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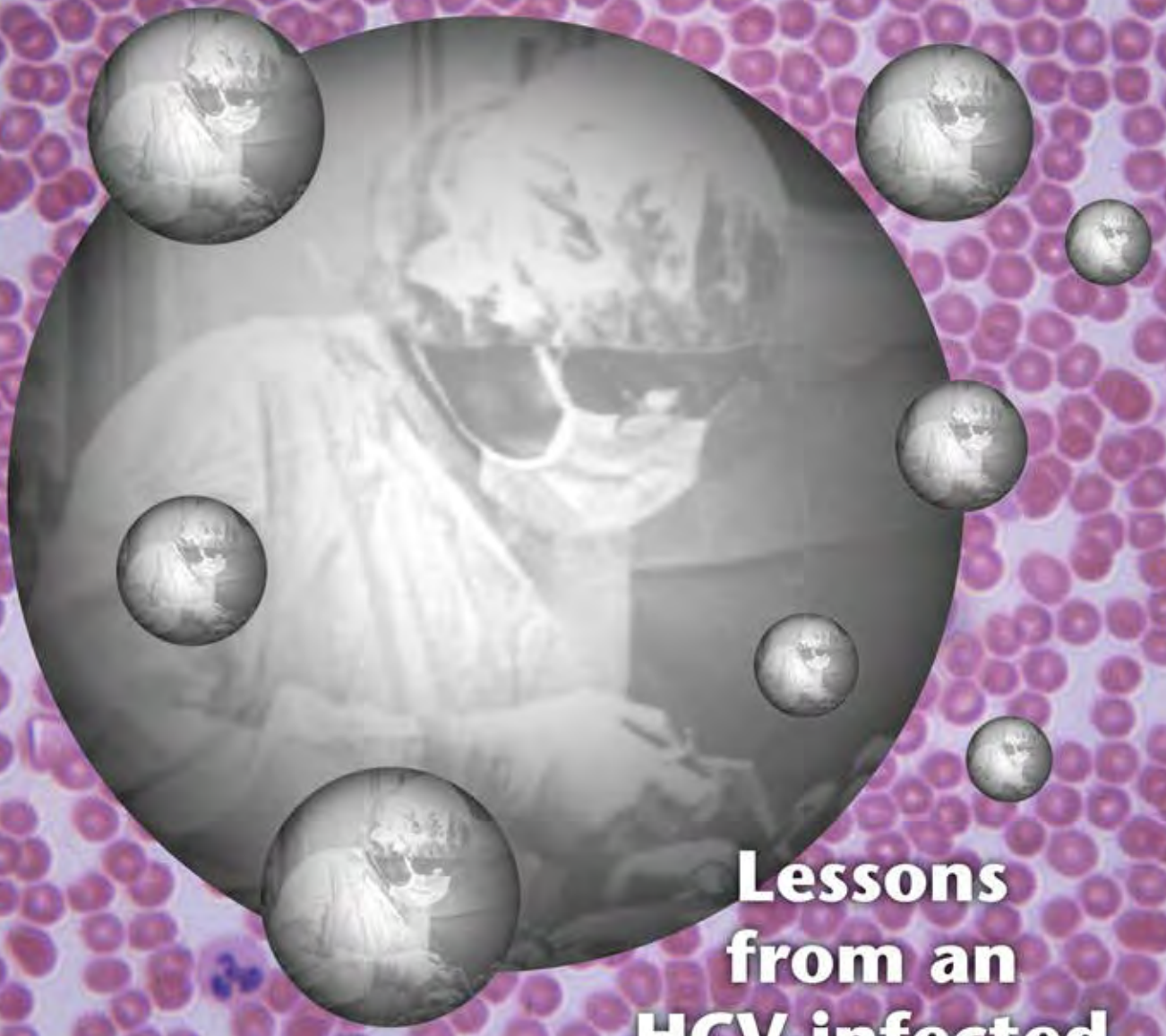

Lessons from an HCV-infected surgeon

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From my perspective

Reduced Medicare payments for physician services and increased professional liability costs are issues of great concern to the College because of the ramifications they have for our members' practices. The College has placed a high priority on developing and advocating for solutions to these problems in an effort to offset their negative impact.

Medicare reimbursement

As you know, last year our General Surgery Coding and Reimbursement Committee submitted to the Centers for Medicare & Medicaid Services (CMS) a list of 240 undervalued services for reassessment as part of the five-year review of the Medicare fee schedule. The committee's recommended payment increases for those services were adopted. As a result, surgeons who perform these procedures experienced some real payment increases.

Unfortunately, these gains were offset when the Medicare fee schedule conversion factor was reduced by 5.4 percent. Basically, this reduction has come about because of an existing law that bases the conversion factor update on a flawed formula that includes a budgetary control device known as the sustainable growth rate (SGR). The Medicare Payment Advisory Commission (MedPAC), an independent federal body that advises Congress on payment issues, has recommended that the formula used to arrive at the conversion factor update be revised and based on a forecast of changes in the costs of providing medical care, as opposed to the SGR, which is based on general economic indicators.

The College has long been vociferous in its objection to the use of the SGR, and, more recently, to the resultant cut in the conversion factor. We have testified to that effect before key congressional committees and have thereby made our position known. In addition, we have joined a coalition of other medical organizations and will spend a substantial amount of money to appropriately voice our concerns through lobbying efforts in Washington during the first part of this year. We are working diligently with the 107th Congress in an attempt to enact legislation that will offset the reduction in the conversion factor and fix the update formula flaws so we do not confront the same situation in future years. We will keep you informed of our activities through reports in future issues of the *Bulletin* and *ACS NewsScope*.

"The College is committed to pursuing and actively working on appropriate means of achieving liability and Medicare reimbursement relief for surgeons."

Professional liability

On the professional liability front, a significant crisis—similar to those experienced in 1975 and in the mid-1980s—is looming. Due to poor business decisions and extension into unknown markets, some medical malpractice carriers have incurred significant losses. Thus, we are seeing double- and even triple-digit increases in liability premiums. The premium increases are specific to some states and have crippled some specialties more than others. States that are experiencing particularly hard times include West Virginia, Pennsylvania, New Jersey, Mississippi, and Florida, to name a few. The specialties that have been most affected include neurosurgery, obstetrics and gynecology, cardiothoracic surgery, and general surgery.

