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From my perspective

While traveling around the country to speak at various meetings, I find that one topic continually becomes the focus of conversation—the work environment of both practicing surgeons and surgical residents. This dialogue is occurring not only within the College chapters, but at regional meetings and academic medical centers as well.

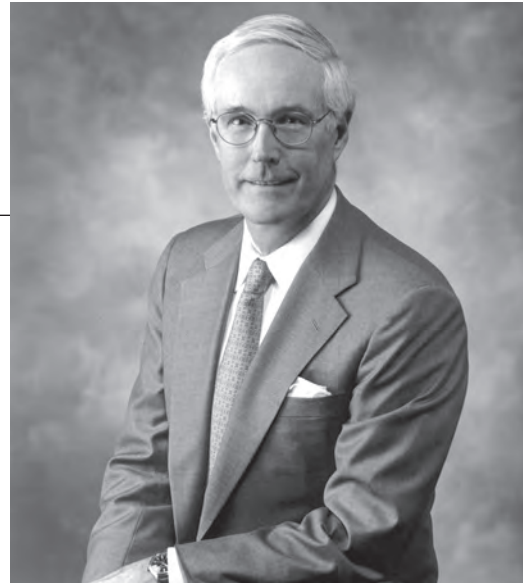
I was pleased to recently participate in an excellent symposium sponsored by the department of surgery at the University of Louisville, KY, which examined the various factors that influence surgical training, including financing, politics, and accreditation. Many important and interesting concepts were raised during the symposium, and I anticipate that future articles for the *Bulletin* will emanate from the discussions that took place during that conference.

In this particular piece, I have chosen to give a general overview of the problems that we need to address to secure the future of surgery. I also offer some broad suggestions regarding what surgeons can do to make surgical practice more enjoyable for themselves and more attractive to residents.

Profession's lost luster

One point that has become very apparent to me is that many surgeons are deeply concerned about the future of our profession. Surgeons today truly enjoy the discipline and practice of surgery, particularly patient care, as well as teaching and research. However, they feel the modern health care system's inherent problems and burdens—including the professional liability crisis, reimbursement reductions, and a stifling regulatory system—inhibit their satisfaction with the work they do.

Further, surgeons believe these same hassles prevent bright young people from entering what is otherwise an incredibly fulfilling career in surgery. Adding to residents' disenchantment with a career in surgery is the fact that they frequently find themselves thrust into noneducational activities. The expectation that residents perform the "scut work" is, in part, one of the traditions of surgical training. However, residents are being forced to do more of these menial tasks because of the economic constraints placed on academic medical centers.



“There are some steps we can take now to make surgical practice less burdensome and surgical training more palatable.”

Groups working together

It is a hopeful sign that so many surgeons, other physicians, and the groups that represent them are coming together to clearly identify the issues and to develop creative solutions through ongoing dialogue.

For example, the Accreditation Council for Graduate Medical Education (ACGME) has spent a considerable amount of time discussing resident training issues—specifically the work environment, the educational environment, and work hours—and, at press time, had just made its views and recommendations public. Other groups are collaborating to address surgical training issues in a fresh and innovative way. Included among these groups are the boards of surgery, the residency review committees, professional organizations, regional surgical societies, and academic medical centers.

I anticipate that these discussions will lead to a better understanding of the current situation and

how we have arrived at it. And, hopefully, a consensus as to how we can resolve these issues will be achieved.

What we can do now

Clearly, it will take a long-term, cooperative effort to regain control of our profession, but there are some steps we can take now to make surgical practice less burdensome and surgical training more palatable.

First, we must make our practices more efficient. For example, we must avoid doing unnecessary, time-consuming, and costly tests. We must learn more about billing procedures and practice management. The College offers a variety of workshops to help surgeons understand the business side of practice.

Additionally, we must engage in lifelong learning, so that we remain competent throughout our careers. I have written several columns about this topic in the past, and the College is working hard to develop a broader range of educational programs that will help surgeons achieve this goal.

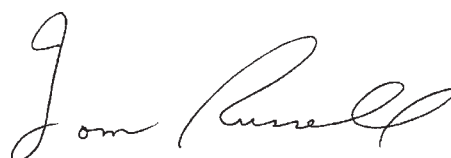
Further, we must emphasize to young surgeons the attractiveness of a surgical career. Some of the joys of a career in surgery include the following:

- We restore health to gravely ill patients. We are able to cure conditions that once seemed hopeless.
- We have the opportunity to have a positive impact on the lives of our patients.
- We are involved in comprehensive, continual patient care.
- Operations are high-tech and high-touch. Ours is not a cold and unfamiliar use of technology. In the process of applying technology, we provide the comfort associated with the “laying on of the hands.”
- We have a variety of options with regard to the intensity and acuity of patient care we provide—from elective to emergency procedures, from inpatient to outpatient services. Also, the various surgical specialties allow surgeons to pursue special interests and to select the specifics and acuity of the type of care they prefer to provide.
- Practicing surgeons become the advisors, role models, and mentors for students and residents.

Certainly, the practice of surgery for individuals at all stages of their career is difficult and de-

manding. However, ours remains a great profession that offers a high level of satisfaction. Repeatedly, surgeons tell me, “I would do it all over again.” We need to continue to concentrate on the positive aspects of surgery and willingly engage in the lengthy discussions and inevitable confrontations that will occur in the process of making our profession and our health care delivery system better in the future.

This is truly a dynamic time for the surgical profession. We must be integral participants in the process of change.



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*

Applications are now being accepted for the **George H.A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award**. The purpose of the award, which consists of a nonrenewable grant of \$40,000 for each of five years (2003-2008), is to provide support for the research by a promising young surgical investigator. The award is restricted to a U.S. or Canadian Fellow or Associate Fellow of the College who has not surpassed the level of assistant professor. Applicants should provide evidence of productive initial efforts in laboratory research. The closing date for receipt of completed applications is August 1, 2002. Application forms may be found on the College's Web site at <http://www.facs.org/dept/fellowship/research.html>, or can be obtained from the Scholarships Administrator at 312/202-5281.

The 2002 American College of Surgeons practice management course, "Charting a Safe Course for Surgical Practices: **A Course in Practice Management for Surgeons by Surgeons**," will be presented on September 21, 2002, in Miami, FL. Charles D. Mabry, MD, FACS, and Frank Opelka, MD, FACS, have designed and will present this educational seminar for surgeons who are interested in improving the management and efficiency of their surgical practice. The course will include lectures as well as skills laboratories, in which participants will work with the instructors to solve real-life practice management problems. Surgeons may register online at <http://www.facs.org/dept/hpa/workshops/pmworkshop.html> or by contacting Irene Dworakowski via e-mail at idworakowski@facs.org or via phone at 202/672-1507 for a brochure.

The American College of Surgeons is pleased to announce that "**Urology Review for Recertification Candidates**" will be offered as a postgraduate course at the 2002 Clinical Congress in San Francisco. This six-hour course has been developed with leading urologists from across the country and is open to all urologists regardless of membership status with the College. Urologists who are not Fellows who register and pay for this course will have the registration fee for the Clinical Congress waived. Individuals who take advantage of this educational opportunity will be asked to complete and return the Fellowship application that will be sent to them upon registering for the course. For further information about the review course, contact Patrice Blair via phone at 312/202-5220 or via e-mail at pblair@facs.org.

The **July update for ACS Surgery: Principles & Practice** includes "Risk Stratification, Preoperative Testing, and Operative Planning"; "Minimally Invasive Esophageal Procedures"; and "The Elderly Surgical Patient." ACS Surgery subscribers can view the July update by logging on to <http://www.acssurgery.com>. Nonsubscribers should visit <http://www.acssurgery.com/learnmore.htm> for more information and to receive \$20 off a subscription to the online version. Need help from customer service? Call 800/545-0554 or 914/962-4559 (outside the U.S), fax 914/962-5076, or e-mail acssurgery@dwweb.

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prepared by the Division of Advocacy and Health Policy

CMS proposes revisions to EMTALA

On May 9, the Center for Medicare & Medicaid Services (CMS) issued a proposed rule on the hospital prospective payment system, which includes several provisions that would modify the Emergency Medical Treatment and Active Labor Act (EMTALA). CMS anticipates that these changes will promote consistent application of EMTALA, clarify the regulations, and address concerns raised by the Advisory Committee on Regulatory Reform to the Secretary of the U.S. Department of Health and Human Services.

CMS proposes the following provisions relating to EMTALA:

- Each hospital would have the discretion to maintain the on-call list in a manner that best meets the needs of its patients. Physicians, including specialists and subspecialists, would not be required to be on call at all times. Instead, hospitals would be expected to have policies and procedures in place to handle situations in which appropriate specialists are not available or on-call physicians cannot respond.
- Calls for the designation of “dedicated emergency departments,” which would be defined as the equipped and staffed areas of hospitals that are used a significant portion of the time to evaluate and treat outpatients for emergency medical conditions.
- Would clarify that EMTALA applies to hospital inpatients only under limited circumstances, such as when a patient has first presented to an emergency department and has been admitted to the hospital on an inpatient basis because his or her emergency medical condition has not stabilized.
- Would narrow the applicability of EMTALA to only those off-campus entities that are departments of the hospital and are “dedicated emergency departments.”
- After reviewing public comments, CMS will release final regulations on the Hospital Inpatient Prospective Payment System, which will include the EMTALA provisions. The College has submitted comments to CMS on behalf of surgery to the proposed EMTALA regulations.

Committees approve Medicare payment legislation

On June 5, the College, as part of the Coalition for Fair Medicare Payment, gave its qualified endorsement of the physician payment provisions in a joint House Ways and Means and Energy and Commerce Committee Medicare prescription drug package. This package, approved by both committees the week of June 17, will postpone a series of projected payment cuts of nearly 15 percent and add approximately \$20 billion to Medicare spending for physician services over the next five years. Under the proposal, physician payments are projected to rise roughly 6 percent in the next three years (2% per year). As a result, the 2005 Medicare conversion factor for physician services will be 20 percent higher than it would be under the current sustainable growth rate (SGR) formula.

An unfortunate aspect of the legislation is that if a permanent solution to revise or replace the SGR formula is not approved by Congress by 2005, physician payments will return to the levels projected under current law, resulting in a drastic 18 to 20 percent reduction in payments for 2006.

CMS could fix Medicare payment problem

The College participated in a press conference regarding Medicare payment issues in May, which included an important report by Terry Coleman, the former Chief Counsel of the Health Care Financing Administration, now known as CMS. Mr. Coleman presented a legal analysis indicating that Congress actually intended for the agency to revise its cost estimates for Medicare physician payment once actual data about the number of patients served and the health of the economy became available. The agency has the authority to make those revisions to the SGR but has chosen to interpret the Medicare law rigidly, claiming that it cannot fix the projection errors made in 1998 and 1999.

Mr. Coleman's analysis also points to another CMS decision to include drug costs in the calculation it uses to determine the amount Medicare spends for professional services. These two agency decisions ultimately will cost physicians \$62 billion over the course of 10 years. Medicare reimbursement has failed to keep pace with the cost of providing care and has been particularly onerous for surgeons and other specialists. The prospect of another 20 percent slash in reimbursement must be stopped. Go the College's Legislative Action Center at <http://capwiz.com/facs/issues/alert/?alertid=63328&type=CO>, and write the President and members of Congress to insist on immediate relief.

Maryland trauma center suspends operation due to surgeon shortage

Washington County Hospital in Hagerstown, MD, has temporarily suspended operation of its level 2 trauma center, citing a shortage of surgeons to staff the facility. President and chief executive officer James Hamill on May 30 announced that the hospital would voluntarily suspend operation of the trauma program effective June 1 while it works to develop a sustainable model of service. Level 2 trauma centers must have a trauma surgeon on site at all times, a hospital spokesperson said. The center lost surgeons to retirement recently, leaving fewer than 10 surgeons to take turns staffing the program. Patients needing emergency specialty care that cannot be provided by the hospital's medical staff will be stabilized and transferred to one of the level 1 trauma centers in Baltimore or Bethesda, MD, or to a level 3 trauma center in the area.

Patient safety legislation introduced

In June, Sen. Jim Jeffords (I-VT) introduced the Patient Safety and Quality Improvement Act as S. 2590. The legislation is cosponsored by Sens. Bill Frist, MD, FACS (R-TN), John Breaux (D-LA), and Judd Gregg (R-NH) and builds on the recommendations made in the 1999 Institute of Medicine study titled *To Err Is Human: Building a Safer Health System*. The bill would create patient safety organizations that would collect and analyze patient safety information and disseminate information to providers regarding ways to improve patient safety. Information submitted voluntarily to patient safety organizations will be privileged and confidential.

In a letter to Senator Jeffords, ACS Executive Director Thomas Russell, MD, FACS, offered the College's strong support for the legislation.

9/11:

Jersey City Medical Center— lessons learned



by Philip Lisagor, MD, FACS,
Jersey City, NJ

September 11, 2001, began as a slow and easy day for me. Nothing was scheduled in the operating room, and I had chosen to remain home and download Zagat's guide to Manhattan restaurants onto my PalmPilot®. I live on the top floor of an apartment building situated right on the Hudson River, directly opposite the site of the World Trade Center. I didn't even look up or out the window when the first explosion occurred, assuming it was part of the blasting on the new Goldman Sachs Tower being built right down the street.

Instead, I completed my download and gathered up my German shepherd and my border collie for their morning walk. Halfway down to the lobby on the elevator, an acquaintance boarded with a camera and told me a plane had run into one of the World Trade Center Towers. I left the building and took the dogs to their favorite corner, still unable to see the burning tower. Eventually, we walked around our building and down the walkway along the Hudson River, and I saw that the North Tower was in flames. I continued to a spit of land in front of my apartment building which juts into the Hudson River directly opposite the twin towers. At this point, I noticed a jetliner in a two-minute turn moving quickly and lower than was usual. I recall thinking that there must be something wrong with the pilot who was flying the plane so close to the burning tower.

