lead and contribute towards the solution. Imagine if Branch Rickey and Jackie Robinson left it to society to integrate baseball, or Martin Luther King left it to society to allow blacks to vote, students left it to society to end the war in Southeast Asia, or today's activists left it to the corpora-

tions to clean up the environment and treat workers fairly.

I wish to conclude on an incredibly optimistic note. Like many veteran docs, I come from humble surroundings. With a declining income, I still maintain a lifestyle way beyond the kid who slept on the couch until ninth grade. I help people. Compared with 27 years ago, the tools I have today to help my patients are so much more advanced than anyone could have imagined when I went to medical school.

If the Lord grants me continuing good health and the ability to practice quality care, if patients continue to come to my office and physicians continue to refer to me, I look forward to an even brighter future.

Jerry Frankel, MD, FACS

After reading the August *Bulletin*, reality seems to be slowly creeping in. The excellent article by Dr. Josef Fischer and comments in the "Letters" section by Drs. Kyle Ver Steeg and George Saj summarize our sorry state. Now, if only the College could do something about the problem! The individual is powerless.

Arthur Verga, MD, FACS

Amidst his well-informed exposition about medical care of the indigent, Dr. Fisher does "not believe that organized medicine, or even disorganized medicine...or individual practitioners can solve...this societal problem."

Why can we not solve this pressing health care problem? We have been progressively disenfranchised by forces that five years ago prompted my editorial

entitled "The tyranny of managed care" (*Annals of Thoracic Surgery*, 61:6-7, 1996). Also, there are public and legislative misconceptions about the practice of medicine, and there is continuous, relentless doctor bashing in the press. There has been excessive emphasis on cost without adequate attention to the value of medical care.

Dr. Fisher has overlooked one of our most precious resources—the *doctor-patient relationship*. We have the privilege of solving or assisting with people's problems. This includes sacred moments during postoperative encounters with patients' families. Our first responsibility is to our patients. However, when the emotions of the moment have settled down, we have a golden opportunity to interact with family members who usually include working, voting citizens.

During the postoperative encounter, after immediate health care questions had been answered, and when it was appropriate, I regularly asked family members about their loved one's experiences with the health care system. Very often, they told of frustration and of unnecessary anxiety. That was when I was able to make inroads toward solving the societal problems to which Dr. Fisher alluded.

I recommend that each surgeon become an educator of the voting public. Seize the moment of the postoperative family encounter to educate the public about the health care system and its funding! Help them realize that funding of indigent health care and medical education are public responsibilities. Tax dollars used for these activities are

well spent. A good level of health care for the poor pays dividends in the form of better health care for the prosperous.

Let us not throw up our hands and say that any aspect of health care is a societal problem that we cannot solve. Let us first and foremost continue to serve our patients and then enlist them and their families as informed voters!

**John R. Benfield,
MD, FACS**

"Medical indigence is society's problem, and society must take responsibility for it." One must applaud Dr. Fischer's basic insight that physicians as individuals and even through organized medicine cannot solve such societal problems as medical indigence. In a similar vein, Dr. Fischer notes that "hamster health care" hassles physicians and results in poor patient care. The authors of the quoted editorial in the *British Medical Journal* appropriately summarized: "Solutions to hamster health care will come from getting off the wheel, not running faster."

Dr. Fischer is correct in his diagnosis of the disease, but who should recommend the treatment? If we as individual physicians and members of medical organizations cannot provide answers to "society," who can? We physicians should provide first-class care to our patients, but we must further provide first-class policy recommendations to our political leaders. We should not feel "truckloads of guilt" for problems we cannot solve, but must take some responsibility for lack of coherent physician leadership at the

policy level. What means should we use to present the best ideas from leaders in all fields? Our medical societies necessarily speak for the legitimate needs of their specific members. Perhaps the pages of our widely read and quoted major medical journals provide the best forum. Their traditions of peer review and editorial independence lend scientific credibility to the important messages we as physicians wish to communicate to our patients and public policymakers.

We should thank Dr. Fischer for his warning and his thoughtful discussion.