The combination of reduced reimbursement and

increased liability premiums is creating access and availability problems in certain areas of the country. The situation is much worse than the malpractice crises we have undergone in the past, because the high cost of insurance can no longer be passed on to patients and payors.

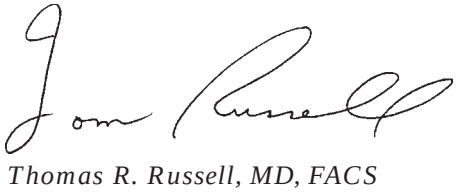
Several of our committees have been actively engaged in discussions aimed at formulating remedies for the current situation. The Board of Regents' Patient Safety and Professional Liability Committee and the Health Policy Steering Committee recently held meetings during which participants placed considerable emphasis on this issue. One point that clearly emerged from these meetings is that the strategy we use to help resolve the liability premium issue must be carried out at both the state and federal levels.

Some of the initiatives the College is pursuing in its efforts to deal with the medical malpractice issue include:

- Enactment of reforms similar to those in California's Medical Injury Compensation Reform Act of 1975 (MICRA). This law provides for a limit on noneconomic damage awards, caps on attorneys' contingency fees, a shorter statute of limitations for filing lawsuits, elimination of joint and several liability, a prohibition against collecting payments from more than one source, and periodic payment of large awards.
- The possibility of partnering with insurance carriers to achieve some relief with regard to malpractice premiums.
- Education of physicians about patient safety and risk management.
- Exposure of expert witnesses who offer testimony in cases that are outside their scope of expertise and at odds with accepted treatment modalities.
- More involvement with other malpractice reform-oriented organizations, such as the American Tort Reform Association and the AMA Task Force on Liability Reform. The College already is extremely active in the Health Care Liability Alliance (HCLA). In fact, Christian Shalgian of our Washington Office staff chairs HCLA, which is composed of medical, hospital, and insurance organizations that have come together to address medical liability issues.
- Exploration of other injury compensation systems, such as maloccurrence insurance or adverse medical event insurance—often referred to as "no-fault" plans. Several states already use this type of insurance to compensate the families of infants who are born with neurological injuries and individuals who have been adversely affected by vaccines.

Many of us in the practice of medicine realize that the current tort system in this country does not really get to the heart of solving the problems, which involves preventing malpractice from occurring in the first place and ensuring that when patients have suffered harm due to medical error, they are justly compensated. Many lawsuits are frivolous and are tried in courts in which lay juries find themselves confronted with conflicting testimony from opposing experts. As it currently exists, the system impedes self-reporting and a significant portion of the award goes to the plaintiffs' lawyers rather than to the injured parties. Clearly, the system is broken, and the costs are escalating for physicians and other providers.

The College is committed to pursuing and actively working on appropriate means of achieving liability and Medicare reimbursement relief for surgeons. Achieving these objectives will take time and effort, but if our Fellows band together, and if we work cooperatively with other medical organizations, we should be able to get a fair hearing from policymakers and ultimately bring about 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*

Thomas R. Russell, MD, FACS, ACS Executive Director, **testified before the House Energy and Commerce Subcommittee on Health** on February 14 about the impact of across-the-board reductions in Medicare physician payments that occurred in 2002 and the importance of reforming the fee schedule update system. In addition to providing technical comments on the flaws in the current system, Dr. Russell shared indications of emerging access-to-care problems that have been brought to the College's attention by its Fellows. The Centers for Medicare & Medicaid Services also participated in the hearing, as did the American Medical Association and organizations representing Medicare beneficiaries, nonphysician providers, and clinic-based practices. Dr. Russell's testimony can be found at *http://www.facs.org/dept/hpa/testimony/medicare.html*

At its February 8-9 meeting, the Board of Regents voted unanimously to **establish an affiliated organization with a 501(c)(6) tax-exempt status**. This action will allow the College to expand its legislative activities and establish a Political Action Committee, as requested by the Board of Governors. Further information about the new organization, the opportunities it will provide, and its relationship to the Fellows will be disseminated in coming months.

Applications are now being accepted for the limited enrollment course **"Skills for the New World of Health Care,"** which will take place April 27-May 5, 2002, at Harvard University. Jointly sponsored by Harvard Medical School, Harvard's Division of Health Policy Research and Education, the Harvard School of Public Health, and the John F. Kennedy School of Government, the program will provide participants with the concepts and mechanics to influence the evolution of our health care system. Topics to be discussed include, among others: the workings of the political environment and the media; hospital and physician reimbursement schemes; the nature and extent of health care fraud; and innovations in health care delivery. Surgeons who participate in the nine-day course will be eligible for up to 54 hours of Category 1 continuing medical education credits. For information contact Eleanor Brimley via e-mail at eleanor_brimley@harvard.edu or via phone at 617/496-1069. The deadline for submission of applications is March 29.

The American College of Surgeons has established a **consultation coding service hotline** for its Fellows in all of the surgical specialties. When you call **800/ACS-7911 (227-7911**), a coding specialist will be able to answer your questions regarding coding problems or denials. Confirmation of ACS Fellowship is required to obtain hotline assistance, which is provided and measured in Consultation Units (CU). One CU is a period of up to 10 minutes with additional 10-minute increments or portions thereof charged at one CU per 10-minute increment. Hotline services will be limited to 2 CUs for each telephone call, and ACS Fellows will be given 10 consultation units (CUs) in one 12-month period. For more information, visit *http://www.facs.org/dept/hpa/coding/secoding.html.*

Dateline Washington

prepared by the Division of Advocacy and Health Policy

College comments on MedPAC proposal

On February 1, the College responded to a request from the Medicare Payment Advisory Commission (MedPAC) for comments on draft recommendations to be included in the commission's March 2002 report to Congress. The College's comments focused largely on the commission's proposal to revise the formula used to calculate the annual update to the Medicare physicians' fee schedule. More specifically, MedPAC is recommending that Congress abandon the sustainable growth rate (SGR) system used to determine the update in favor of a new system that reflects estimated changes in input prices for the coming year.