Then the unthinkable happened. The plane that had turned over Liberty State Park and the Statue of Liberty continued into the South Tower. There was an immediate orange fireball, and true to my military training, I hit the ground and covered up, fearing a possible blast effect. No blast was noted, so I stood up and began the short walk home. When the second plane hit, screams of terror sounded from about every direction. I let out an expletive and returned to my apartment.

Once home, I woke my daughter and her friend. I told the two recent college graduates that the World Trade Towers had been blown up. Meanwhile, my wife, unbeknownst to me at the time, was just finishing a physical therapy session in an office located directly across from the South Tower when the first plane hit the North Tower.

She was out on the street witnessing the flames from the North Tower and the sight of people falling to their death when the second plane hit the South Tower. She immediately joined a sea of humanity making its way northward and eventually caught the last ferry boat over to Jersey. Hours later she returned from Weehawken, NJ, on foot to our home in Jersey City.

My daughter and her friend began photographing the burning towers, when suddenly the South Tower collapsed. Unaware of the theory of a top-down collapse based upon structural failure, I assumed a nuclear device had gone off in the basement of the tower, and I got all of us down behind a wall to avoid the certain blast effect that I thought would blow out the windows of my apartment. Again, no blast effect occurred.

By now I had received a call indicating that the hospital where I chair the department of surgery, Jersey City Medical Center (JCMC), was on alert. I figured that whatever brought the South Tower down would soon bring down the North Tower. Still fearing a blast effect, I instructed the girls to take the two dogs for a walk in the direction of the Jersey City Medical Center. I prepared to go to work to see what could be done, though I considered it a dubious possibility that we would receive many victims of the horrific collapse of the South Tower.

Nonetheless, I got on my bicycle and headed west into a beautiful, crystalline blue sky. Behind me, though, was a growing cloud not unlike what I would imagine a nuclear cloud to resemble. Traffic was horrible due to the flood of commuters fleeing to New Jersey and gapers turning out to view the attack, but being on a bicycle allowed me to weave between cars, and I arrived at the hospital in no more than 25 minutes.

I arrived at JCMC and went to my ninth-floor surgery suite, which is high on a hill and overlooks all of Manhattan. At that point, the North Tower collapsed under my direct vision.

I glanced at a poster for a lecture on "Third World Medicine" I had given many years ago at the University of Padua while on active duty and stationed with the U.S. Army in Vicenza, Italy. The talk was based on my experience with training Afghan mujahideen medics in the mid-1980s. Somehow I sensed these events were related. The hospital chief executive officer soon arrived in my of-

Left inset: The JCMC emergency room view of unfolding events on 9/11.

fice, and we discussed plans and began to walk around.

My previous military experience had included being Deputy Commander of the Thirty-First Combat Support Hospital in Saudi Arabia during Operation Desert Storm, Commander of the European Contingency Hospital throughout the Eastern Mediterranean, and having served as the acting U.S. Forces Korea Surgeon during the war games known as UFL (Ulchi Focus Lens). This experience paid off as we attempted to deal with the injured patients that were to come through our doors that day.

Lessons learned

The following are some of the salient features that went into allowing JCMC to easily and successfully respond to the demands we encountered on September 11, 2001.

- *Don't reinvent the wheel.* Civilian triage isn't based upon military triage. However, both civilian and military triage are designed to increase the efficiency of dealing with disaster.¹ A mass casualty situation is one in which the ability to respond is overwhelmed. The basic principles of responding to a disaster or to a mass casualty situation is to conserve medical personnel and material resources.

- *Prepare for unusual injury patterns.* Military casualties have been defined as killed in action (KIA), wounded in action (WIA), and died of wounds (DOW).² KIA are handled outside of the medical practice. Physicians and surgeons attempt to reduce the DOW from the WIA group. Traditionally, the WIA to KIA ratio is greater than five. On 9/11, it turns out that more than 3,000 individuals died, and the number of wounded and requiring hospital admission was less than 500. This reversal of the WIA to KIA ratio is highly unusual in a military or terrorist attack.

Living triage resulted from the mechanisms of injury: massive crushing and extreme heat. The walking-wounded, self-rescued individuals were the first to present for care. These individuals had been more on the periphery of the catastrophe. Most of them would be classified as minimally injured and would be triaged for care outside the emergency department.

A bit later, some rescue workers who had been

closer to Ground Zero and more involved in rescuing people from the towers were brought in. These admissions included delayed injuries—those who could be initially seen and admitted for later care, including patients who had lost consciousness but were awake upon arrival, and a couple of closed fractures of lower extremities. Along with the delayed injuries came a few urgent patients, including an airway-breathing problem and a couple of patients with evidence of blood loss. A final classification of patients would be “expectant patients”—patients who could not survive because of the severity of their injuries and the demands on the health care system given the sheer number of injured. On 9/11, these patients did not materialize.

Echelonment of care is a basic military principle built upon an immediate response to injury in the battlefield by a combat lifesaver buddy and then care at the battalion level by medics, a field PA (physician assistant), or a young general medical officer in the position of the battalion surgeon. From here the wounded go to a collecting area, which may be a clearing company either in the main support battalion or the rear support battalion; then the patient is taken to a Combat Support Hospital, or, previously, to a Mobile Army Support Hospital for complete surgical care. Eventually, military casualties are prepared for evacuation or movement to general hospitals. On 9/11, there were some immediate responders; however, many immediate responders were killed when the towers came down, and the command and control elements of the EMS service were taken out simultaneously. St. Vincent's Medical Center was the nearest trauma-ready hospital and they were quickly occupied with patients. Burn patients were triaged to the local burn unit at New York Hospital.

As communications and transportation fell apart, suddenly and without prior planning, a staging area was set up across the Hudson River. An ad hoc fleet of evacuation boats was assembled. Shortly after the attacks, patients began to arrive at Jersey City Medical Center, a Level 2 trauma center, after being evacuated by ferry boat to Liberty State Park. Other patients, more of the walking wounded self-rescued, managed to leave Manhattan by the PATH train and arrived in Hoboken, NJ, eventually making their way to local commu-

nity hospitals in Hudson County, including St. Mary's of Hoboken and Christ Hospital of Jersey City.

- *Coordinate evacuation routes.* Coordinated evacuation is difficult to achieve in the best of situations. When planning goes out the door and the communication and transportation systems are suddenly and radically changed, it is even more difficult to achieve. On the battlefield, hospitals first appear within the corps. A corps is a grouping of three to five divisions and has a separate corps support command. The corps support command may comprise up to 50,000 to 70,000 soldiers and is commanded by a Brigadier General. Under this individual is a Medical Brigadier General who commands a medical brigade. The medical brigade will have a couple of subsidiary commands called medical groups, and each medical group, in addition to evacuation helicopter assets, will include a multitude of hospitals. To avoid overwhelming any given hospital, the medical brigade will have a medical regulating officer who knows the moment-to-moment bed and blood availability status of all the hospitals and is able to direct patients to the facilities that are most accessible and ready to receive casualties.

No such system was in effect 9/11. Communication was out, and the ability of New Jersey to serve as a medical reserve asset for New York City had not been tested. In fact, when phone service was possible, the State Commissioner of Health was in touch with the CEO of JCMC and plans were detailed to send less severe patients to other local hospitals and to facilities further from the waterfront. The intent was to keep JCMC more available for the most seriously injured.

- *Physicians and nurses rise to the challenge.* This is a fact that I have seen proven time and again. Physicians and nurses respond without question. JCMC had good internal coordination and more than 100 percent staffing was immediately obtained. As a result of department of surgery initiatives implemented throughout the year, there was good teamwork with emergency department members and with other staff, including nursing, ophthalmology (which became important when the number of injuries from glass fragments in the air became apparent), operating room, orthopaedics, medicine, and laboratory and imaging.

- *Develop minimal care out of the emergency department.* A standard goal is to keep the walking wounded and more seriously injured patients separated. On 9/11, the hospital auditorium was where we sent the walking wounded for triage and transfer to the emergency department (ED) if their injuries warranted the move.

It is also imperative to develop some sort of quick-and-dirty field medical card to track patients and for database development. This turned out to be a difficult process at JCMC.

- *Minimize time in the emergency department.* This principle requires that clinicians be better skilled in times of need. In particular, the number of X rays obtained should be kept to a minimum. Many fractures can be diagnosed clinically and if not open, proper splinting reduces them to a delayed category and can save time and supplies from radiology. By the same token, laboratory tests should be kept to a minimum. Type and cross should be the main laboratory test in addition to tests for occult bleeding in urine or stool and arterial blood gases when clinical acumen and oximetry isn't adequate. It is also very desirable to enforce unidirectional flow through the ED. This requires that when a patient leaves the ED for an imaging study, that patient doesn't return to the ED but instead goes either to the OR, the pre-op holding area, the ICU or the ward. Generally, patients can be triaged and treated in the ED within 10 minutes.

- *Conserve resources.* It is imperative not to rush the first delayed patients to the OR. If they are delayed, they need to wait because urgent patients may well be on the way. If overwhelming casualties develop early, blood must be conserved by identifying expectant patients, and this process can be difficult.

Triage is more than sorting patients by injury; it is deciding the order of treatment based upon the injury, the availability of personnel and material resources, and the changing nature of the tactical situation. The JCMC, by encouraging the State Health Commissioner to arrange for less injured patients to be mobilized further from the scene, worked early on to conserve resources.

Finally, delayed and emergent patients should be transferred further away as soon as they are stable.

- *Be alert for chemical and biological agents.*

Conventional weapons may also include chemical and biological agents. Decontamination should be a civic function done in the field, yet every hospital must have plans to re-decontaminate patients before admission to the hospital. This step was not taken on 9/11, and it will be a challenge to carry out in the future. Additionally, beware of acts of terrorism in your immediate area of operations. All patients should be cleared of weapons. Ideally this is a police function, but in combat and in civilian catastrophes, the local and military police are usually tied up with other matters, so hospitals need to develop plans to fulfill these requirements.

Final observations

By the end of the day on 9/11, JCMC had seen 148 patients in about a six-hour period. A questionable number of other patients had been seen in minimal care. Only 26 patients were admitted, and there were no deaths. Three orthopaedic operations were eventually performed, and three patients ended up in the ICU including one inhalational injury on a ventilator. Specific injuries included flying glass eye injuries. (Having an eye service with slit lamp exams in the ED is a valuable goal in future catastrophes.) Crush injuries were noted along with one significant burn and many emotional injuries. Of the 26 admissions, 21 were to the surgery service, and five were to the medical service, including nonventilator inhalations.

Later I was asked to address "Lessons Learned on 9/11." In preparing these remarks, I consulted my notes on lessons learned with the Thirty-First Combat Support Hospital in Operation Desert Storm³ and my after-action report from UFL. I observed that the lessons learned from 9/11 were the equivalent of lessons learned in Desert Storm and in UFL war gaming. These lessons include:

1. Control beds and blood in the overall area.
2. Coordinate which patients go where.
3. Nurses and physicians always rise to the occasion.
4. Need stronger administrative support for re-supply.
5. Need better communications (the Internet functioned throughout).
6. Need better record keeping.

7. Need plans for nuclear, biological, and chemical attacks.

8. Need plans to disarm possible combatants or terrorists.

9. Need police support to secure the immediate perimeter.

10. Need to formulate plans and rehearse them at regular intervals and at unannounced times. □

References

1. Swan KG, Swan KG Jr.: Triage: The past revisited. *Military Med*, 161(8):448-452, 1996.
2. Personal communications with Brig. Gen. Rostic Zaitchuk, USA (Ret).
3. Smith W, Lisagor P: Experience of the 31st Combat Support Hospital in Operation Desert Shield and Desert Storm: A commander's story. *J US Army Med Dept*, November/December, 4-10, 1992.

Dr. Lisagor is chairman, department of surgery, Jersey City Medical Center, and Colonel, U.S. Army Medical Corps.



The American Joint Committee on Cancer:

Updating the strategies in cancer staging

by Frederick L. Greene, MD, FACS, Charlotte, NC

Since its inception, the American Joint Committee on Cancer (AJCC) has been instrumental in fostering the concepts of cancer staging through the Tumor (T), Node (N), and Metastasis (M) system initially espoused by Pierre Denoix in the 1940s.* As a result of the partnership with the International Union Against Cancer (UICC), a worldwide staging system developed and was formally recognized in the late 1980s, when the UICC and AJCC launched an effort to coordinate publications on cancer staging that would be periodically updated and reflect support for a global TNM system.†

The prime motivation for having a unified and worldwide system of cancer staging is to ensure that a common language is used by all those caring for cancer patients and, in the case of TNM, to maintain a dialog in solid tumor management that will be understood by clinicians in all specialties. As in any language, there are always new and interesting phrases that creep into the vernacular, and these must be codified and documented appropriately as new data become available in cancer care. While new strategies of cancer classification become apparent, it is also important that the basic principles by which TNM was developed are not radically changed so that future generations will understand the strategies formulated by past generations.

Importantly, in the 1970s, the first edition of the *AJCC Cancer Staging Manual* was published. It has been re-edited every five to seven years since, reflecting new staging information resulting from advances in clinical and pathological diagnostic studies relating to many solid tumors. In 1997,

the fifth edition of the *AJCC Cancer Staging Manual* was published, continuing the publication's tradition of serving as a resource for physicians and cancer registrars throughout the U.S. An updated version of the manual became available earlier this year.

This article describes the collaborative efforts of the ACS and the AJCC in developing strategies for cancer staging, describes the role of the *AJCC Cancer Staging Manual*, and informs readers about recent updates to that publication.

College's role

The American College of Surgeons was instrumental in the formation of the AJCC more than four decades ago. In January 1959, the AJCC (formerly known as The American Joint Committee for Cancer Staging and End Results Reporting) was established in response to invitations to six organizations by the chairman of the board of chancellors of the American College of Radiology and the Chair of the ACS Board of Regents to participate as cofounders. The six organizations (see Table 1, p. 14) remain as founding organizations of the AJCC and continue to participate fully in its activities. In addition to these founders, sponsoring organizations (see Table 2, p. 14) and liaison organizations (see Table 3, p. 14) help to direct the efforts of the AJCC.