**Wayne F. Larrabee, Jr.,
MD, MPH, FACS**

Careers in surgery

I am a colon and rectal surgeon in Seattle, WA, who has an interest in resident surgical education. I have appointments with the University of Washington and the Swedish Hospital residency program and hear directly from surgical residents all the time. I read with interest your recent article regarding the recent general surgery match (June 2001). As I am sure you are aware, the Canadian surgery match had similar results this year, with many good programs having unfilled positions.

I believe that this problem will get worse, and am afraid that a shortage of surgeons across North America is likely to occur. In many rural areas, foreign-trained surgeons are being increasingly relied on to fill vacant spots (in both Canada and the U.S.). Not only is there a high attrition rate in surgical training programs, but also amongst young practicing surgeons.

I know four young surgeons (under age 40) who have given up surgery in the last two months. Two of these were young women who found it impossible to juggle family responsibilities with surgical practice. One was a young man with an MD/MBA who has found more lucrative and less time-consuming work in a health-related business. The final surgeon was a bright, hardworking young man who found the frustrations of surgical practice outweighed the benefits. It is this final surgeon who I think represents the attitude I am increasingly seeing in medical students and residents.

For most of these young people, the downsides of surgical training (and practice) outweigh the potential benefits. I have taught many extremely bright, hardworking students who find surgery fascinating, but who also want flexible work schedules (with the ability to pursue travel and hobbies, and so on) and know what the realities of surgical training are. Many of the female students I work with want a part-time medical practice, which is also very difficult in surgery. As you know, remuneration for surgical work is down, levels of job frustration are increasing, and many established surgeons are looking for a way out. Young medical students and residents are well aware of these issues, and I think for many of them their expectations for a balanced life do not jibe with the current reality of surgical residency and surgical practice.

I am afraid we will have an uphill battle changing their minds.

Mark Kimmins, MD, FRCSC

I am a retired internist who, at 70, returned to school for my master's degree. Along with my younger colleague, Robin D'Errico, we wrote an analysis on the impact of more women physicians. During the course of interviewing both male and female physicians, we were surprised to learn that many male practicing physicians were unaware of this feminine transition. (In veterinary medicine, women already comprise more than 70 percent of the students.)

Lee Sataline, MD, FACP

ACS issues

I have enjoyed your "From my perspective" writings in the *Bulletin*. The summary for August 2001 leads to these comments.

Tax status: I believe the need to lobby is part of our current reality. It is too bad you can't have two separate branches, but that is not realistic. One reason I was a board member of the ASGS was to lobby on the part of surgeons. The danger of this is the British example of separating all the physicians into their separate camps and then doing them in politically as they are all so small. Thus, I and my multispecialty clinic remain strong supporters of the AMA. "One voice for medicine" rings true to me.

Your general demeanor suggests you will keep all of American medicine in mind as the lobby for surgery moves ahead. Getting all surgery under one umbrella is a concept that I support, but often sharing the umbrella with our nonoperating colleagues is good politics.

Branding. I am so glad the Regents are addressing the meaning of FACS. I often ask myself why I pay the dues each year. It gets me no referrals, little respect, and seems like a redundant expense. The new general surgeons we hire ask if they should bother. They get a mixed message. Boards count but FACS doesn't seem to add much.

Keeping the brand pure with more disciplinary actions will add to the meaning of the title. This is the hardest of the activities the College does. It is even harder at the local level.

Demographics: There seems to be a real change in the physician market. I am a bit puzzled by it. It always helps to have some numbers to help make sense of the verbiage that is getting out.

Ben Knecht, MD, FACS

Telemedicine

Would that the spectacular advances, described in your "Cybersurgeon" column in the August issue, be as trouble-free as implied. From experience, I respectfully suggest that the picture may not be quite so rosy as implied by the author. In her estimates of how telemedicine is going to improve communications and "telemonitoring" she missed one critical element: the American plaintiff's bar.

Nobody disputes the dazzling changes in surgical education that are, indeed, just over the horizon. What doctors in this country may not be aware of is that the plaintiff's bar is also awakening to the vast potential for further profit extending before them.