While pleased with the overall direction that MedPAC took in its draft recommendations, the College expressed concern about a number of issues that the commission did not address. In particular, the College observed that the commissioners failed to adequately address needed adjustments to account for the effects of new technology, fluctuations in practice patterns, changes in patient severity, and other legitimate factors that may affect physician spending. The College also asked the commission to take a more cautionary tone in its assumption that physician willingness and ability to serve beneficiaries have not been affected by the cumulative payment reductions. This inference is based on early 1999 data that do not take into account the impact of the fully phased-in resource-based practice expense values, the most recent conversion factor reduction, or latest escalation in malpractice premiums.

College testifies on payment issues

On February 14, ACS Executive Director Thomas R. Russell, MD, FACS, testified before the House Energy and Commerce Subcommittee on Health during a hearing on Medicare physician payment issues. The hearing, which also included testimony from Tom Scully, Administrator of the Centers for Medicare & Medicaid Services (CMS), focused predominantly on MedPAC's recommendations for replacing the SGR as a means of updating physician payments under the Medicare fee schedule. During the hearing, Dr. Russell emphasized that Congress must develop an update process that more efficiently tracks beneficiaries' needs and the costs of providing the services to meet them.

President unveils 2003 budget plan

On February 4, President Bush unveiled his Administration's budget plan for fiscal year 2003. Release of the President's budget, which includes large increases in funding for defense programs and homeland security, signals the beginning of the formal budget process on Capitol Hill.

Under the budget proposal, the Department of Health and Human Services would receive $489 billion to be allocated among its various agencies. The plan includes new funding for research at the National Institutes of Health, expansion of the number of community health

centers, and increased grants to schools of nursing to help improve education and enrollment in these programs.

The President has stressed that Congress should address payment adequacy for both Medicare+Choice plans and physicians under the Medicare fee-for-service program. Unfortunately, the document does not include any funding for a midyear correction of the 5.4 percent reduction in the physician payment update. Instead, the plan states that the Administration will work with Congress "…to smooth out adjustments in the physician update system in a budget neutral manner."

Other Medicare issues of particular interest to surgeons include:

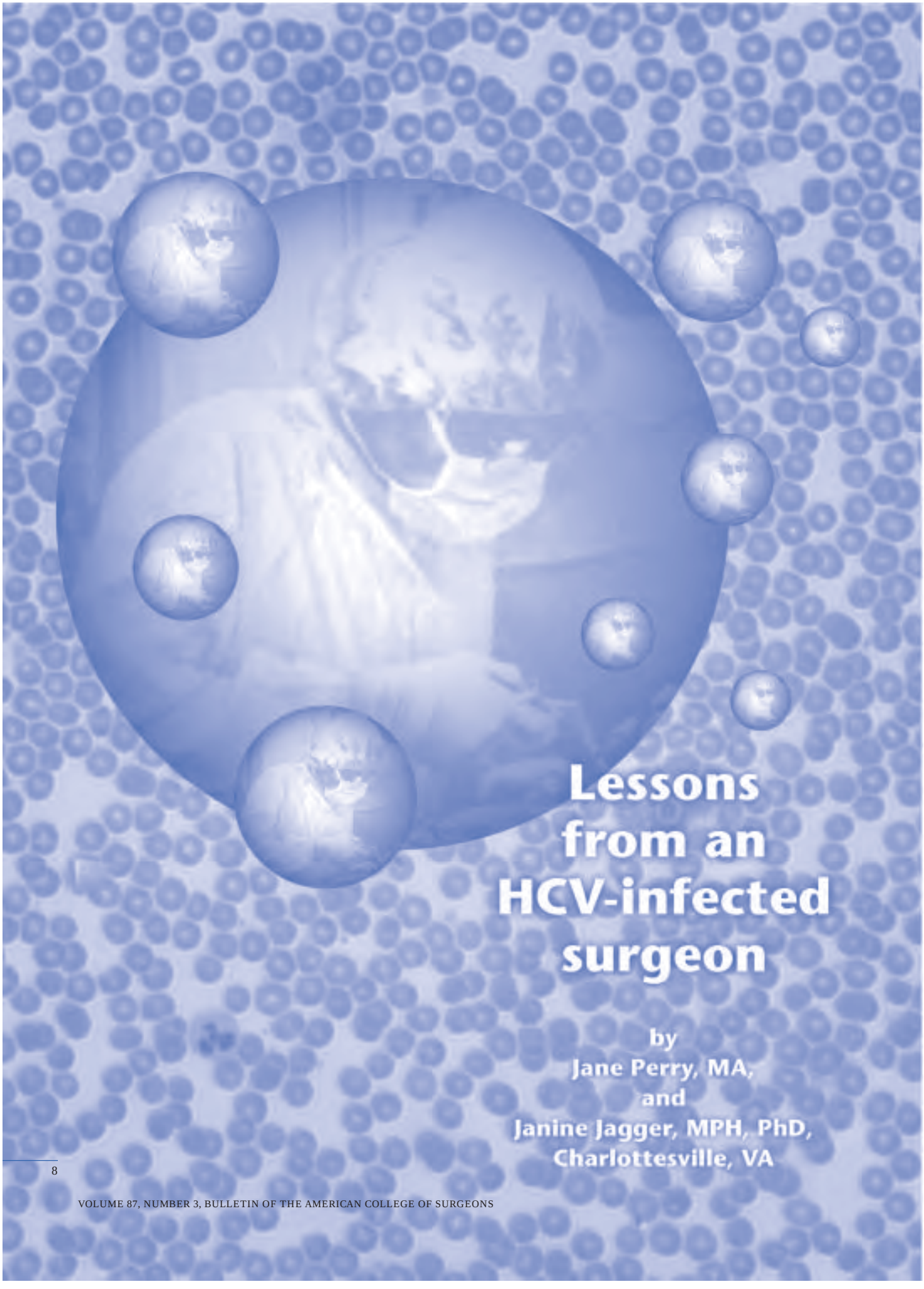
- Extending existing legislative mandates governing graduate medical education (GME) payments, which will reduce funding by $570 million over a 10-year period.
- Reducing funding for Medicare peer review organizations.
- Renewing a proposal calling for "new discretionary user fees to be paid by providers for submitting paper claims and duplicate or unprocessable claims."