As a further indication of support for the TNM system of cancer staging, the College's Commission on Cancer (COC) mandated use of the TNM system for all patients with solid tumors cared for in COC-approved hospitals in the U.S. This acceptance of TNM and the role of the AJCC in cancer staging has helped to foster education in the use of the TNM system among all those caring for cancer patients and has strengthened the collaboration between the AJCC and the ACS.

*Denoix PF: Tumor, node and metastasis (TNM). *Bull Inst Nat Hyg (Paris)*, 1:1-69, 1944.

†Hutter RV: At last —worldwide agreement on staging of cancer. *Arch Surg*, 122:1235-1239, 1987.

In addition to this partnering effort, the College has served as the administrative support arm of the AJCC. The housing of the AJCC office and support staff in the ACS headquarters in Chicago, IL, and the continued role of the Medical Director of the Cancer Program of the College as executive director of the AJCC, has fostered this close relationship.

New manual available

In May 2002, the AJCC reached an additional significant milestone. The sixth edition of the *AJCC Cancer Staging Manual* was published and became available for all those individuals taking part in cancer care, both in the U.S. and throughout the world. The changes in TNM cancer staging strategy appearing in the sixth edition will be used by cancer registrars and physicians beginning in January 2003.

The groundwork for the latest edition began several years ago when several hundred clinicians, registrars, and dedicated AJCC personnel combined their efforts to develop task forces specific to organ sites of cancer. These groups reviewed pertinent literature, patient databases, and new clinical and pathological techniques that would impact staging strategies appearing in the sixth edition. These groups met and worked diligently to debate concepts that are critically important not only to cancer staging, but to the methods of collecting and analyzing a vast amount of material related to staging concepts. To complement the efforts of the task forces, representatives of the UICC have contributed greatly and have ensured that the sixth editions of both the AJCC and UICC publications will be seamless and reflect the important working relationship between both organizations.

The panels that prepared the sixth edition of the *AJCC Cancer Staging Manual* required a full understanding of the tenets upon which TNM staging is based, as well as a full knowledge of new concepts of imaging and pathologic diagnosis, especially in this era of molecular biology. In certain organ sites, especially the breast, new concepts of sentinel node imaging were fully discussed and led to new descriptors for this important concept in the new manual. In the new editions of both the AJCC and UICC publications, terms to

record minimal cellular involvement are proposed. The importance of the isolated tumor cell is discussed in the new publication and, hopefully, will lay the groundwork for future editions as the role of immunohistochemistry and polymerase chain reaction (PCR) technology evolve in the identification and use of molecular markers and minimal tumor involvement.

The sixth edition of the *AJCC Cancer Staging Manual* includes changes in the staging of breast cancer, hepatobiliary tumors, pancreatic carcinoma, and melanoma. In addition, staging of head and neck cancer will reflect the surgeon's role in identifying "resectable" versus "unresectable" tumors. In order for staging to be relevant, it has to apply to the primary use of extirpation of solid

Table 1

AJCC founding organizations

American Cancer Society
 American College of Physicians
 American College of Radiology
 American College of Surgeons
 College of American Pathologists
 National Cancer Institute

Table 2

AJCC sponsoring organizations

American Cancer Society
 American College of Surgeons
 American Society of Clinical Oncology
 Centers for Disease Control and Prevention

Table 3

AJCC liaison organizations

American Urological Association
 Association of American Cancer Institutes
 National Cancer Registrars Association
 North American Association of Central Cancer Registries
 American Society of Colon and Rectal Surgeons
 Society of Gynecologic Oncologists
 Society of Urologic Oncology

tumors. Once the concepts of resection are planned, then the staging strategies must be equally effective in planning both chemotherapy and radiation management. This implies that the TNM system must never become static but should always be a dynamic and useful system for all clinicians.


In addition, the pathologist continues to play a role in the ultimate analysis of TNM staging based on resection of solid tumors. Through the coordinating efforts of the College of American Pathologists (CAP), a founding organization of the AJCC, synoptic reporting of cancer for all COC-approved hospitals will be instituted in 2003 and will be based on the principles of TNM as espoused by the AJCC. This interaction is another indication of the importance of open dialog among organizations dedicated to cancer care.

The role of the AJCC goes well beyond creation and maintenance of the TNM system for cancer staging. The organizations and individuals supporting the AJCC are also dedicated to the education and promotion of TNM concepts for all physicians, nurses, registrars, and members of the health care team who treat our cancer patients. The target population for immediate use of the sixth edition of the *AJCC Cancer Staging Manual* will be the cancer registrars who work diligently in hundreds of hospitals throughout the U.S. to ensure that clinical information is recorded properly and that this information is maintained in a consistent form to be used for primary patient care and clinical research. In developing the new manual, the input of our cancer registry community was solicited and recommendations for improvements in the sixth edition were adhered to whenever possible. The goal of the editorial board was to make the publication as "user friendly" as possible and to have it serve as an educational tool for medical students, house officers, physicians, cancer registrars, and all those who care for the cancer patient.

In partnering with a new publisher, Springer-Verlag, the AJCC has also realized the importance of new methods of information gathering and dissemination represented by computerization, the Internet, and CD-ROM technology. The new version uses these exciting techniques to help physicians and registrars in their daily application of TNM staging. Through modern concepts of infor-

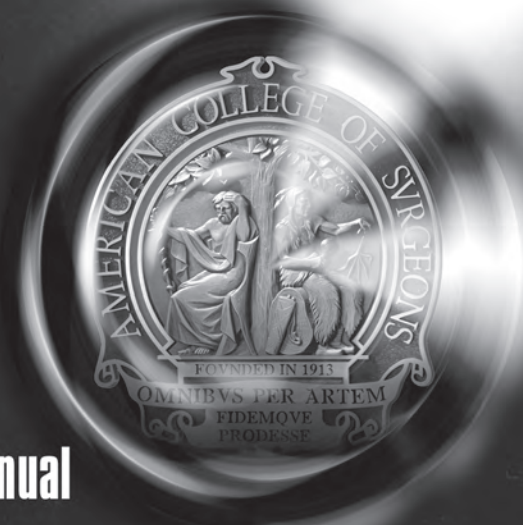
mation transfer and dissemination, the educational mission of the AJCC will be realized. The eventual goals of the AJCC relating to cancer staging can never be attained unless newer generations of practitioners and registrars are introduced to cancer staging strategies during their training.

Both the current and future goals of the AJCC and the American College of Surgeons are intertwined and based on the premise that excellent patient care can only be derived through the education and dedication of enlightened physicians. The *AJCC Cancer Staging Manual* is another example of this partnering effort. We anticipate that all surgeons and Fellows of the American College of Surgeons will embrace the concepts developed in the sixth edition and will use this valuable material in their daily patient management whether it be at tumor conference, in the operating room, in documentation of the medical record, or at any venue where excellence in cancer staging is paramount.

Surgeons who are interested in purchasing a copy of the sixth edition of the *AJCC Cancer Staging Manual* may order via the Internet at www.cancerstaging.net or by phoning 800/777-4643. 

Dr. Greene is chairman, department of surgery, Carolinas Medical Center, Charlotte, NC, and chair, American Joint Committee on Cancer.





88th annual

Clinical Congress

San Francisco, CA, October 6-10, 2002

Preliminary Program





FROM THE CHAIR, BOARD OF REGENTS COME TO THE 2002 CLINICAL CONGRESS

Dear Colleagues,

On behalf of the entire College, I would like to extend our warmest invitation for you to join us in San Francisco for the 88th Annual Clinical Congress of the American College of Surgeons.

The continuing advances in science and technology and changes in the health care environment necessitate an active approach to learning throughout the continuum of a surgeon's training and practice. The College's Program Committee has exerted another outstanding effort to bring to all of our members an extensive array of educational sessions and courses that it hopes will meet the needs of Fellows in the daily care of their patients.

The program touches upon virtually every area currently of special interest to surgeons, including contemporary topics such as the role of axillary dissection, advances in minimally invasive surgery, best practices relating to abdominal and pelvic radiation injuries, and bioterrorism. Advances in technology will be addressed in sessions on image-guided surgery, surgical robots in the operating room, and telemedicine. Competency issues are incorporated into the program through topics such as enhancing patient safety and moving from competence to virtuosity. Sessions on stem cells in clinical practice and abdominal organ transplantation round out the scientific component. The program also includes contemporary educational issues, such as attracting and training surgeons, the importance of role models, and ethics and entrepreneurial surgeons. The named lecturers include an outstanding collection of clinicians, academicians, surgeon scientists, surgeon historians, and surgeon ethicists. Programa Hispanico will be offered again this year.

The aforementioned sessions are complemented by a multitude of postgraduate courses, including skills-oriented courses on topics such as ultrasound, stereotactic breast biopsy, lymphatic mapping, and computers. In addition, didactic postgraduate courses provide the opportunity for in-depth exposure to a variety of clinical subjects, including minimal access surgery, professional liability, and a review course in urology. Presentations of papers on leading-edge clinical research, presentations of research done by young investigators, and video-based educational sessions complete the comprehensive selection of sessions and activities. As always, the meeting will include both scientific and technical exhibits.

The Clinical Congress has been designed to offer myriad educational opportunities to keep you abreast of the latest developments and to challenge your ability to experience all that you want to see and hear. I hope you will join us in San Francisco this year.

With best wishes,

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

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

THE SOURCE FOR LIFELONG LEARNING

Continuing advances in science and technology and changes in the health care environment necessitate an active approach to learning during the continuum of a surgeon's training and practice. Staying current is not always enough. Staying ahead is the goal we can help you reach through a wide variety of learning activities at the 2002 Clinical Congress.

GOAL AND OBJECTIVE

The Clinical Congress is designed to provide an exceptional variety of learning opportunities that will enable individuals to participate in activities that match their educational needs to support lifelong learning. At the conclusion of the Clinical Congress, participants should be able to apply the knowledge acquired to enhance the care of their surgery patients.

NAMED LECTURES BY RENOWNED SURGEONS

Medicine in the Twenty-First Century
Haile T. Debas, MD, FACS

Information Exchange and Communication—Are They the Same?
Thomas B. Ferguson, MD, FACS

The Saga of Liver Transplantation
Thomas E. Starzl, MD, PhD, FACS

Blood Substitutes—The Future Is Now
Ernest E. Moore, MD, FACS

Conflicts of Interest—Recognition, Disclosure, and Management
Roger S. Foster, Jr., MD, FACS

Esophageal Cancer: What Price Swallowing?
John Wong, MBBS, FACS(Hon)

The Ignoble Renal Artery, Renin, Angiotensin, Hypertension, and the Surgeon Scientist
James C. Stanley, MD, FACS

Xenotransplantation and Cloning—Facts and Future
Ainslie G. R. Sheil, MBBS, FACS(Hon)

From Mainz to Modem with Martin in the Middle

Seymour I. Schwartz, MD, FACS

GENERAL SESSIONS ON CONTEMPORARY TOPICS

- **Image-Guided Surgery: From Technology to Patient Care**
- **The New Member of the OR Team: The Surgical Robot**
- **Stem Cells in Clinical Practice**
- **The Scope of Practice and the Future of the General/Trauma Surgeon**
- **Knowledge at the Point of Care: Handheld Computing for Surgeons**
- **Radio-Guided Surgery**
- **The Morbidity and Mortality Conference As an Educational and Risk Reduction Tool**
- **Heroes: The Influence of Role Models in Career Choice**
- **Programa Hispanico**
- **Advances in Pancreatic Cancer Care**
- **Artificial Heart as Destination Therapy**
- **From Competence to Virtuosity**
- **Should Axillary Dissection Be Abandoned?**
- **Unconventional Acts of Civilian Terrorism: Likely Agents and Strategies for Preparedness**
- **The Ethics of Entrepreneurialism in Surgery**
- **Bariatric Surgery**

MULTIDISCIPLINARY SESSIONS

- **Complications of Abdominal Surgery: Getting Out of Trouble in the Operating Room**
- **Perioperative Care of the Diabetic Surgical Patient: Optimizing Outcomes**
- **Abdominal and Pelvic Radiation Injuries: Prevention Strategies**
- **New Modalities in the Diagnosis and Management of Major Vessel Injury**
- **Abdominal Organ Transplantation: An Update for the Non-Transplant Surgeon**

SPECIALTY SESSIONS

- **Advances in Minimally Invasive Surgery for Thoracic Disease**
- **Ileal Pouch, Anal Anastomosis (Restorative Proctocolectomy): A Twenty-First Century Update**
- **Technology Transfer: Can the Robotic Stereotactic Radiosurgery Experience in Neurosurgery Be Transferred to the Treatment of Neoplastic Diseases of the Thorax, Head and Neck, Spine, and Pancreas?**
- **Recurrent Thyroid Cancer Evaluation and Treatment**
- **Role of Ultrasound and Cross-Sectional Imaging in Evaluating Pelvic Pathology and Assessing the Need for Major Gynecologic Procedures**
- **Cryptorchidism—Current Concepts and Management**
- **Telemedicine in the Twenty-First Century: Outreach, Education, and Innovation**
- **Current Risk Assessment in Prostate Cancer: How It Impacts Treatment Decisions Both Before and After Primary Therapy**
- **New Technical Approaches in Venous Surgery**

POSTGRADUATE COURSES

- 14 skills-oriented courses
- 16 didactic courses

ADDITIONAL ACTIVITIES

- Video-based education—more than 120 videos and films
- More than 300 papers presented in the Surgical Forum and Papers Sessions
- Technical exhibits from approximately 300 companies
- More than 150 scientific exhibits

POSTGRADUATE COURSES

The Clinical Congress offers a wide variety of postgraduate courses from which to choose. This year, select from 14 different skills-oriented courses (designated as SC) and 16 didactic courses (designated as PG). Descriptions of each course are listed on the following pages.

SC01

Image-Guided Breast Biopsy (core lectures)

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

4 hours

Sunday, October 6, 7:30 am–12:00 noon

Fee: \$250

The objective of this course is to teach surgeons how to identify mammographic abnormalities and to recognize when they should order additional image studies. Surgeons will learn to differentiate between benign and malignant lesions and when to recommend close follow-up as opposed to operation. Surgeons will learn to correlate the mammographic image with the pathologic finding and to implement appropriate clinical pathways. The technique for the performance of stereotactic biopsy and ultrasound-guided biopsy will be reviewed.