Take just the issue of licensure. Already the state of Kan-

sas has taken legal action against a radiologist, based in California, reading X rays from Kansas and reporting on them on the Internet. They went after him for "practicing without a license." There are others involving surgical consultations on the Internet. This is only one of a myriad of problems, the scope of which we do not yet perceive, but which we are guaranteed to become painfully aware of in the next five years as cyber medicine grows. There is an organization, established by a number of our specialty societies and the AMA, called MEDEM and headquartered in San Francisco that is engaged in studying the problem and issuing the first guidelines through what promises to be a jungle of new and as-yet unknown exposures.

Mark Gorney, MD

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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/young surg.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 312/202-5354; fax 312/202-5013; e-mail dcoulombe@facs.org

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*Sponsored by the
Surgical Research and Education Committee of the
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Chapter news

by Rhonda Peebles, Chapter Services Manager, Organization Department

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

India conducts education program

Last March, the India Chapter held its fifth annual conference, which was conducted jointly with the Society of Asian Indian Origin Surgeons of North America (SAISNA) (see photo, this page). The education program was well attended by Fellows and other surgeons from across India, as well as from the U.S.

Argentina launches electronic newsletter

In July, Alberto Cariello, MD, FACS, Secretary, reported that the Argentina Chapter has implemented an electronic newsletter for members. In addition to announcements about upcoming surgical education programs in Argentina, the newsletter also features links to other Web sites. Since its inception, three issues have been published. For more information, contact Dr. Cariello at ahcariello@way.com.ar. Also, last

May, the Argentina Chapter conducted its Ninth Annual International Course in Buenos Aires, where 296 physicians attended the education program.

Illinois hosts annual meeting

The Illinois Chapter hosted its 51st annual meeting May 31 to June 2 (see top photo, p. 43). In addition to members and residents' presentations, C. James Carrico, MD, FACS, Chair of the ACS Board of Regents, addressed the Illinois Chapter members. The title of Dr. Carrico's talk was What's the ACS Done for Me Lately? A longstanding custom of the chapter's annual meeting is its Robert J. Patton Resident Award Competition. The 2001 winners included:

- Tammy Wu, MD, Southern Illinois University: Autologous Ear Reconstruction: Prefabrication and Prelamination in a Rat Model.
- Abdalmajid Katranji, MD,* University of Illinois (Peoria): The Omental Flap: Versatility, Utility, and Results.
- Karen Difenbach, MD, University of Illinois (Peoria): The Diagnosis and Management of Biliary Dyskinesia in the Pediatric Population.

*Denotes Participant in the Candidate Group.



India Chapter opening ceremony, left to right: V. J. Anand, MB, BS, FACS, Secretary; A. D. Sehgal, MB, BS, FACS, Governor; R. S. Gupta, MB, BS, FACS, President; Dr. A. S. Anand, Honorable Chief Justice of India and Chief Guest for Inaugural Ceremony; Sandip Mukerjee, MD, FACS, President-Elect; S. P. Agarwal, MD, FACS, Director General of Health Services of India; J. S. Beniwal, MB, BS, FACS, representing SAISNA; and P. K. Kakar, MD, FACS, Vice-President.

Chapter anniversaries

| Month | Chapter | Years |
|---------|---------------------------|-----------|
| October | Alabama | 50 |
| | Belgium | 2 |
| | San Diego (California) | 28 |
| | Manitoba (Canada) | 45 |
| | Colombia | 36 |
| | Jacksonville (Florida) | 44 |
| | France | 14 |
| | Delaware | 44 |
| | Hong Kong | 6 |
| | India | 8 |
| | Kansas | 50 |
| | Jamaica | 9 |
| | Japan | 14 |
| | Federal District (Mexico) | 41 |
| | North Carolina | 45 |
| | Ohio | 46 |
| | Panama | 4 |
| | Metropolitan Philadelphia | 15 |
| | Saudi Arabia | 10 |
| | South Carolina | 51 |
| | Switzerland | 2 |
| | Tennessee | 49 |
| | North Texas | 31 |
| | South Texas | 31 |
| | Thailand | 4 |
| | Utah | 50 |
| | Virginia | 36 |
| | Venezuela | 35 |
| | Vermont | 51 |