The President's budget also dedicates $190 billion for 10 years to targeted improvements and comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection, and enhanced private options for all beneficiaries.

In addition, President Bush attempts to address the problem of the uninsured though a number of tax code proposals targeted at expanding access in the private health insurance market. These initiatives include:

- New refundable tax credits for low- and moderate-income individuals and families who are not covered by an employer plan or enrolled in public plans.
- New tax provisions to improve and permanently extend medical savings accounts.
- A new deduction for long-term care insurance premiums.

While President Bush proposes a significant increase in funding for disaster preparedness initiatives such as hospital readiness and strengthening the public health infrastructure to respond to bioterrorism, his plan calls for eliminating funding for Title XII programs under the Public Health Service Act that foster trauma care system planning and development. The College and its trauma coalition have successfully secured funding for this important program over the last two fiscal years. Additionally, the program that allows children's hospitals to underwrite their graduate medical education programs is being decreased from $285 million to $200 million, and the Agency for Healthcare Research and Quality may experience a $50 million cut.



Lessons from an HCV-infected surgeon

by
Jane Perry, MA,
and
Janine Jagger, MPH, PhD,
Charlottesville, VA

The International Health Care Worker Safety Center at the University of Virginia, Charlottesville, is devoted to the prevention of occupational exposures to blood-borne pathogens in the health care workplace. Recently, a plastic surgeon contacted us who was occupationally infected with hepatitis C virus (HCV) from a sharps injury he sustained during his residency. At our request, he consented to be interviewed about his exposure and infection.

The surgeon, who prefers to remain anonymous, is chief of plastic and reconstructive surgery at an academic medical center in the U.S. He is married and the father of four children. His experience sheds light on the personal and professional realities confronting an infected surgeon. "Dr. Jones," as we call him in this article, hopes to educate surgeons about the potential consequences of sharps exposures and the need to make the operating room as safe as possible—both for patients and the operating room personnel who care for them.

Exposure and infection

Dr. Jones began performing surgery in 1979, during his residency. He went through five years of residency training, then started his own practice in 1984. The time frame is significant because measures to prevent occupational exposures were implemented gradually in the late 1980s and early 1990s, and a test for hepatitis C wasn't available until 1989.

He remembers that, at the beginning of his residency, he often came out of the operating room soaked in blood from the waist down. "You were bathed in blood regularly, got stabbed with instruments. You just changed the instrument and got back to work. There was little protection."

Because it was rare to report sharps injuries at that time, he did not have a documented exposure incident he was able to correlate to his infection. However, he suspects that his infection occurred in 1980: "There was one particular patient I remember vividly. She had elevated liver enzymes; we tested her for hepatitis B, but she was negative. We concluded she had non-A non-B hepatitis. While performing surgery on her, I sustained a deep injury from a large retention needle. That could have been the event that led to my hepatitis C infection, but no test was available then."

Safety checklist for the OR

The list below can be used to help bring ORs into compliance with the requirements of the 2001 Bloodborne Pathogens Standard developed by the Occupational Safety & Health Administration (OSHA).[1]

The standard was revised in 2001, as mandated by the Needlestick Safety and Prevention Act, and became fully effective July 18, 2001. The revised standard has several new requirements. Health care employers must now: (1) document annually in their exposure control plan that they have evaluated and implemented "safer medical devices designed to eliminate or minimize occupational exposure" to HIV, HCV, and other blood-borne diseases, *and* review and update their exposure control plans at least annually to reflect changes in sharps safety technology; (2) solicit input from nonmanagerial (front-line) health care workers in identifying, evaluating, and selecting safety-engineered sharp devices, and document input in the exposure control plan; and (3) maintain a sharps injury log with detailed information on percutaneous injuries to employees.

- Are blunt suture needles, stapling devices, adhesive strips, or tissue adhesives used whenever clinically feasible in order to reduce the use of sharp-tip suture needles?
- Are scalpels with safety features, such as round-tipped blades, retracting blades, and shielded blades, used?
- Are alternative cutting methods, such as blunt electrocautery devices and laser devices, used when appropriate?
- Is manual tissue retraction avoided through the use of mechanical retraction devices?
- Has all equipment that is unnecessarily sharp been eliminated? (Example: towel clips have been identified as a cause of injury in the operating room, yet blunt towel clips are available that do not cause injury and are adequate for securing surgical towels and drapes. Other examples of devices that do not always need to have sharp points include surgical scissors, surgical wire, and pick-ups.)
- Is double-gloving employed in the surgical suite?
- Do circulating nurses and other personnel close to the surgical site wear eye protection, such as goggles or face shields, that have a seal above the eyes to prevent fluid from running down into the eyes?

In 1981, about a year after this incident, Dr. Jones became very ill and was unable to work. His liver enzymes were significantly elevated, but he tested negative for mononucleosis and hepatitis B and was not icteric. After a month, he recovered from his illness. He finished his residency several years later, and went into private practice.

In 1992, he became ill again. His liver enzymes were checked and were twice the normal level. By that time, a marker for hepatitis C had been discovered, and he was given an HCV antibody test; the results were positive. A confirmatory polymerase chain reaction test was performed; it was positive as well. He was infected with hepatitis C.

A liver biopsy showed moderate inflammation with signs of chronic, persistent HCV infection. Dr. Jones had no risk factors for HCV other than a history of occupational blood exposures. He had never undergone surgery requiring a blood transfusion, gotten a tattoo, or taken intravenous drugs.