SC02

Ultrasound for Surgeons

CHAIR: William R. Fry, MD, RVT, FACS, *Colorado Springs, CO*

4 hours

Sunday, October 6, 1:00–5:00 pm

Fee: \$250

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

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

SC03

Ultrasound Instructors Course

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

4 hours

Monday, October 7, 8:00 am–12:00 noon

Fee: \$100

Prerequisite: Approval by the National Ultrasound Faculty Vice-Chair for Education; application required. *E-mail Darrell Sparkman at dsparkman@facs.org for additional information.*

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

SC04

Breast Ultrasound

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

7 hours

Monday, October 7, 8:30 am–12:00 noon and 1:00–5:00 pm

Fee: \$1,000

Prerequisite: Ultrasound for Surgeons (SC02). *(Due to limited seating and workshop capacity, early registration is encouraged.)*

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

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

SC05

Computers in Surgery: Creating a Scientific Presentation

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

3 hours

Workshops (choice of one):
Monday, October 7, 9:45 am–12:45 pm
Monday, October 7, 2:00–5:30 pm
Fee: \$325

The objective of this course is to provide the advanced computer user with instruction in creating a successful scientific presentation using PowerPoint®, electronically manipulating still and moving images for presentation, improving presentation skills, and publishing the presentation on the Web. The course will focus primarily on advanced PowerPoint techniques and is designed to enhance the ability of the surgeon to present and publish scientific material in an electronic format. As a prerequisite, participants should have knowledge of basic computer concepts and a familiarity with PowerPoint. This three-hour course will be presented entirely in a workshop format and does not include a lecture component.

SC06

Computers in Surgery: Basic Course

CHAIR: David A. Krusch, MD, FACS, Rochester, NY
6 hours

Lectures (choice of one):

Monday, October 7, 9:45 am–12:45 pm

Monday, October 7, 2:00–5:30 pm

Workshops (choice of one):

Tuesday, October 8, 8:30 am–12:00 noon

Tuesday, October 8, 1:30–5:00 pm

Fee: \$425

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

SC07

Ultrasound in the Acute Setting

CHAIR: Heidi L. Frankel, MD, FACS, New Haven, CT
6 hours

Monday, October 7, 12:30–6:30 pm
Fee: \$750

Prerequisite: Ultrasound for Surgeons (SC02). (*Due to limited seating and workshop capacity, early registration is encouraged.*)

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

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

SC08

Abdominal Ultrasound: Transabdominal/Intra-operative/Laparoscopic

CHAIR: Junji Machi, MD, PhD, FACS, Honolulu, HI
12 hours

Tuesday, October 8, 7:30–9:30 am, 10:00 am–12:00 noon, and 1:00–5:00 pm; Wednesday, October 9, 7:30 am–12:00 noon

Fee: \$1,500

Prerequisite: Ultrasound for Surgeons (SC02). (*Due to limited seating and workshop capacity, early registration is encouraged.*)

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

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

SC09

Head and Neck Ultrasound

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

7 hours

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

Fee: \$750

Prerequisite: Ultrasound for Surgeons (SC02). (*Due to limited seating and workshop capacity, early registration is encouraged.*)

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

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

SC10

Stereotactic Breast Biopsy

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

8 hours

Wednesday, October 9, 7:30 am–12:00 noon and 1:00–5:00 pm

Fee: \$750

Prerequisite: Image-Guided Breast Biopsy (SC01). (*Due to limited seating and workshop capacity, early registration is encouraged.*)

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

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

SC11

Vascular Ultrasound

CHAIR: R. Eugene Zierler, MD, FACS, *Seattle, WA*

8 hours

Wednesday, October 9, 7:30 am–12:00 noon and 1:00–5:30 pm

Fee: \$750

Prerequisite: Ultrasound for Surgeons (SC02). (*Due to limited seating and workshop capacity, early registration is encouraged.*)

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

The objective of this course is to provide the

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

SC12

Lymphatic Mapping and the Significance of Sentinel Node Biopsy

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

8 hours

Wednesday, October 9, 8:00 am–12:00 noon and 1:00–5:00 pm

Fee: \$350

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

SC13

Handheld Devices for Surgeons: PalmPilot® Basics

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

3 hours

Wednesday, October 9, 8:30 am–12:00 noon

Fee: \$425

Designed to expand on the didactic general session "Knowledge at the Point of Care: Handheld Computing for Surgeons," this hands-on course will teach participants the basic use and function of a personal digital assistant (PDA). Participants will receive a basic PDA to keep after the course. They also will learn to use the device; to enter and synchronize addresses, appointments, and to-do lists; and to find, download, and use clinically applicable handheld applications. These include databases that contain drug information;

information about procedures, diagnoses, and laboratory results; and billing and documentation templates.

SC14

Surgical Education: Principles and Practice

CHAIRS:

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

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

6 hours

Wednesday, October 9, 8:30 am–12:30 pm and 2:00–5:00 pm

Fee: \$275

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

PG15

Endocrine Surgery

CHAIR: Barbara K. Kinder, MD, FACS, *New Haven, CT*

6 hours

Monday, October 7, 9:45 am–12:45 pm and 1:30–5:00 pm

Fee: \$275

The objective of this course is to provide a thorough summary and review of the recent developments in the diagnosis and management of patients who need surgical therapy for thyroid, parathyroid, adrenal, and endocrine pancreas disorders.

PG16

Diseases of the Liver, Biliary Tract, and Pancreas

CHAIR: Gary C. Vitale, MD, FACS, *Louisville, KY*

6 hours

Monday, October 7, 1:30–5:00 pm; Tuesday, October 8, 8:30 am–12:00 noon

Fee: \$400

The objective of this course is to update participants on the etiology, pathophysiology, diagnosis, and treatment (both surgical and nonsurgical) of patients with diseases of the liver, biliary tract, and pancreas. A

number of new innovations in the area, especially in diagnostics and therapeutics, as well as the evolution of surgical operations in this complicated area, will be presented. A multidisciplinary approach that includes medicine, surgery, radiology, and other subspecialties will be used.

PG17

Vascular Surgery: Technical Tips that Enhance Surgical and Endovascular Outcomes

CHAIR: John W. Hallett, Jr., MD, FACS, *Bangor, ME*
6 hours

Monday, October 7, 1:30–5:00 pm; Tuesday, October 8, 1:30–5:00 pm
Fee: \$325

The objective of this course is to review the most important technical factors and maneuvers that ensure the best outcomes for surgical and endovascular approaches to the most common vascular problems.

PG18

Thoracic Surgery

CHAIR: Mark S. Allen, MD, FACS, *Rochester, MN*
6 hours

Monday, October 7, 1:30–5:00 pm; Tuesday, October 8, 1:30–5:00 pm
Fee: \$400

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

PG19

Gastrointestinal Disease

CHAIR: Barbara L. Bass, MD, FACS, *Baltimore, MD*
6 hours

Monday, October 7, 1:30–5:00 pm; Tuesday, October 8, 1:30–5:00 pm
Fee: \$400

The objective of this course is to review up-to-date and contemporary treatments of surgical gastrointestinal disease. Emphasis will be placed on the diagnosis and evidence-based management of gastrointestinal disorders that may benefit from multidisciplinary assessment and intervention. The impact of novel imaging and diagnostic modalities on

surgical management will be addressed. This course is intended to be of value to practicing general surgeons and surgical residents with specific interest in gastrointestinal disease.

PG20

Minimal Access Surgery

CHAIR: Joseph F. Amaral, MD, FACS, *Providence, RI*
6 hours

Tuesday, October 8, 8:30 am–12:00 noon; Wednesday, October 9, 8:30 am–12:00 noon
Fee: \$400

Minimal access surgery has revolutionized and revitalized general surgery. The depth and range of minimal access surgery have been extended over the past five years, although a number of controversial areas remain. Participants will learn about various techniques in minimal access surgery, as well as the results of various randomized prospective trials providing evidence of the importance of this new modality. Contemporary controversies, such as minimal access surgery for large and small bowel (including neoplastic) disease will be discussed.

PG21

Essential Technical Elements in Trauma

CHAIR: John A. Weigelt, MD, FACS, *Milwaukee, WI*
6 hours

Tuesday, October 8, 8:30 am–12:00 noon; Wednesday, October 9, 8:30 am–12:00 noon
Fee: \$400

This course will present state-of-the-art technologic and technical aspects of surgical care for the injured patient. The evaluation of patients and operative approaches and maneuvers relevant to specific problematic injuries will be presented in an interactive format based on illustrative cases to provide maximum practical value for participants.

PG22

Cardiac Surgery

CHAIR: R. Morton Bolman III, MD, FACS, *Minneapolis, MN*
6 hours

Tuesday, October 8, 8:30 am–12:00 noon; Wednesday, October 9, 8:30 am–12:00 noon
Fee: \$300

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

PG23

Urology Review for Recertification Candidates

CHAIRS:

Richard D. Williams, MD, FACS, *Iowa City, IA*
Jerome P. Richie, MD, FACS, *Boston, MA*

6 hours

Tuesday, October 8, 8:30 am–12:00 noon; Wednesday, October 9, 8:30 am–12:00 noon

Fee: \$300

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

PG24

Colon and Rectal Surgery

CHAIR: W. Brian Sweeney, MD, FACS, *St. Paul, MN*

6 hours

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

Fee: \$275

The objectives of this course are to: (1) provide an update on the diagnosis and management of common anorectal conditions using a problem-oriented approach; (2) present a comprehensive review of intestinal anastomosis; and (3) discuss and debate the current recommendations for preoperative evaluation and postoperative surveillance of patients with colorectal cancer.

PG25

CPT and ICD Coding and Documentation for Surgeons

PHYSICIAN RESOURCES:

Karen R. Borman, MD, FACS, *Jackson, MS*
Albert Bothe, Jr., MD, FACS, *Chicago, IL*

WORKSHOP INSTRUCTOR: Teri R. Gatchel, MBA, *Chicago, IL*

6 hours

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

Fee: \$350

This course is intended for surgeons and their staff who are new to coding. The course will introduce participants to the key principles of ICD-9-CM and CPT coding, including use of the books. ICD-9-CM topics will cover diagnosis codes, how carriers use these codes to establish medical necessity, the neoplasm table, and coding for comorbidities. CPT topics include CPT concepts, guidelines and definitions, evaluation and management codes, add-on versus stand-alone codes, and the use of modifiers. Participants will learn how the accurate use of both coding systems to report patient encounters will result in the appropriate reimbursement for services. Participants are required to bring their copies of the 2002 editions of *Current Procedural Terminology* and *ICD-9-CM* to the course.

PG26

Surgical Infection and Antibiotics

CHAIR: William G. Cheadle, MD, FACS, *Louisville, KY*

6 hours

Tuesday, October 8, 8:30 am–12:00 noon; Wednesday, October 9, 8:30 am–12:00 noon

Fee: \$275

The objective of this course is to review the use and mechanisms of action of antimicrobials in the treatment of surgical infections. Infections commonly treated by surgeons will be discussed, and current issues in the management of critically ill septic patients will be highlighted.

PG27

Breast Disease

CHAIR: V. Suzanne Klimberg, MD, FACS, *Little Rock, AR*

6 hours

Tuesday, October 8, 8:30 am–12:00 noon; Wednesday, October 9, 8:30 am–12:00 noon

Fee: \$325

Breast disease has been among the most extensively studied conditions during the past two decades, and knowledge about it has increased geometrically. As studies from the National Surgical Adjuvant Breast and Bowel Project and others and randomized prospective trials have come to fruition, the degree of specificity in dealing with breast disease has become astounding. Participants will become familiar with the various combinations and permutations in the treatment of malignant and near-malignant disease, as well as the results of various randomized trials and of established

and newer therapies. The management of the patient at high risk for breast cancer will also be discussed.

PG28

Plastic Surgery: Management of Devastating Defects of the Abdomen and Perineum

CHAIR: Alan E. Seyfer, MD, FACS, *Portland, OR*

6 hours

Tuesday, October 8, 8:30 am–12:00 noon; Wednesday, October 9, 8:30 am–12:00 noon

Fee: \$275

The objective of this course is to examine coordinated therapies to achieve optimal outcomes in patients with destructive or ablative wounds of the abdominal wall and perineum. Etiologies to be discussed include injury that destroys tissue, radical excision of tumors, and debridements to control infection. Specific areas of focus will include complex wounds, enteric fistulas, compromised (for example, irradiated) tissue, and loss of abdominal and perineal structural support. Suggested therapies will emphasize a sequential approach that first controls the primary problem, and, second, achieves a durable and functional closure.

PG29

Pediatric Surgery: Esophageal Disorders and Anomalies in Infancy and Childhood

CHAIR: Charles N. Paidas, MD, FACS, *Baltimore, MD*

6 hours

Wednesday, October 9, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$275

The objective of this course is to review relevant embryology and pathophysiology of esophageal anomalies and disorders in childhood. Discussions will focus primarily on major clinical management issues, especially diagnostic approaches, therapeutic options and controversies, and outcomes.

PG30

A Surgeon's Personal Guide to Risk Management and Trial Participation

CHAIRS:

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

Bruce L. Allen, MD, FACS, *San Mateo, CA*

6 hours

Session I: Wednesday, October 9, 8:30 am–12:00 noon

Fee: Session I only: \$150

Session II: Thursday, October 10, 8:30 am–12:00 noon

Fee: Session II only: \$150

Fee: Both sessions: \$275

This course has two objectives: (1) to examine the surgeon's individual responsibility to evaluate and improve personal performance as it relates to patient safety, and (2) to provide a guide to the surgeon's participation in the litigation process invoked by real or perceived errors.