Nebraska meets in Omaha

The Nebraska Chapter conducted its 2001 Spring Meeting in Omaha, June 15-16. Special guest speakers included Philip S. Barie, MD, FACS, Cornell University, New York, NY, and Paul E. Collicott, MD, FACS, a Regent of the College from Lincoln, NE. Dr. Barie presented a lecture on nosocomial pneumonia, and afterward, he presided over the residents' research presentations. This year, the two winners were:

Jason Rehm, MD, University of Nebraska: Aneurysm Induction in Mice Deficient in Matalloprotease 9 or 12.

Michael Jobst, MD,* Creighton University: Myocellular Energetics and Creatine Transporter Regulation in Sepsis (see middle photo, right).

*Denotes participant in the Candidate Group.



Illinois Chapter, left to right (all MD, FACS): Norman C. Estes; Donald S. Ross, Governor; Dr. Carrico, visiting speaker; Peter Schwab; Lorin D. Whittaker, Jr.; and Philip T. Seigert, Governor.



Nebraska Chapter: Eugene Waltke, MD, FACS, President, presents a \$500 award to Dr. Jobst.



Brooklyn-Long Island Chapter, left to right: Anthony J. Tortolani, MD, FACS, President; Joseph R. Cali, MD, FACS, Governor; Dr. Bender; Saqib Chaudhry, MD, FACS, Immediate Past-President; Sylvia Drucker, Chapter Administrator; and A. Addison Barman, MD, FACS, former Governor.

10 largest chapters

As of the end of June, the 10 largest chapters of the College included:

| Chapter | Active | Retired | Fellows | | Total* |
|----------------------|--------|---------|------------|------------|--------|
| | | | Associates | Candidates | |
| Southern California | 2,254 | 467 | 88 | 136 | 2,945 |
| Northern California | 1,776 | 414 | 67 | 127 | 2,384 |
| Ohio | 1,773 | 291 | 72 | 186 | 2,322 |
| Florida | 1,626 | 663 | 48 | 46 | 2,383 |
| New Jersey | 1,603 | 212 | 60 | 109 | 1,984 |
| South Texas | 1,512 | 217 | 95 | 117 | 1,941 |
| Metropolitan Chicago | 1,388 | 177 | 74 | 178 | 1,817 |
| Michigan | 1,283 | 268 | 64 | 170 | 1,785 |
| Massachusetts | 1,233 | 176 | 52 | 126 | 1,587 |
| North Carolina | 1,186 | 279 | 78 | 126 | 1,669 |

*Data exclude 2001 Initiates.

Source: K. White, ACS Information Services Department, June 2001.

Brooklyn-Long Island (NY) conducts annual meeting

The Brooklyn-Long Island Chapter conducted its 71st annual meeting on June 2, in conjunction with the Nassau Surgical Society (see bottom photo, p. 43). ACS President Harvey W. Bender, Jr., MD, FACS, addressed the members of the two surgical organizations. His talk was titled The State of the ACS. In addition, the Distinguished Service Award was presented to John W. Shepard, MD, FACS.

Missouri Chapter meets

The Missouri Chapter conducted its 34th annual meeting June 22 to 24. On June 22, the education program was devoted to cancer care, and Pond Keleman, MD, Saint Louis University, presented a course on breast carcinoma sentinel node biopsy. On June 23, a variety of topics were discussed, including endovascular repair, training and credentialing for advanced laparoscopic techniques, and robotics and minimally invasive cardiac surgery. The winners of the resident paper presentations included:

Washington University: First place, Steven Hunt, MD; second place, Julie Margenthaler, MD*; and

third place, Matthew Mutch, MD.

Student Abstract Presentations, University of Missouri: First place, Adam Griesemer; second place, Adrian Ray; and third place, Andrea Martin.

Poster Presentations: First place, residents, Miquel Bongera, MD, University of Missouri, and first place, students, Jared B. Smith, St. Louis University.