Struggle to practice

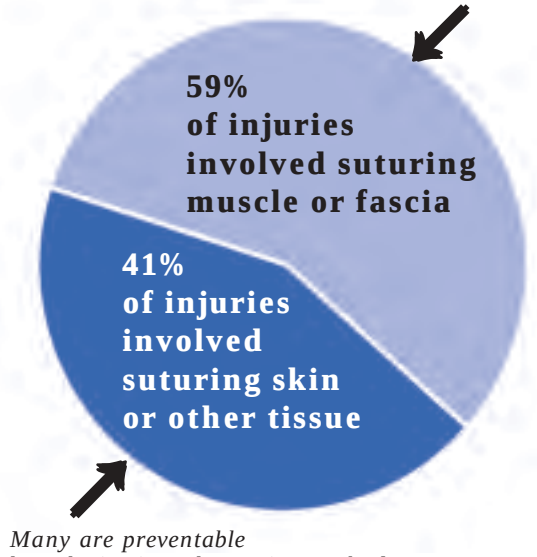
Over the next several years, Dr. Jones struggled to maintain his practice. He experienced severe fatigue, sweating, nausea, diarrhea, and loss of appetite. His doctor suggested treatment with interferon, which was considered experimental at the time. He took it for three months while continuing to practice. At the end of treatment, his liver enzymes were normal, but six months later he was symptomatic again. He further reduced his work schedule, and his health improved for about a year, although his liver enzymes again became elevated. Another liver biopsy was performed and showed some fibrosis, and a second course of interferon was recommended. He decided to leave his practice for three months and undergo treatment in another part of the country, because he did not want his colleagues to know about his illness. However, he had been getting his interferon from the hospital pharmacy, and after he left, word got out that he had hepatitis C.

When he returned, his colleagues told him they didn't feel comfortable referring patients to him. They were worried about the liability implications. They said they would only refer patients if he was willing to disclose his HCV status. Later, a hospital committee met to formally consider the issue of informed consent, and reached the same conclusion: he should inform patients of his serostatus. Dr. Jones complied but found he quickly lost patients. They refused to allow him to perform surgery once they learned he was infected with hepatitis C.

Potentially preventable suture needle injuries

Six hospitals, 15 months, suture needle injuries = 197

100% preventable with the use of blunt suture needles



Many are preventable by substituting alternative methods of skin closure

Source: Jagger J, Bentley M, Tereskerz P: A study of patterns and prevention of blood exposures in OR personnel. *AORN J*, 67(5):979-996, 1998.

During 1992 and 1993, he was a defendant in two lawsuits. One related to a scar from an abdominoplasty procedure, the other to a silicone breast implant. During the course of the litigation, the patients' attorneys discovered Dr. Jones was infected with hepatitis C and added claims for emotional distress due to lack of informed consent. They said that their clients were now afraid they might have contracted hepatitis C during surgery. One of the lawsuits cited a case in which a surgeon, a member of Alcoholics Anonymous, was successfully sued on the grounds that the patient had a right to know that the surgeon was a recovering alcoholic. (The state supreme court upheld this decision.) The lawsuits were eventually dropped. The patient who brought the silicone breast implant suit decided to sue the implant manufacturer instead. Neither patient developed HCV, but Dr. Jones, of course, had to pay the legal fees for his defense.

By 1995, Dr. Jones was forced to close his practice: he didn't have enough patients to remain financially viable, and his illness made it difficult for him to work on a regular basis. He began giving serious thought to changing specialties or even leaving medicine altogether.

Move to academia

Within a month of closing his practice, however, he was contacted by the chairman of the surgery department at a nearby state university who was sympathetic to his situation. He invited Dr. Jones to join the faculty in a teaching role. Dr. Jones would oversee and instruct the residents under him, providing knowledge, resources, and direction, while the residents would perform the actual surgery.

This opportunity meant he could still be involved in medicine in some capacity, using his experience to teach others. In March 1995, he joined the faculty at the university and continues in that position today. He supervises upper-level residents in plastic surgery, diagramming operations beforehand and giving residents direction with a laser pointer during the actual procedure. He is always double-gloved. Occasionally he scrubs in and uses a blunt hemostat to direct the residents within the surgical site itself, but they perform all the cutting and suturing. The medical center in which he now works does not have an explicit policy about infected surgeons, but remains comfortable with this informal arrangement.

His greatest fear now in the operating room

ACS Insurance Program and communicable disease

The ACS Long-Term Disability Plan does provide coverage for "communicable diseases." This is how the coverage is described in the brochure:

> If you contract a "communicable disease," you may be eligible for residual disability benefits even though you are not totally disabled. In order to be eligible for the residual disability benefit, you must be under 65 and earning less than 75 percent of your average net monthly income due to contracting the communicable disease. Benefits will not begin until the applicable elimination period has been satisfied. The amount and duration will be determined in the same manner as the Residual Disability Benefit [described in brochure].
>
> A "communicable disease" means any of the following conditions, but only if the applicable medical profession recommends or appropriate governmental agency requires the disclosure of the diagnosis of the disease and it results in a limitation of your practice due to contracting the disease: Acute Viral Hepatitis of the non-A type, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or tuberculosis.

To clarify: This coverage applies to insured individuals who have contracted a communicable disease but are not totally disabled and the applicable medical profession recommends or appropriate governmental agency requires the disclosure of the diagnosis of the disease and it results in a limitation of their practice due to contracting the disease. If an insured individual with a communicable disease is totally disabled, he or she would be eligible for benefits under the regular disability provisions of the plan.

For further information, contact the ACS Insurance Plan Administrator at 800/433-1672, or e-mail usia-acs@usi-administrators.com.

is getting stuck by the residents, who are relatively new to surgery. Hepatitis C has several variants, of course, and there are other pathogens of concern, including HIV and hepatitis B. Since he began teaching, he has sustained two injuries from residents handling sharp devices under his direction. One involved a needle-tip Bovie coagulator (the device was plugged in, so he also received an electrical shock). In the second incident, a resident was using a retractor rake to pull aside a piece of tissue. The rake went through the tissue and stuck Dr. Jones' finger. Both of these injuries were preventable, because blunt alternatives exist for both devices. Dr. Jones stresses that many unnecessarily sharp instruments are used in the OR, endangering health care workers. He cites sharp towel clips as a prime example.