Session I, "The Surgeon's Personal Guide to Risk Management," will address issues related to self-evaluation, patient safety, and liability. The government, legal system, and population at large are reacting to the Institute of Medicine report, *To Err Is Human: Building a Safer Health System*, in ways that bring into focus the relationship between liability and patient safety. In spite of our progress in identifying systems as being responsible for most medical errors and as patient safety in hospitals is increasingly questioned, individuals at the point of service remain the prime targets of litigation. Physicians have always worked diligently through peer review to guard the safety of patients, but only recently has the relationship of patient safety to liability been so clearly defined.

In this context, methods to improve the safety of patients under our care, and consequently to control liability, will be presented. Self-assessment and targeted continuing medical education to address weaknesses (Pat O'Leary, MD, FACS), the use and abuse of guidelines and evidence-based practices (Josef E. Fischer, MD, FACS), safe application of new technologies (Jon A. van Heerden, MD, FACS), the development of interpersonal and communication skills (Sara C. Charles, MD, FACS), and workload factors (Lazar J. Greenfield, MD, FACS) are among the topics on the agenda. Our self-esteem as it relates to our capabilities, weaknesses, and scope of practice will be discussed.

In spite of our careful attention, patients occasionally pursue litigation, and Session II, "The Surgeon's Personal Guide to Trial Participation," will focus on what happens in the courtroom. The surgeon's role in the litigation process will be elucidated through the medium of a mock trial and related didactic material. To improve our understanding of what constitutes malpractice, the plaintiff lawyer's concepts will be outlined. An expert will address our concerns regarding the current crisis in the cost and availability of medical malpractice insurance.

SCIENTIFIC PROGRAM REGISTRATION

American College of Surgeons

88th Annual Clinical Congress
San Francisco, CA
October 6–10, 2002

Mail to:

American College of Surgeons
Attn: Jeff Smith
PO Box 92340
Chicago, IL 60675-2340

or

Fax to:

800/682-0252 or 312/202-5003

or

Register online at www.facs.org

SPECIALTY

- SUR - General Surgery
- THO - Cardiothoracic Surgery
- CRS - Colon & Rectal Surgery
- OBG - Gynecology & Obstetrics
- NEU - Neurological Surgery
- OPT - Ophthalmic Surgery
- ORT - Orthopaedic Surgery
- ORL - Otorhinolaryngology
- PED - Pediatric Surgery
- PLA - Plastic & Maxillofacial Surgery
- URO - Urology
- VAS - Vascular Surgery
- Other: _____

► *Advance registration closes on August 12 for U.S. registrants and on July 22 for international registrants.*

► *Do not include hotel deposit with this form. It will delay your reservation.*

► *Cancellation deadline: August 12 for U.S. registrants and July 22 for international registrants. Refunds will not be issued after these dates.*

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

CATEGORY	On or Before 7/22 (international) or 8/12 (U.S.)	After 7/22 (international) or 8/12 (U.S.)
1 <input type="checkbox"/> Fellow of the American College of Surgeons ...	No fee	No fee
2 <input type="checkbox"/> Initiate	No fee	No fee
3 <input type="checkbox"/> Associate Fellow	No fee	No fee
4 <input type="checkbox"/> Member of ACS Candidate Group	No fee	No fee
5 <input type="checkbox"/> Surgical Resident—with verification letter	\$195 _____	\$220 _____
6 <input type="checkbox"/> Guest Physician (U.S.)	\$525 _____	\$575 _____
7 <input type="checkbox"/> Guest Physician (international)	\$525 _____	\$575 _____
8 <input type="checkbox"/> Medical Student—with verification letter	No fee	No fee
A <input type="checkbox"/> Hospital Administrator	\$225 _____	\$275 _____
B <input type="checkbox"/> Hospital Purchasing Agent	\$225 _____	\$275 _____
C <input type="checkbox"/> Medical Association Personnel	\$225 _____	\$275 _____
D <input type="checkbox"/> Nurse	\$225 _____	\$275 _____
E <input type="checkbox"/> Physician Assistant	\$225 _____	\$275 _____
F <input type="checkbox"/> Technician	\$225 _____	\$275 _____
H <input type="checkbox"/> PhD	\$525 _____	\$575 _____
K <input type="checkbox"/> Social Program	\$ 50 _____	\$ 75 _____
(Name) _____		
R <input type="checkbox"/> Commercial Press	\$225 _____	\$275 _____
(Company Name) _____		
Registration Subtotal	\$ _____	\$ _____

*Register Online & Save Time
www.facs.org*

(Form continues on back)

SCIENTIFIC PROGRAM REGISTRATION *(continued)*

POSTGRADUATE COURSE SELECTION (SC)–Skills-Oriented (PG)–Didactic

<input type="checkbox"/> SC01	Image-Guided Breast Biopsy (Core Lectures)	\$250	<input type="checkbox"/> PG15	Endocrine Surgery	\$275
<input type="checkbox"/> SC02	Ultrasound for Surgeons	\$250	<input type="checkbox"/> PG16	Diseases of the Liver, Biliary Tract, and Pancreas	\$400
<input type="checkbox"/> SC03*	Ultrasound Instructors Course	\$100	<input type="checkbox"/> PG17	Vascular Surgery: Technical Tips That Enhance Surgical and Endovascular Outcomes	\$325
	Prerequisite: Refer to page 5 (By Application Only)		<input type="checkbox"/> PG18	Thoracic Surgery	\$400
<input type="checkbox"/> SC04*	Breast Ultrasound	\$1,000	<input type="checkbox"/> PG19	Gastrointestinal Disease	\$400
	Prerequisite: Ultrasound for Surgeons (SC02)		<input type="checkbox"/> PG20	Minimal Access Surgery	\$400
<input type="checkbox"/> SC05	Computers in Surgery: Creating a Scientific Presentation	\$325	<input type="checkbox"/> PG21	Essential Technical Elements in Trauma	\$400
	Workshops: Monday (choose one) <input type="checkbox"/> 9:45 am–12:45 pm or <input type="checkbox"/> 2:00–5:30 pm		<input type="checkbox"/> PG22	Cardiac Surgery	\$300
<input type="checkbox"/> SC06	Computers in Surgery: Basic Course	\$425	<input type="checkbox"/> PG23	Urology Review for Recertification Candidates	\$300
	Lectures: Monday (choose one) <input type="checkbox"/> 9:45 am–12:45 pm or <input type="checkbox"/> 2:00–5:30 pm		<input type="checkbox"/> PG24	Colon and Rectal Surgery	\$275
	Workshops: Tuesday (choose one) <input type="checkbox"/> 8:30 am–12:00 noon or <input type="checkbox"/> 1:30–5:00 pm		<input type="checkbox"/> PG25	CPT and ICD Coding and Documentation for Surgeons	\$350
<input type="checkbox"/> SC07*	Ultrasound in the Acute Setting	\$750	<input type="checkbox"/> PG26	Surgical Infection and Antibiotics	\$275
	Prerequisite: Ultrasound for Surgeons (SC02)		<input type="checkbox"/> PG27	Breast Disease	\$325
<input type="checkbox"/> SC08*	Abdominal Ultrasound: Transabdominal/ Intraoperative/Laparoscopic	\$1,500	<input type="checkbox"/> PG28	Plastic Surgery: Management of Devastating Defects of the Abdomen and Perineum	\$275
	Prerequisite: Ultrasound for Surgeons (SC02)		<input type="checkbox"/> PG29	Pediatric Surgery: Esophageal Disorders and Anomalies in Infancy and Childhood	\$275
<input type="checkbox"/> SC09*	Head and Neck Ultrasound	\$750	<input type="checkbox"/> PG30	A Surgeon's Personal Guide to Risk Management and Trial Participation	
	Prerequisite: Ultrasound for Surgeons (SC02)			Session I Only	\$150
<input type="checkbox"/> SC10*	Stereotactic Breast Biopsy	\$750		Session II Only	\$150
	Prerequisite: Image-Guided Breast Biopsy (SC01)			Both Sessions	\$275
<input type="checkbox"/> SC11*	Vascular Ultrasound	\$750			
	Prerequisite: Ultrasound for Surgeons (SC02)				
<input type="checkbox"/> SC12	Lymphatic Mapping and the Significance of Sentinel Node Biopsy	\$350			
<input type="checkbox"/> SC13	Handheld Devices for Surgeons: Palm Pilot Basics	\$425			
<input type="checkbox"/> SC14	Surgical Education: Principles and Practice	\$275			

Postgraduate Course Fee Subtotal \$ _____

* Requires prerequisite(s) for registration.
Please refer to the course descriptions on pages 4–8
for more information.

I plan to attend the CAS-ACS symposium on Professionalism
in the Medical Education Environment. **No Fee**
(For more information, see page 30.)

Cancellation Policy

- Registration and postgraduate course fees will be refunded if a written request is received at the College and postmarked no later than July 22 for international registrants or August 12 for U.S. registrants. A \$50 handling fee will be retained.
- The American College of Surgeons reserves the right to cancel any regularly scheduled session prior to the start of the meeting.
- Formal, written confirmation will be mailed to all registrants upon processing.
- Please ensure legibility prior to mailing or faxing.



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

Please specify Audio Visual
 Mobile Other

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

Check (enclosed) MasterCard Visa American Express

Card Number _____

Name on Card _____ Expiration Date _____

Signature _____

Registration Subtotal \$ _____

PG Course Fee Subtotal \$ _____

Total Amount \$ _____

GENERAL INFORMATION

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

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

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

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

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

Registration confirmation will be mailed to all advance registrants upon processing. Prior to the meeting, advance registrants will receive their official name badge, attendance verification card, and postgraduate course ticket(s), if applicable. Course syllabi will be distributed on-site in San Francisco.

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

INITIATES REGISTRATION

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

FAMILY AND GUESTS

Spouses, guests, and young adults (16 years or older) may register under the Social Program category, which includes a badge, admittance to the exhibit area, shuttle



SFCVB PHOTO BY PHILLIP H. COLBENTZ

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

POSTGRADUATE COURSES AND FEES

Only registered meeting attendees may purchase postgraduate course tickets. Seating capacities are limited and ticket requests will be filled on a first-come, first-processed basis. All courses require a ticket for admission. Tickets may only be exchanged before the beginning of a course. A complete listing of postgraduate courses begins on page 20.

REGISTRATION LOCATION AND HOURS

Registration locations and hours are listed below:

	Moscone Center	Hilton San Francisco
Saturday, 10/5	Not available	1:00 pm–5:00 pm
Sunday, 10/6	10:00 am–8:00 pm	10:00 am–6:00 pm
Monday, 10/7	7:00 am–5:00 pm	7:00 am–5:00 pm
Tuesday, 10/8	7:00 am–5:00 pm	7:00 am–12:00 noon
Wednesday, 10/9	7:00 am–5:00 pm	Not available
Thursday, 10/10	7:00 am–1:30 pm	Not available

REGISTRATION FEES AND CREDENTIALS

Category	On or	
	before 7/22 (intl.) or 8/12 (U.S.)	After 7/22 (intl.) or 8/12 (U.S.)
ACS Fellow 2001 dues paid	No fee	No fee
2001 dues delinquent (U.S.)	\$375	\$375
2001 dues delinquent (Canada)	\$320	\$320
2001 dues delinquent (international)	\$155	\$155
ACS Initiate	No fee	No fee
Associate Fellow	No fee	No fee
ACS Candidate Group participant	No fee	No fee
Surgical resident*	\$195	\$220
Guest physician*	\$525	\$575
Medical student*	No fee	No fee
PhD	\$525	\$575
Allied health care personnel	\$225	\$275
Commercial press	\$225	\$275

*The American College of Surgeons is pleased to offer discounted registration fees for residents and medical students. Please submit a letter verifying educational status with the completed registration form to expedite processing. Residents should obtain a letter from their program director; students should contact their department chairs.

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

DEADLINE FOR REGISTRATION

The registration deadline for international registrants (including Canada) is July 22. The deadline

for U.S. registrants is August 12. Registrations received and postmarked after the deadlines will be billed according to the pricing structure published on the registration form.

CANCELLATION

Refunds will be issued if written requests are postmarked no later than July 22 for international registrants and August 12 for U.S. registrants. A \$50 handling fee will be retained for all refunds. Cancellations and registrations postmarked after the deadline will not be eligible for refunds.

ACCREDITATION

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

CME CREDIT

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

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

ANNUAL MEETING/CONVOCATION

New times! The following events will be held at the Moscone Center on Thursday, October 10th:

Annual Meeting of Fellows and Initiates	2:00–2:45 pm
Convocation Ceremony	6:00–8:00 pm

CAS-ACS SYMPOSIUM

Sunday, October 6, from 2:00 to 5:00 pm, the Candidate and Associate Society of the American

College of Surgeons will sponsor a symposium to discuss professionalism and how it is taught in the medical environment. Michael E. Whitcomb, MD, senior vice-president of the division of medical education at the Association of American Medical Colleges, will speak and take part in an open-microphone discussion. Dr. Whitcomb is also editor-in-chief of *Academic Medicine*, the leading journal devoted to issues relevant to academic medicine. For more information, contact the Division of Member Services, Candidate and Associate Society. Please indicate on the registration form that you plan to attend.

AFFILIATE GROUP FUNCTIONS

Groups planning a social function or business meeting to be held in conjunction with the Clinical Congress need to make arrangements through the ACS. For information and a function space request form, please fax a request to 312/202-5003.

SHUTTLE BUS SERVICE

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

CLINICAL CONGRESS NEWS

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

CHILDREN

The ACS policy regarding children is as follows:

- Under 12—not permitted on social program tours.
- Under 16—not permitted on exhibit floor or in scientific sessions.
- 16 and over—must have a badge to enter exhibit area or meeting rooms.

This policy includes infants in strollers and arms.

The American College of Surgeons does not provide child care arrangements. If child care arrangements are needed, please contact American Childcare Services,

Inc., at 415/285-2300 at least five days prior to your child care needs. In business since 1976, American Childcare Services, Inc., is licensed, bonded, and insured and has child care providers who are thoroughly screened, CPR-certified, and field-trained.

HELP AND INFORMATION CENTER

The Help and Information Center will be located in the Moscone Center and will be available during registration hours. Assistance with general information, travel, housing, local information, and a messaging center will be available.