Finally, new officers and council members for the Missouri Chapter were elected: Donald Jacobs, MD, FACS, President; John Shook, MD, FACS, Vice-President; David Ota, MD, FACS; Secretary-Treasurer; and council members John Adams, MD, FACS, Terry Lairmore, MD, FACS, and Jeffrey Wadley, MD, FACS.

Correction

In the August "Chapter news" column, the New Jersey Chapter's anniversary was reported incorrectly. In fact, the New Jersey Chapter will observe its 50th anniversary on December 1, 2001, at the Parsippany Hilton. For more information, contact Art Ellenberger, Executive Director, at 973/239-2826.

*Denotes participant in the Candidate Group.

The *Journal* page

Message from the Editor

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

November is a memorable month for the American College of Surgeons because the Articles of Incorporation were filed with the Secretary of the State of Illinois on November 25, 1912. On November 13, 1913, 1,059 surgeons constituted the initial group admitted to Fellowship in the American College of Surgeons. The 1998 edition of the College's *Yearbook* states: "Since 1930, the Graduate Medical Education Committee of the College has been involved in issues of the education of surgical residents, the learning and working environment, and optimal preparation of medical students for graduate surgical education."

Dr. William Silen's editorial (see pages 514-515 in the November 2001 issue of the *Journal of the American College of Surgeons*) merits consideration by all Fellows. For years Dr. Silen was regarded as one of the outstanding surgical teachers. I share with him a strong con-

cern about the current status of surgical education in medical school and during the residency period. The focus on the bottom line, and the monies to be generated by the faculty, has relegated surgical education to the role of a neglected element. The classic three-legged stool on which academic surgery is based—that is, patient care, research, and education—has become grossly unstable because the one leg of patient care, which translates into money, has been elongated, while the research leg has not had equivalent growth, and the education leg has been pared.

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 November lead article

A trend analysis of the relative value of blue dye and isotope localization in 2000 consecutive cases of sentinel node biopsy for breast cancer.

Anna M Derossis, MD, Jane Fey, MPH, Henry Yeung, MD, Samuel DJ Yeh, MD, Alexandra S Heerdt, MD, FACS, Jeanne Petrek, MD, FACS, Kimberly J VanZee, MD, FACS, Leslie L Montgomery, MD, FACS, Patrick I Borgen, MD, FACS, Hiram S. Cody III, MD, FACS. From the Breast Service, Department of Surgery, and the Department of Nuclear Medicine, Memorial Sloan-Kettering Cancer Center, New York, NY.

Background: Among the advocates of blue dye, isotope, or combined dye-isotope mapping of the sentinel lymph node (SLN) for breast cancer, there is no universal consensus as to which technique is optimal, and whether the relative value of each method changes with increasing experience. The objective of this study was to examine the relative contributions of blue dye and radioisotope to successful identification of the SLN, as the SLN-mapping technique evolved over our first 2000 consecutive cases.

Study design: Among the first 2000 consecutive SLN biopsy procedures for breast cancer, performed by eight surgeons (none previously experienced in SLN techniques) at one institution, using a combined technique

of blue dye and isotope mapping, we report the institutional learning curve and the relative contributions of dye and isotope to identifying both the SLN and the positive SLN, by increments of 500 cases.

Results: Comparing the first 500 with the most recent 500 cases, success in identifying the SLN by blue dye did not improve with experience, although success in isotope localization steadily increased, from 86% to 94% ($p < 0.00005$). With the increasing success of isotope mapping, the marginal benefit of blue dye (the proportion of cases in which the SLN was identified by blue dye alone) steadily declined from 9% to 3% ($p = 0.0001$). Parallel to this trend, the proportion of positive SLNs identified by blue dye did not change with experience (89% to 90%), but isotope success steadily increased from 88% to 98% ($p = 0.0015$). The proportion of positive SLNs identified by blue dye alone declined from 12% to 2% ($p = 0.0015$).

Conclusions: Using a combined technique of blue dye and radioisotope mapping, and with refinement of the radioisotope technique, we report 97% success identifying the SLN. Although we continue to recommend the use of both methods in SLN mapping for breast cancer, we observe with experience a declining marginal benefit for blue dye.