Sharp-tip suture needles are the leading cause of injury in the OR, according to a study conducted jointly by the International Health Care Worker Safety Center and the Association of Operating Room Nurses, yet use of this device is rarely necessary.[2] Blunt-tip suture needles can be substituted for suturing muscle and fascia; for cutaneous closures, staples and tissue adhesives or adhesive strips often can be employed. (Dr. Jones notes, however, that staples and tissue adhesives cannot be used around the eyes and mouth.) The OR study found that substituting blunt-tip suture needles for sharp-tip ones wherever clinically feasible could potentially reduce sharps injuries in surgical settings by as much as one-third overall (see figure, p. 10).

Ms. Perry *is director of communications, International Health Care Worker Safety Center, University of Virginia, Charlottesville, and editor of the center's journal,* Advances in Exposure Prevention.

Lifetime difficulties

Dr. Jones' life today is far different from the one he enjoyed 10 years ago.

In addition to losing his surgical practice, he continues to have active symptoms of HCV. About once a month, he experiences debilitating attacks of fatigue with flu-like symptoms; these episodes last between 24 to 48 hours and are well-documented in the literature on hepatitis C. He also suffers from night sweats and myalgia. His illness has had a profound impact on his family. His children, ages 11, 16, 18, and 20, all have jobs, and have had to adapt their lifestyle to his changed financial circumstances.

After he became ill in 1992, he applied for and received disability benefits. (He was not eligible for workers' compensation because he never filed a claim.) In 1999, however, his disability was cut off. Although he receives a salary as a member of the medical school faculty, it is only a fraction of his former income. It covers basic living expenses for his family of six but is "not enough to put my kids through college or lead the lifestyle that I trained and struggled so hard to have."

Why did he lose his disability? The company—one of the major disability carriers in the country—reviewed its policy and decided that infection with hepatitis C was not a sufficient reason for health care workers to claim disability. To support its position, the company cited the Centers for Disease Control and Prevention (CDC). (In 1998, the CDC stated, "Currently, no recommendations exist to restrict professional activities of health care workers with HCV infection."[3]) The company concluded, based on the CDC position, that there was no reason, in terms of infection risk to patients, why he should not be able to continue his practice as a surgeon. Denying disability benefits to a surgeon on these grounds may be an unintended use of the CDC's position, Dr. Jones says, but the decision "will disturb any surgeon in private practice. I will contest the company's decision in court, but if the carrier ends up being successful in denying me disability on this basis, there will be more infected surgeons hiding in the closet than ever before."

Dr. Jones is troubled by the disjunction between policy statements and legal decisions on the issue of informed consent: "In courts of law, issues of

informed consent are settled in favor of patient-plaintiffs. When it comes to getting hospital privileges, neither courts nor hospital administrators are going by the CDC position regarding HCV-infected physicians—but disability carriers are. They are saying an HCV-infected physician should be able to practice without restriction, which leaves infected surgeons between a rock and a hard place. Should they inform patients of their serostatus, as the American Medical Association advises, and risk losing their practice and their disability, or should they practice without restriction and risk being sued by patients for lack of informed consent?"

He believes that if a surgeon is physically able and is asymptomatic, he or she should be permitted to practice. But he also believes that infected surgeons should avoid performing exposure-prone procedures and that patients should be informed of their surgeon's serostatus. "I believe it is the patient's right to know, even if it means that the surgeon loses patients."

Switching to a specialty that is not exposure-prone is one alternative for an infected surgeon. Plastic surgeons who are infected may choose to limit themselves to noninvasive procedures, such as laser resurfacing, laser photocoagulation, children's port wine stains, chemical peels, and microdermabrasions. For such procedures, Dr. Jones does not believe informed consent is necessary.

Other possibilities for infected surgeons might include training others in endoscopic procedures, because training is performed on animals, and robotic surgery performed by means of a computerized virtual-reality program. Dr. Jones notes that such a program is in an experimental stage at his medical center but is about 10 years away from being perfected.

Along with his support for informed consent, Dr. Jones strongly believes that a national policy is needed regarding HCV-infected surgeons and invasive procedures. He believes that many infected surgeons, in lieu of official guidelines, have developed their own, self-imposed restrictions. "At my hospital, there are two other surgeons who are occupationally infected with hepatitis C. One has chosen to limit herself to classroom teaching, and the other is doing what I do, guiding the residents while they perform the surgeries. We have chosen these alternatives because we do not want to give the disease to anyone else."

The irony, he says, is that "my illness could have been so easily prevented. It is all a question of awareness." But he acknowledges that getting surgeons to take the issue of exposure prevention seriously has been difficult: "We are heading in the right direction of being more aware and better protected—but we still need to go much, much further." Ω

Author's note

The International Health Care Worker Safety Center has a sharps injury tracking program available that is designed specifically for the OR setting. It is called Access/EPINet-OR and is suitable for inpatient and outpatient surgery as well as labor and delivery suites. Tracking of sharps injuries in health care facilities is mandated by the 2001 revision of OSHA's Bloodborne Pathogens Standard. For more information, call 434/982-0702, or e-mail gingerparker@virginia.edu.

References

1. Occupational Safety & Health Administration: Bloodborne Pathogens (29 CFR 1910.1030). Web site: http://www.osha.gov/Preamble/Blood_toc/Blood_toc_by_sect.html.
2. Jagger J, Bentley M, Tereskerz P: A study of patterns and prevention of blood exposures in OR personnel. *AORN J*, 67(5):979-996, 1998.
2. Centers for Disease Control and Prevention: Recommendations for the prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. *MMWR*, 47(no. RR-19):1-39, 1998.

Dr. Jagger *is director, International Health Care Worker Safety Center, and Becton Dickinson Professor of Health Care Worker Safety, University of Virginia Health System, Charlottesville.*

Health care organizations wield influence in Washington

Washington, DC, is home to thousands of interest groups that work the halls of the House and Senate office buildings educating members of Congress and their staff on legislation that would benefit the organizations' members, looking for support for a particular bill, or asking for funding.