FRIENDS OF BILL W

Friends of Bill W will meet Sunday, October 6, through Wednesday, October 9, 7:00–8:30 pm, at the Hilton San Francisco and Towers.

CLIMATE

San Francisco is blessed with a temperate marine climate and enjoys mild weather year-round. Average temperatures for October range between a high of 68 and a low of 54 degrees Fahrenheit.

LOST AND FOUND

Lost-and-found areas will be located in the ACS Convention Office at the Hilton San Francisco and Towers and in the Convention and Exhibit Office at the Moscone Center. Individuals looking for or finding lost items should contact one of these offices.

SOCIAL PROGRAM

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

In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

As part of the health care industry's process to help small practices to comply with the privacy and security requirements in the Health Insurance Portability and Accountability Act (HIPAA), the WEDI Strategic National Implementation Process has created the "Small Practice Implementation Guide." Appendix A of that guide offers a simple model audit tool, which surgical practices may use to determine whether they need to make any changes.

True or false?

Some statements worth considering as you determine whether your practice is compliant with the mandates are as follows:

- My office does not use a patient sign-in sheet that includes confidential patient information, such as reason for visit, and so on. T/F
- My office does not place patient schedules in any places that may be seen by patients or other non-staff individuals. T/F
- In my office, all confidential conversations take place to the maximum extent possible in areas that cannot be overheard by other patients or non-staff individuals. T/F
- In my office, patients and non-staff individuals cannot gain access to our computers or fax machines and cannot view our computer screens. T/F
- Each computer user in my office has a personal computer password. These passwords change on a regular basis, and passwords of terminated employees are deleted immediately. T/F
- In my office patients and other non-staff individuals do not have any opportunities to access patient medical records, laboratory reports, and faxes. T/F
- My office has formal, documented procedures to ensure patient confidentiality when transferring to other offices paper files, orders, images, and specimens. T/F
- My office has formal documented procedures for accepting confidential patient information from outside of our office. T/F
- My office has confidentiality statements in place, and we inform patients of our confidentiality policies. T/F
- My office has formal privacy and security procedures regarding access to confidential information, access to computer information, and access to areas of the office that may contain confidential information. T/F
- My office requires the return of all keys and other items that allow access to the office and to computer files when a person no longer is authorized to access information. T/F
- My office has formal privacy and security policies for all office personnel, and training for all office personnel is documented. T/F
- My office uses laptops or other portable equipment (personal data assistants, electronic ordering systems, and so on) that hold confidential patient information, but this equipment is secure and can only be accessed by authorized personnel. T/F
- My office has policies and procedures in place to ensure patient confidentiality by off-site contractors, such as billing, accounting, and transcription services. T/F
- My office has a comprehensive survey of all our computer systems, including all software. T/F
- My office has a disaster plan to protect patient information and contingency plans in the event of a computer systems failure. We also perform regular virus checks and correct any identified problems. T/F
- All confidential information—paper and electronic—is stored with appropriate safeguards. T/F
- Internet transmissions, including e-mail and telephone conversations, are secure. T/F
- My office requires patients to sign a consent form. T/F
- My office has confidentiality statements on all faxes and e-mail sent by the office staff. T/F

If you find any of the statements are "false," you may need to change some office procedures. Main-
continued on page 44

Keeping current

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

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first and only Web-based and continually updated surgical reference. A sample chapter and detailed information on *ACS Surgery*, including how to save \$20 on a subscription to the online version, is available by visiting www.acssurgery.com/learnmore.htm.

V. Cost-Effective Non-Emergency Surgery
2. Risk Stratification, Preoperative Testing, and Operative Planning. Nicolas V. Christou, MD,

FACS; Alden H. Harken, MD, FACS; Douglas W. Wilmore, MD; and Jyoti Arya, MD. In an update to their recently published chapter, Drs. Christou, Harken, Wilmore, and Arya discuss a 2002 study by Myers and colleagues examining the assessment of exercise capacity as a measure of preoperative risk.

The study's results suggest that activities of daily living, such as climbing stairs, can be expressed in quantifiable terms (metabolic equivalents or METs) and used to help determine cardiovascular risk. According to Drs. Christou and others, the implication of Myers and other researchers is that a patient older than age 40 who requires an elective surgical procedure and is known to be capable of walking up several flights of stairs (that is, capable of over five METs), may be given beta blockers and cleared for surgery. Subscribers may view the full text of "Risk Stratification, Preoperative Testing, and Operative Planning" at www.acssurgery.com.

V. Operative Management

8. Minimally Invasive Esophageal Procedures. Marco G. Patti, MD, FACS, and Piero M. Fisichella, MD. In the late 1990s and the first years of the twenty-first century, minimally invasive esophageal procedures have continued to evolve, thanks to better instrumentation and improved surgical expertise. In addition, as experience with these procedures accumulates and the follow-up period lengthens, it becomes possible to analyze techniques and their results more rigorously, which will in turn lead to further improvements. In this chapter, Drs. Patti and Fisichella focus on minimally invasive techniques for the treatment of abnormal gastroesophageal reflux and motility disorders of the esophagus. Some of the procedures described are:

- Laparoscopic Nissen fundoplication

Online discount

As a special member benefit for ACS Fellows, Associates, and Candidates who are not already subscribers to the College-sponsored *ACS Surgery: Principles and Practice*, we are pleased to offer a \$20 discount on subscriptions to the online version of the reference. You pay an annual subscription fee of \$179, instead of the customary \$199 rate. Please go to www.acssurgery.com/learnmore.htm for more information and to save \$20 on the online version.

Subscribers to the print and CD-ROM versions of *ACS Surgery* continue to receive free online access to the monthly updates and full text by visiting www.acssurgery.com. You will need your nine-digit account number, which may be obtained by calling 800/545-0554 or 914/962-4559 (outside the U.S.), by faxing 914/962-5076, or by e-mailing acssurgery@dwcweb.net. Updates also are available quarterly through subscription to the *ACS Surgery* CD, which incorporates every online update from the previous three months, and yearly through subscription to the annual hardcover edition of *ACS Surgery*, which incorporates every online update from the preceding year.

- Laparoscopic Heller myotomy
- Right and left thoracoscopic myotomy
- Reoperation for reflux and achalasia.

Subscribers may view the full text of “Minimally Invasive Esophageal Procedures” at www.acssurgery.com.

VI. Special Preoperative Problems

7. The Elderly Surgical Patient. James M. Watters, MD, FACS, and Jacqueline McClaran, MD. In their new chapter, Drs. Watters and McClaran discuss the five factors that are critical for obtaining the best outcomes from surgical treatment of elderly patients: (1) careful preoperative preparation of the patient and optimization of medical and physiologic status; (2) minimization of perioperative starvation and inactivity and the stresses of hypothermia, hypoxemia, and pain; (3) meticulous perioperative care to avoid clinical complications from perturbations of fluid and electrolyte balance, impaired cardiovascular and respiratory function, and inappropriate pharmacotherapy; (4) careful surgical judgment and technique to achieve the desired goals and avoid technical complications; and (5) optimization of physical and cognitive function.

They discuss assessment of respiratory, cardiovascular, and cognitive function; postoperative management of renal function, pain, cognition, and other factors; and conclude with a specific discussion on older patients’ body composition, organ function, oxygen transport, and thermoregulation, among other issues.

Subscribers may view the full text of “The Elderly Surgical Patient” at www.acssurgery.com.

Looking ahead

New and revised chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in 2002 include the following:

- “Outpatient Surgery,” by Richard B. Reiling, MD, FACS, and Daniel P. McKellar, MD, FACS.
- “Open Esophageal Procedures,” by Richard Finley, MD, FACS, and John Yee, MD.
- “Emergency Department Evaluation of the Patient with Multiple Injuries,” by Felix Battistella, MD, FACS.
- “Thoracoscopy,” by Valerie W. Rusch, MD,

FACS, and Raja Flores, MD.

- “Anal Procedures,” by Ira J. Kodner, MD, FACS.

• “Multiple Organ Dysfunction Syndrome,” by John C. Marshall, MD, FACS.

- “Biliary Tract Procedures,” by Bernard Langer, MD, FACS, and Bryce R. Taylor, MD, FACS.

• “Liver Resections,” by Yuman Fong, MD, FACS. □

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

Socioeconomic tips of the month

Answers to common hotline questions

Q.

What code should we use when our surgeon performs an excision of tumors in the abdomen?

A.

You should report either code 49200, Excision or destruction by any method of intraabdominal or retroperitoneal tumors or cysts or endometriomas, or code 49201 if the procedure was extensive.

Q.

When performing destruction of lesions on the anus, is it appropriate to report code 46924 for each lesion taken?

A.

Code 46924, Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle; extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery) includes the destruction of one or more lesions. You're allowed to report the service only once.

Q.

Which ICD-9-CM code would I use to report the reversal of a vasectomy?

A.

You should use code V26.0, Tuboplasty or vasteroplasty after previous sterilization.

Q.

How do I report the excision of a subcutaneous lipoma from the thigh?

A.

You should report code 27327, Excision, tumor, thigh or knee area, subcutaneous.

Q.

How do I code for the surgical take-down of a tracheostomy?

Around the corner

September

- Postgraduate course on coding, compliance, and reimbursement presented by the ACS during the Society of Laparoendoscopic Surgeons' Eleventh International Congress and ENDO EXPO on September 11, 2002, in New York, NY. Contact Flor Tilden at 305/665-9959 for registration form.

- ACS-sponsored practice management course for surgeons on September 21, 2002, in Miami, FL. Visit the ACS Web site at <http://www.facs.org/dept/hpa/index.html> to register.

A.

"Take-down" has several meanings. In general, it does not imply a repair was performed. If the "take-down" is for the purpose of repair or closure of a tracheostomy site or wound, you should refer to codes 31750-31899 and select the code that most appropriately describes the procedure performed. If the "take-down" was performed in preparation for some other procedure, such as a thyroidectomy, you should append modifier -22 to the appropriate thyroidectomy code (codes 60240-60271) and submit a copy of the operative report with the claim. If the "take-down" is performed at the time of a laryngectomy, it would be considered an inherent part of the laryngectomy, and you would not report the service separately.

Q.

How do you code for a brachial-to-brachial artery bypass in the arm?

A.

If the brachial-brachial bypass is done for trauma, either code 35236 or 35266 should be reported, depending on whether a vein

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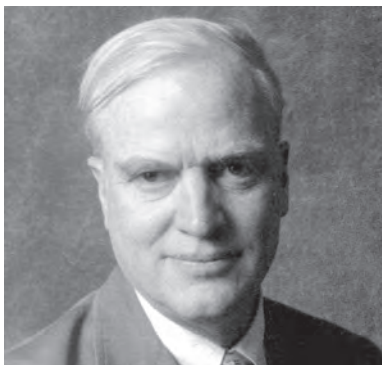
College news

Dr. Harrison receives Jacobson Award

Michael R. Harrison, MD, FACS, became the eighth recipient of the Jacobson Innovation Award of the American College of Surgeons during a ceremony on June 7, 2002, at the College's headquarters in Chicago, IL.

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

Dr. Harrison received the award in honor of his work in creating the specialty of fetal surgery. To that end, his contributions include developing techniques for both open fetal sur-



Dr. Harrison

gery—through an incision in the gravid artery—and minimally invasive fetal surgery—through fetoscopic and sonographic techniques he dubbed “fetendo.” In addition, Dr. Harrison has made significant contributions to the field of pediatric surgery in developing new therapies for babies with small lungs (congenital diaphragmatic hernia); for babies with congenital lung tumors; for babies with urologic conditions; and for babies with myelomeningocele.

Considered to be a surgeon ahead of his time, Dr. Harrison's experimental work in animal models and other clinical work on human fetuses and newborns made him the originator of the specialty of fetal surgery in the U.S. and abroad, and his accomplishments are accepted as being the guiding force for the future of fetal medicine. He is widely regarded as the “father of fetal surgery.”

Dr. Harrison, who currently resides in San Francisco, CA, received his BA degree, cum laude, from Yale University, New Haven, CT, in 1965, and his medical degree, magna cum laude, from Harvard Medical School in 1969. He was captain of the lightweight crew at Yale.

After medical school, Dr. Harrison began his general surgery training at Massachusetts General Hospital, Boston, MA. His residency training was deferred when he spent two years as a research associate in the Laboratory of Immunology, Na-

Jacobson Innovation Award recipients

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

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

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

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

1999, John F. Burke, MD, FACS, Boston, MA: Development and implementation of a number of innovative techniques in burn care, including the codevelopment of an artificial skin (Integra™).

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

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

tional Institute of Allergy and Infectious Diseases, at the National Institutes of Health. He returned to Massachusetts General Hospital in 1973, and completed his residency in 1975. From 1976 to 1978, Dr. Harrison was a pediatric surgery fellow, first at the Rikshospitalet in Oslo, Norway, and then at the Children's Hospital of Los Angeles (CA).

Dr. Harrison has spent most of his career at the University of California, San Francisco. He has been an assistant professor of surgery (1978-1982); associate professor of surgery and pediatrics (1982-1988); and professor of surgery and pediatrics (1988-1991). Dr. Harrison continues his work at the University of California, San Francisco, and is currently chief, division of pediatric surgery (1988-present); director, Fetal Treatment Center (1981-present); and professor of surgery, of pediatrics, and of obstetrics, gynecology, and reproductive sciences (1991-present). In addition, Dr. Harrison served as surgeon-in-chief for Lucile Packard Children's Health Services from 1997 to 1999.

Throughout his career, Dr. Harrison has remained active in clinical practice and is a member of many prominent organizations in the surgical profession, including being a founder and president of the International Fetal Medicine and Surgery Society, and serving as chair of the American Pediatric Surgical Association's Committee on Fetal Therapy. He has served on the editorial boards of the *Journal of Pediatric Surgery* and *Fetal Therapy and Diagnosis*.