The sheer volume of interest groups and their requests, constrained resources (compounded by the constant quest for budget neutrality), and competing political agendas result in an ongoing battle for time, attention, and funding from legislators. These demands apply to new as well as established programs.

To achieve its legislative and regulatory goals, it is essential that the College collaborate with other medical organizations on key agenda items whenever possible or at least understand their inability to support surgery's views. The most effective organizations in the political arena are those that have the ability to mobilize knowledgeable members to serve as advocates who can share examples of policy in action or front-line experience. This article discusses a few of the organizations that touch the surgical profession and may be in a position to provide opportunities for collaboration.

Physicians' organizations

Several physicians' organizations are potential allies of the College. The functions and goals of these organizations are described in this portion of the article.

American Medical Association (AMA)

The AMA was established in 1847 with the goal of unifying physicians to improve health care in the U.S. Its headquarters is in Chicago, IL, and for the last 59 years, the organization has maintained an active office in Washington, DC. The AMA includes more than 290,000 members spanning the range of specialties and has used its status as one of the largest health care organizations to emphasize its positions to members of Congress and the Administration. The organization's stated mission is to promote the

by Erin LaFlair, Legislative Assistant, Division of Advocacy and Health Policy

science and the art of medicine and the betterment of public health.

The AMA actively supports Patients' Bill of Rights legislation, Medicare reform, regulatory relief for physicians, correction of the flaws in the system that is used to calculate the Medicare physician payment update, funding for graduate medical education (GME), and fair confidentiality laws for patients and physicians. The AMA's advocacy agenda is directed largely by the House of Delegates (HOD), its policymaking body. The HOD meets twice each year and is composed of 549 delegates from state medical associations, national specialty societies (the College currently has five delegates), and other interest groups. The College has worked with the AMA on issues such as regulatory relief, tort reform, and the 2002 Medicare fee schedule update. To contact the AMA Washington Office, call 202/789-7400 or visit the organization's Web site at *www.ama-assn.org*.

American College of Physicians-American Society of Internal Medicine (ACP-ASIM)

The ACP-ASIM has 115,000 physician members in medical specialties that include general internal medicine, cardiology, gastroenterology, hematology, oncology, and immunology. The ACP, founded in 1915, was originally focused on the advancement of clinical knowledge. The ASIM, founded in 1956, focused primarily on socioeconomic issues. In 1998, the two groups determined they were pursuing similar paths in the advancement of internal medicine and merged into a single organization.

Headquartered in Philadelphia, PA, with an office in DC, the ACP-ASIM uses its large primary care constituency to effectively advocate for internists on Capitol Hill. The ACP-ASIM's current legislative priorities include reducing the negative physician payment update for 2002, regulatory reform, tax credits for health insurance, the Patients' Bill of Rights, prescription drug coverage, and the deduction of student loan interest. To contact the ACP-ASIM Washington office, phone 202/261-4500 or visit their Web site at *www.acponline.org*.

The American Academy of Family Physicians (AAFP)

The AAFP was founded in 1947 and is considered one of the larger representatives of general medicine. Its membership consists of more than 93,000 physicians with the goal of promoting high quality standards, cost-effective health care, and an optimal supply of family physicians. Its legislative agenda is similar to that of the ACP-ASIM—regulatory relief, corrections to the Medicare fee schedule, patient safety, managed care reform, and a prescription drug benefit under Medicare. The AAFP is headquartered in Leawood, KS, with an office in Washington. To contact the Washington office, phone 202/232-9033 or visit *www.aafp.org*.

American Society of Anesthesiologists (ASA)

The ASA, an educational and scientific association of physicians, was founded in 1905 and considers itself the foremost advocate of patients who are in need of anesthesia or pain relief. The ASA has its main office in Park Ridge, IL, and represents more than 37,000 members. The ASA has long been an advocate of quality care and has been recognized by the Institute of Medicine and other policymakers as a pioneer in developing effective patient safety programs. The organization also has supported increased Medicare payments and Food and Drug Administration regulation of medical products and anesthesiology drugs. The College and the ASA have found common ground in patient safety issues. The ASA Washington office can be reached at 202/289-2222 or online at *www.asahq.org*.

American Academy of Pediatrics (AAP)

The AAP was established in 1930 and has dedicated its membership of 55,000 pediatricians to advancing the health, safety, and well-being of infants, children, adolescents, and young adults. The AAP is headquartered in Elk Grove Village, IL, and has played an active role in the policy arena through its DC office for more than 25 years. Because its patient population has unique issues that are frequently overlooked by larger umbrella organizations, the AAP's emphasis is often different than that of other physician groups in Washington. Its current legislative agenda includes modifying the enrollment procedures of Medicaid and the State Children's Health Insurance Program (SCHIP) in an effort to ensure access to care for as many children as possible. Other areas of emphasis include the