In addition, Dr. Harrison is committed to disseminating knowledge about his work in fetal surgery. One of his first publications in 1980 reported a fetal surgery model in the lamb for congenital diaphragmatic hernia. He subsequently has published more than 400 papers on a multitude of fetal surgery topics, and has served as a lecturer for numerous surgical and medical societies around the world. In 1984, he published the first comprehensive textbook on fetal therapy, *The Unborn Patient: Prenatal Diagnosis and Treatment*, which is now in its third edition.

Dr. Harrison's work in fetal surgery began immediately after his residency was completed. During the 1980s and 1990s, he created and practiced the techniques that have made fetal surgery the major contribution it is within the surgical profession. His efforts took him from laboratory to clinical trials and were furthered by the development of laparoscopy, which led to his groundbreaking work in creating the techniques for fetoscopic surgery that he calls fetendo—it has become the basis for minimally invasive fetal surgery worldwide. Dr. Harrison's work has made an impact on the performance of surgery to treat the smallest patients through a wide range of techniques.

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


SOCIOECONOMIC TIPS, from page 35

graft or a synthetic graft was used as the bypass conduit. If the procedure is performed for an aneurysm, look at codes 35011, 35013, or 35045, which describe aneurysm repairs of the upper extremity, and select the appropriate code. If the bypass is performed for a reason other than trauma or aneurysm, you should report code 37799, Unlisted procedure, vascular surgery.

Q. How do you code for the passing of the dilator into the esophagus with no visualization for stricture without an EGD?

A. You should report code 43450, Dilation of esophagus, by unguided sound or bougie, single or multiple passes.

Q. How do I know if I should use the benign or malignant code when reporting the removal of a skin lesion?

A. When reporting the removal of skin lesions, you should wait until the pathology report comes back and code according to the results in the report. 

ACS trauma fellowship honors Dr. Carrico

The Board of Regents of the American College of Surgeons has named a faculty-level trauma fellowship to honor C. James Carrico, MD, FACS. Dr. Carrico is President-Elect of the College and the Immediate Past-Chair of the Board of Regents. He is the Doris & Bryan Wildenthal Distinguished Chair in Medical Science and professor of surgery at the University of Texas Southwestern Medical Center in Dallas, TX.

The first recipient of the C. James Carrico MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care will be Jeffrey L.



Dr. Carrico

Johnson, MD, of Denver (CO) Health Medical Center, for his project entitled “The role of



Dr. Johnson

gene polymorphisms in post-injury hyperinflammation and multiple organ failure.”

Residents recruited to participate in end-of-life curriculum project

Eighty residency programs from surgery, internal medicine, family medicine, and neurology are being recruited to participate in the fifth year of a Residency End-of-Life Curriculum Project funded by the Robert Wood Johnson Foundation.

Since 1998, 250 residency programs have participated in a one-year project designed to assist them in introducing and enhancing an end-of-life curriculum that meets Accreditation Council on Graduate Medical Education (ACGME) training

requirements, including the new ACGME core competencies.

Residency programs will have the opportunity to assess their current educational offerings in end-of-life care, including assessing the knowledge and self-confidence of residents and faculty. A team of two to four faculty members and residents from each program will attend two curriculum workshops that will help them develop the educational and clinical structure needed to incorporate end-of-life care into their existing curricu-

lum and evaluation system. Each program will have the opportunity to publish an abstract detailing progress in the *Journal of Palliative Medicine*. Residency programs will be recruited on a first-come, first-served basis, beginning immediately.

For further information and registration materials, contact David Weissman, MD, or Rose Hackbarth at tel. 414/ 805-4607 or via e-mail at dweissmn@mcw.edu.

Bozzini endoscope returns home

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

“The Bozzini is on its way back to Vienna!” This cryptic comment to one well-informed urologist elicited the response: “And just what is the Bozzini?” The answer lies in the following reprise of the Bozzini saga.

For more than three decades the American College of Surgeons had in its custody an instrument unique in the history of endoscopy, which was returned to its home during the American Urological Association (AUA) Centennial Meeting on May 28, 2002. The Bozzini endoscope is the first internally illuminated (by a candle) device for inspecting the interior of human body cavities. Constructed in 1806 by Philipp Bozzini of Mainz, Germany, it resided originally in the Josephinum Museum in Vienna, Austria. A century-and-a-half later, it was donated to the College by a pharmaceutical company that had acquired it under mysterious circumstances, possibly from a World War II soldier who “liberated” it from the Josephinum during the British occupation of Vienna in 1945. Archival records of the pharmaceutical firm have not survived several mergers and changes of name, so the provenance of the instrument has resisted all inquiries to date.

Invention and introduction

Bozzini reported his invention as a “Lichtleiter” or “light carrier” in the *Journal of Practical*



At the AUA Centennial Meeting: Thomas R. Russell, MD, FACS, ACS Executive Director (left), looks on as Dr. Engel offers a brief history of the Bozzini endoscope.

Medicine and the Art of Wound Healing (Berlin, 1806). His 1807 pamphlet was entitled “The Light Conductor or Description of a Simple Device and Its Use for the Illumination of the Inner Cavities and Interstices of the Living Animal Body” (translated by L. B. Murdoch, in the *Quarterly Bulletin of the Northwestern University Medical School*, vol. 23 [1949], p. 332-354).

Conflicting reactions greeted the introduction of this primitive endoscope, with the Viennese Faculty of Physicians counseling caution against premature conclusions and downplaying the extent of the anatomy usefully available for inspection. Bozzini thought that the larynx might be visualized with his instrument, but he died before completing such an inspection, which was successfully

carried out in the mid-nineteenth century by Johann Czermak, a Polish physiologist, using a head mirror designed by Dr. Ludwig Türck.

Aside from his enthusiasm in publicizing the value of the Bozzini endoscope, Czermak was blessed with a large throat and had trained himself to tolerate the impact of a mirror against his palate. Thus the demonstration of his vocal cords to a succession of astonished viewers could be carried out with remarkable ease. Other advocates of the instrument were less adroit and less well-trained, but the merits of laryngeal inspection gradually became widely recognized by clinicians everywhere. And despite the restricted field of vision for inspecting the uterine cervix, the Bozzini was slowly adapted into gynecological practice.

In his valuable book *Medicine and the Reign of Technology* (Cambridge, 1978), S. J. Reiser has concisely described the various factors that contributed to resistance against the “anatomization” of the living body resulting from the stethoscope, the ophthalmoscope, and other endoscopic inventions that allowed physicians to localize disease to various organs or body systems.

The personal hesitancy of many older clinicians today to adopt an endoscopic technique for operations previously conducted through large surgical incisions is analogous to the resistance of nineteenth century physicians whose technologic resources were limited to inspection, percussion, and direct auscultation.

Traveling exhibit

When the Bozzini endoscope came into possession of the American College of Surgeons more than three decades ago, it was made freely available for demonstrations at urologic gatherings, such as the 1971 annual meeting of the AUA in Chicago, IL.

At that meeting, the Bozzini was exhibited along with other urologic instruments from the eighteenth, nineteenth, and early twentieth century. Dr. and Mrs. Irving M. Bush prepared a booklet containing the 1806 Bozzini article in German, as well as the previously noted 1949 translation by L. B. Murdoch.

In 1972, the Bozzini was once again loaned for historical purposes, this time to Mr. David Wallace of London for demonstration during his presidential address to the Section of Urology of the Royal Society of Medicine. In gratitude for the loan, Mr. Wallace graciously returned the “Lichtleiter” in an elegant box designed to emphasize for nonurologists the historic eminence of this instrument, which had been sent to London in a safe but commonplace cardboard package, understandably considered inappropriate for such a uniquely precious artifact.

Going home

After the College moved its headquarters to a more commodious, modern building in 1998, the Chair of the Board of Regents, Harvey Bender, Jr., MD, FACS, appointed an Archives Committee under Regent Mary H. McGrath, MD, FACS, to address the preservation and dis-

play of College documents, portraits, and artifacts that had been retained under unsatisfactory conditions in older quarters.

Prominent among the displayed artifacts was the Bozzini endoscope, which was to be featured as well in the historical volume celebrating the centennial of the AUA in 2002. As one of the volume’s editors, Wendy C. Husser, Executive Editor of the *Journal of the American College of Surgeons*, arranged for the curator of the Didusch Museum at the American Urological Association, Rainer M.E. Engel, MD, FACS, to visit the College concerning a possible return of the Bozzini to its proper resting place in Vienna.

From August 2000 until now this suggestion traveled through various administrative channels of the College and the AUA, with the ultimate decision for return of the original instrument to Vienna in exchange for a working copy, fashioned by Mercedes-Benz engineers from Philipp Bozzini’s original drawings.

The transfer occurred at the AUA Centennial Meeting as an instrumental triple play from College officials to AUA representatives, who then handed it over to official visitors from the Josephinum Museum (see photo, p. 39).

Thus, nearly two centuries after its construction in Germany, this technologic analog of the Elgin Marbles and forerunner of thousands of urologic endoscopes is finally headed back to its original European environs. Bozzini and Czermak must be smiling.

2003 ACS Traveling Fellowship to Japan announced

The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Japan.

Purpose

The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America.

Basic requirements

The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:

- Has a major interest and accomplishment in clinical and basic science related to surgery.
- Holds a current full-time academic appointment in Canada or the U.S.
- Is under 45 years of age on the date the application is filed.
- Is enthusiastic, personable, and possesses good communication skills.

Activities

The Fellow is required to spend a minimum of two weeks in Japan.

- To attend and participate in the annual meeting of the Japan Surgical Society, which will be held in Sapporo, Japan (June 4-6, 2003).
- To attend the Japan ACS Chapter meeting during that congress.
- To visit at least two medical centers (other than the annual meeting city) in Japan before or after the annual meeting of the Japan Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons.

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and designated representatives of the Japan Surgical Society and the Japan ACS Chapter. The surgical centers to

be visited would depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Japan.

His or her spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction in addition to professional activities.

Financial support

The College will provide the sum of \$7,500 U.S. to the successful applicant, who will also be exempted from registration fees for the annual meeting of the Japan Surgical Society. He/she must meet all travel and living expenses. Senior Japan Surgical Society and ACS Japan Chapter representatives will consult with the Fellow about the centers to be visited in Japan, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his/her own travel arrangements in North America, as this makes available to him/her reduced fares and travel packages for travel in Japan.

The American College of Surgeons' International Relations Committee will select the Fellow after review and evaluation of the final applications. A personal interview may be requested prior to the final selection.

Applications for this traveling fellowship may be obtained from the College's Web site (www.facs.org), or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is November 1, 2002.

The successful applicant and an alternate will be selected and notified by February 28, 2003.

ACGME announces new restrictions for resident duty hours

On June 12, the Accreditation Council for Graduate Medical Education (ACGME) announced new restrictions for resident duty hours. Most notably: (1) residents must not be scheduled for more than 80 duty hours per week, averaged over a four-week period, with the provision that individual programs may apply for an increase in this limit of up to 10 percent; (2) there is a 24-hour limit on on-call duty, with an added period of up to six hours for continuity and transfer of care, educational debriefing and didactic activities, and no new patients may be accepted after 24 hours; (3) when residents take call from home and are called in to the hospital, the time spent in the hospital must be counted toward the weekly limit, and (4) time spent in patient care activities external to the educational

program (moonlighting) must be approved and monitored and if it occurs in the primary program and institution, it must be counted toward the weekly limit.

Other limits include: one day in seven must be free of patient care responsibilities and on-call can occur no more frequently than every third night, both averaged over a four-week period, and there must be a 10-hour minimum rest period between shifts.

Most importantly for surgical programs, "in the case that a specialty believes it cannot conduct its educational activities within the proposed constraints," an exemption beyond the 10 percent increase can be obtained with the approval of both the ACGME Program Requirements Committee and the Board of Directors. In a June 6

letter to David Leach, MD, director of the ACGME, the American College of Surgeons called for a more flexible range of 80 to 96 hours a week and stressed that "the essential nature of the number of complex procedures that a resident must perform in order to be adequately trained must be part of the formula in determining these work hours. Circumstances must be allowed to determine duty hours."

These new standards will go into effect on July 1, 2003. The ACGME invites comments on the new duty hour standards and all responses should be submitted via electronic mail by August 1, 2002, to the following address: dutyhours@acgme.org. To review the entire document, *Report of the ACGME Work Group on Resident Duty Hours*, visit <http://www.acgme.org>.

CAS-ACS to sponsor symposium at Clinical Congress

The Candidate and Associate Society of the American College of Surgeons (CAS-ACS) will sponsor a symposium during this year's Clinical Congress for residents and residency program directors from 2:00 to 5:00 pm on Sunday, October 6, 2002, in San Francisco, CA.

The program will focus on issues of professionalism and how

it is taught in the medical education environment. Scheduled speakers include Michael E. Whitcomb, MD, senior vice-president for medical education and director of the division of medical education at the Association of American Medical Colleges. Dr. Whitcomb is also editor-in-chief of *Academic Medicine*, the leading journal de-

voted to issues relevant to academic medicine.

Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the College's Division of Education, will also join the symposium as a speaker.

For more information about the symposium or the CAS-ACS, contact Peg Haar via e-mail at phaar@facs.org, or tel. 312/202-5312.

Spring Meeting Web cast highlights key issues for the twenty-first century surgeon

An opportunity to visit “A Town Meeting—The Twenty-First Century Health Care System,” which opened the College’s Spring Meeting, April 14, in San Diego is now available through the College’s Web site. A Web cast of this important session, the Assembly for General Surgeons, can be accessed by visiting the College’s home page at <http://www.facs.org> and scrolling down the page. The following speakers’ presentations are included in the Web cast:

- The Honorable David Satcher, MD, PhD, former Assistant Secretary for Health and U.S. Surgeon General: The U.S. Health Care System.

- Sir Barry Jackson, MBBS, MS, FRCS, FACS(Hon), president-elect of the Royal Medical Society: The National Health System: Directions and Lessons.

- Don E. Detmer, MD, FACS, Dennis Gillings Professor of Health Management, University of Cambridge: To Err Is Human: Will We Cross the Quality Chasm? The Institute of Medicine Perspective.

- Anthony A. Meyer, MD, FACS, professor of surgery, University of North Carolina: Quality Surveillance and Outcome Reporting.

- George F. Sheldon, MD, FACS, professor and chairman, department of surgery, Univer-

sity of North Carolina: Evolving Health Workforce Shortage—Failed Expectations?

- Haile T. Debas, MD, FACS, dean, school of medicine, University of California, San Francisco: Professionalism in Clinical Practice.

- A. Brent Eastman, MD, FACS, University of California, San Diego, and ACS Regent: Professionalism in Clinical Practice.

Visitors can download a high-speed or low-speed version of each speaker’s presentation, and a text transcript accompanies each speaker’s remarks.

IN COMPLIANCE, from page 32

taining the confidentiality of patient information and allowing appropriate access to that information within and outside of your practice is key to HIPAA privacy compliance.


This audit tool is a preliminary step and is not intended to be a comprehensive guide to meeting HIPAA privacy and security regulations. The industry is developing additional tools to help you and your staff to comply with these requirements. The College will bring those materials to your attention as they are introduced.

Proposed changes

On March 27, 2002, HHS issued a notice of proposed rulemaking making a series of proposed changes to the privacy rule. One of these changes rescinded the requirement that your practice develop authorization forms to receive a patient’s consent for the use and disclosure of confidential patient information. You will still need to give a copy of the practice’s “Notice of Privacy Practices” to your patients and document that the notice has

been given or that a good faith effort was made to provide the notice. To accomplish this, you may want to have patients sign a form acknowledging that they received the notice and place that form in the medical record. In future editions of “In compliance,” we will review the documents your practice will need to develop.

Tip for privacy officer

HIPAA will require practices to develop a privacy policy manual where you keep all of the policies and forms you have developed to comply with the regulation. The practice staff members need to have access to the information in the manual. Are you going to maintain that document electronically or on paper? 

ACS guidance on HIPAA issues is based on information contained in the “Small Practice Implementation Guide” version 1.2 (<http://snip.wedi.org/public/articles/indexcfm?Cat=17>), © 2001, The Workgroup on Electronic Data Interchange.



Letters

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

9/11/01

The *Bulletin* did a great job on the 9/11 article in the May issue of this year. Thank you so very much.

I am very proud to be a part of Saint Vincent's and to be a surgeon.

Marc K. Wallack, MD, FACS

I just read with great personal interest the article by Dr. Feeney et al in the May *Bulletin* describing the extraordinary experience of Saint Vincent's Hospital after the terrorist attack on the World Trade Center on September 11, 2001. My colleagues and friends, Drs. Wallack, Blumenthal, and their entire trauma team are justifiably proud of their response to this disaster.

I was also pleased to see briefly mentioned in the article the role of the Burn Center at The New York Presbyterian Hospital, which served as a unique resource in receiving dozens of severely burned patients.

No picture of the medical response to these events would be complete without discussion of the role of the NYU Downtown Hospital as well. Founded in 1922 as the Beekman Hospital, two years following the first terrorist attack ever on American soil at the corner of Wall and Broad Streets, NYU Downtown Hospital is a 185-bed community hospital located only three blocks from Ground Zero.

Without the resources available at a Level 1 trauma center, this facility successfully treated over 350 acutely injured patients in just two hours between when the first plane hit and the collapse of the second tower. The ground beneath the hospital literally shook when each

tower fell. Making this response even more difficult were the acrid dust and smoke that covered every inch of the hospital and every employee, along with subsequent fears concerning air quality and the potential collapse of other nearby buildings.

In addition to a decrease in water pressure, there was complete loss of all steam service, telephones, computers, ventilation, and electrical service. Transportation of supplies and personnel was made nearly impossible by the hospital's location south of the security perimeter, within the so-called frozen zone established by heavily armed law enforcement, and the absence of any public transit. For days following the attack, many of the staff walked or rode bicycles just to get to the hospital.

The assistance of surgeons and others from NYU Medical Center (including the trauma team from Bellevue Hospital) and the Hospital for Joint Diseases was invaluable. By the end of that horrific day, NYU Downtown Hospital treated nearly 500 acutely injured patients and uncounted hundreds of others who required only first aid-type medical assistance and comfort. I have never been prouder to work with such a heroic team.

I hope that in the lessons learned from September 11, and in subsequent planning, there will be proper recognition of the critical role of community hospitals in the response to nearby mass casualty disasters.

Howard L. Beaton, MD, FACS
(Chief of surgery and emergency services,
NYU Downtown Hospital)

The mass murder of thousands of Americans on September 11, 2001, signaled the end of the age of innocence in America. Physicians hold a special position of trust, leadership, respect, and intelligence. We should lead by ex-

ample during this difficult time for our country. Whether by being involved in politics, environmental issues, nuclear weapons elimination, child abuse prevention, public education, the arts, religious groups, military service, or a host of other public issues—the physician should be involved. We abrogate our responsibility as a profession when we do not both participate and take a leadership role in nonmedical areas that affect the well-being of our citizens.

When the Medical Aspects of a Nuclear Explosion program was presented to my medical society three years ago, some individuals would have thought that it was "tilting at windmills." The *Mobile Press'* September 20, 2001, article, however, clearly pointed out this unthinkable possibility. The unfortunate fact remains that there are over 25,000 nuclear weapons in the world today; the detonation of any one of these would make the New York and Washington, DC, disasters appear minor.

Terrorists may soon have the capability to use these terrible weapons. Basic knowledge in the medical effects of chemical, biological, and nuclear weapons would be prudent study for all physicians. Physicians, individually and collectively, should speak up about public issues that threaten the very fabric of our civilization.

Get involved in your community—whether local, regional, or global. In the words of the late Todd Beamer on United Flight 93, "Let's roll!"

Ralph B. Pfeiffer, Jr., MD, FACS

Hepatitis C virus

I read the article by Jane Perry and Janine Jagger in the March *Bulletin* about the HCV-infected surgeon with great interest, and thought that a few observations with regard to sharps safety might be helpful.

For some years I have adopted the following practices, which I believe help avoid some common risks of sharps injuries but are not universally practiced:

1. No one is permitted to touch either a scalpel blade or a sharp needle. All such instruments must be handled with one or two clamps. When removing a suture needle from a needle holder, it is held with a clamp and the needle holder released. All blades are held in a clamp when being applied to or removed from the handle.

2. The scalpel is placed on a folded towel in a kidney dish, and the dish is placed longitudinally between the patient's approximated thighs. The surgeon then picks up the scalpel. It is never passed directly from one person to another. The kidney dish also prevents accidental dropping of the scalpel that can result in penetration of a boot or shoe and injury to toe or foot. When not performing abdominal surgery, the kidney dish is placed on an adjacent table. At the end of the operation, the surgeon is responsible for carrying the blade and all needles in a clamp directly to the sharps container.

3. I train residents in abdominal surgery holding a long clamp in the right hand one to two centimeters away from the resident's scalpel. In the event that the resident approaches too close to a sensitive area (to use Watergate terminology), the blade is firmly clamped. The left hand holds a sponge stick that can be used for retraction and exposure. This action eliminates the need to have fingers anywhere near the blade (and should, incidentally, enable surgeons who have acquired blood-borne diseases to teach in situ surgery without risk to the patient).

4. Some years ago, I designed a syringe and needle with a retractable sleeve that returned to the covered state by spring action. No one seemed to be interested at that

time. However, in today's climate, perhaps there may be more interest in pursuing this idea.

5. Retractors could be more versatile than those currently used. For example, a retractor resembling a human hand with detachable fingers that could be moved up and down slots and secured with wing nuts, and which would be covered with insulated padded sleeves, would virtually remove the need to have fingers anywhere near needles or scalpels and could even have a light on one or more of the fingers.

As the article by Perry and Jagger clearly shows, the stakes are much too high not to apply every effort toward reducing the risks to both staff and patients. The surgeon who has not been stuck by a needle either has just entered the operating room for the first time, or exists only in works of fiction.

**Ian Campbell Cree, MB, MS,
FRCS(Eng) FRCSC, FACS**

Surgical residencies

I read with great interest Dr. Michael Zinner's article on surgical residencies in the March *Bulletin*. In his article, he asks "Are we still attracting the best and the brightest?" and presents fascinating statistics regarding both surgeons' incomes, indebtedness of medical students, and openings in first-year general surgery positions. Dr. Zinner appropriately points out the changing demographics of the surgical candidates and the numerous new stresses that face future general surgery applicants.

I was distressed, however, that stronger conclusions were not drawn in his article. We face an impending crisis of an available workforce in the medical field and in surgery in particular. There is no question that surgical residencies are among the most demanding of all postgraduate training programs in the medical profession. They are

not compensated or rewarded with intangible benefits in the manner in which they used to be. The decline we are seeing in medical school applicants and, more frighteningly, in applicants to surgical programs, is a reflection of a general recognition that the expense that applicants are being asked to make is not commensurate with the rewards that will ultimately be given them.

I believe that it is incumbent upon those of us who are within the medical profession to realize that some fundamental changes need to be made. These changes should be not only in more humane residencies, but also in restoring professionalism to the field of medicine and to surgery in particular. We need to again reassert our control of our own destinies not only on behalf of our profession, but also on behalf of our patients, present and future.

It is my feeling that we will be faced with a crisis of unavailability of qualified surgeons in 20 to 30 years if strong measures are not taken immediately to address these issues. Medical schools and postgraduate surgical training programs need to be at the forefront of correcting this situation.

I would be interested in learning if Dr. Zinner or others associated with surgical residency programs had more specific recommendations as to how to make the field of surgery more attractive for applicants at this time.

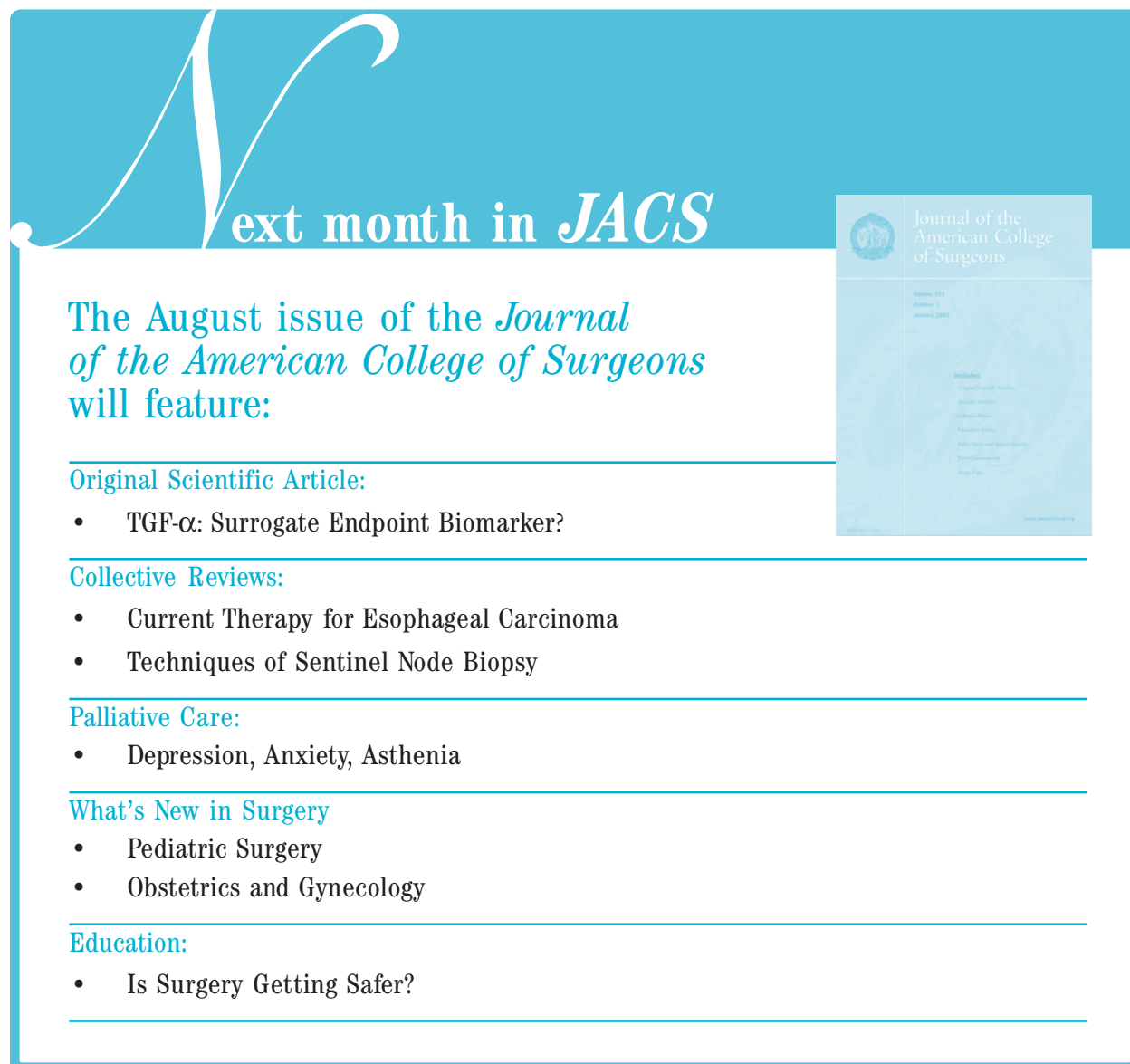
Ron H. Stark, MD, FACS

Series on injury prevention debuts on ACS Web site

The Subcommittee on Injury Prevention and Control of the College's Committee on Trauma has begun a series called "Quarterly Summaries

on Injury Prevention." These summaries are posted on the ACS Web site at <http://www.facs.org/dept/trauma/injmenu.html>.

The latest 2002 summary features timely information on farm injury prevention with links to other related Web sites.



ext month in *JACS*

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

Original Scientific Article:

- TGF- α : Surrogate Endpoint Biomarker?

Collective Reviews:

- Current Therapy for Esophageal Carcinoma
- Techniques of Sentinel Node Biopsy

Palliative Care:

- Depression, Anxiety, Asthenia

What's New in Surgery

- Pediatric Surgery
- Obstetrics and Gynecology

Education:

- Is Surgery Getting Safer?