Surgical specialty societies

Organization/contact	Telephone	Web site
American Academy of Facial Plastic and Reconstructive Surgery Stephen Duffy, Executive Vice-President American Academy of Facial Plastic and Reconstructive Surgery 310 South Henry St., Alexandria, VA 22314	703/299-9291	*www.facial-plastic-surgery.org*
American Academy of Ophthalmology Cathy Greeley Cohen, Vice-President, Governmental Affairs American Academy of Ophthalmology 1101 Vermont Ave., NW, Ste. 700, Washington, DC 20005-3570	202/737-6662	*www.eyenet.org*
American Academy of Orthopaedic Surgeons David A. Lovett, Esq., Director of the Washington Office American Academy of Orthopaedic Surgeons 317 Massachusetts Ave., NE, Ste. 100, Washington, DC 20002	202/546-4430	*www.aaos.org*
American Academy of Otolaryngology-Head and Neck Surgery Beverly Nissenbaum, Director, Department of Health Policy and Government Affairs American Academy of Otolaryngology-Head and Neck Surgery One Prince St., Alexandria, VA 22314-3357	703/836-4444	*www.entnet.org*
American Association for Thoracic Surgery Corinne Colgan, Assistant Director, Government American Association for Thoracic Surgery c/o Smith Bucklin & Associates 2025 M St., NW, Ste. 800, Washington, DC 20036	202/367-1265	*www.aats.org*
American Association of Neurological Surgeons Katie Orrico, JD, Director, Washington Office American Association of Neurological Surgeons 725 15th St., NW, Ste. 800, Washington, DC 20005	202/628-2072	*www.neurosurgery.org*
American College of Obstetricians and Gynecologists Lucia DiVenere American College of Obstetricians and Gynecologists P.O. Box 96920, 409 Twelfth St., SW, Washington, DC 20090-6920	202/638-5577	*www.acog.org*
American College of Osteopathic Surgeons Guy D. Beaumont, Executive Director American College of Osteopathic Surgeons 123 N. Henry St., Alexandria, VA 22314-2903	703/684-0416	*www.facos.org*
American Pediatric Surgical Association Erin LaFlair, Committee Liaison American Pediatric Surgical Association c/o American College of Surgeons 1640 Wisconsin Ave., NW, Washington, DC 20007	202/337-2701	*www.eapsa.org*
American Society of Bariatric Surgeons Christopher Gallagher, Committee Liaison American Society of Bariatric Surgeons c/o American College of Surgeons 1640 Wisconsin Ave., NW, Washington, DC 20007	202/337-2701	*www.asbs.org*
American Society of Cataract and Refractive Surgery Nancy McCann, Director of Government Relations American Society of Cataract and Refractive Surgery 4000 Legato Rd., Ste. 850, Fairfax, VA 22033	703/591-2220	*www.ascrs.org*

Surgical specialty societies *(continued)*

Organization/contact	Telephone	Web site
American Society of Colon and Rectal Surgeons Erin LaFlair, Committee Liaison American Society of Colon and Rectal Surgeons c/o American College of Surgeons 1640 Wisconsin Ave., NW, Washington, DC 20007	202/337-2701	*www.fascrs.org*
American Society of General Surgeons Domenic Ruscio, Washington Consultant American Society of General Surgeons c/o Cavarocchi-Ruscio-Dennis Associates 317 Massachusetts Ave., NW, Suite 200, Washington, DC 20002	202/546-4732	*www.theasgs.org*
American Society of Plastic Surgeons Bill Seward, Director of Government Affairs American Society of Plastic Surgeons 444 E. Algonquin Rd., Arlington Heights, IL 60005	847/228-9900	*www.plasticsurgery.org*
American Urological Association Cherie McNett, Washington Representative American Urological Association 1120 North Charles St., Baltimore, MD 21201	410/727-1100	*www.auanet.org*
American Urological Association Randolph B. Fenninger, Washington Consultant American Urological Association c/o MARC Associates 1101 Seventeenth St., NW, Ste. 803, Washington, DC 20036-4704	202/833-0007	*www.auanet.org*
Congress of Neurological Surgeons Katie Orrico, JD, Washington Representative Congress of Neurological Surgeons 725 15th St., NW, Ste. 800, Washington, DC 20005	202/628-2072	*www.neurosurgery-online.com*
Society of American Gastrointestinal Endoscopic Surgeons Erin LaFlair, Committee Liaison Society of American Gastrointestinal Endoscopic Surgeons c/o American College of Surgeons 1640 Wisconsin Ave., NW, Washington, DC 20007	202/337-2701	*www.sages.org*
Society of Gynecologic Oncologists Scott Wilber, Washington Representative Society of Gynecologic Oncologists c/o Smith Bucklin & Associates 2025 M St., NW, Ste. 800, Washington, DC 20036-3309	202/367-1237	*www.sgo.org*
Society of Surgical Oncology Erin LaFlair, Committee Liaison Society of Surgical Oncology c/o American College of Surgeons 1640 Wisconsin Ave., NW, Washington, DC 20007	202/337-2701	*www.surgonc.org*
Society of Thoracic Surgeons Bob Wilbur, Washington Representative Society of Thoracic Surgeons c/o Smith Bucklin & Associates 2025 M St., NW, Ste. 800, Washington, DC 20036-3309	202/367-1100	*www.sts.org*

prevention of injury due to automobiles and flammable sleepwear, funding for research into the cause of Sudden Infant Death Syndrome, and care for children with disabilities. The College has worked closely with the AAP on injury prevention and trauma care issues, as well as the promotion of legislation that would provide coverage for surgical procedures for children with birth defects. For more information about the AAP, contact the DC office at 202/347-8600; their Web address is *www.aap.org*.

American Nurses Association (ANA)

The ANA is headquartered in Washington, DC. With 180,000 members, it is one of the largest and strongest voices for the nursing profession. The ANA represents the interests of more than 2.6 million registered nurses nationwide, and its priorities include Medicare reform, patients' rights, safe needle devices, whistleblower protections for health care workers, and adequate reimbursement for health care services. The top priority, however, is health care reform with an emphasis on an expanded role for registered nurses and advanced practice nurses in the delivery of basic and primary health care. The ANA also seeks to obtain additional funds for nurse education and improvements in the health care workplace. To contact the ANA, call 202/651-7000 or visit *www.ana.org*.

American College of Emergency Physicians (ACEP)

The ACEP was founded in 1968 and represents 21,000 emergency medicine physicians. The group is headquartered in Irving, TX, and has had an office in Washington for 17 years. The ACEP has supported many of the same issues as the College, including passage of Patients' Bill of Rights legislation, physician payment reform, and funding for GME. It has also placed major emphasis on issues that uniquely affect emergency physicians, such as the Emergency Medical Treatment and Labor Act, injury prevention awareness, and, most recently, emergency room readiness for bioterrorism threats. The ACS has worked closely with the ACEP on trauma system planning and payment issues. The phone number for the ACEP Washington office is 202/728-0610, and its Web site is *www.acep.org*

Hospital groups

Other major players in terms of health care advocacy include organizations that represent hospitals and other health care facilities. These organizations are as follows.

American Hospital Association (AHA)

The AHA is a national organization that represents 5,000 hospitals, health care systems, and networks and has 37,000 individual members. Founded in 1898 with offices in Chicago, IL, and Washington, DC, the AHA's stated mission is "advancing health in America." Since the September 11 attacks, the AHA has been placing greater emphasis on disaster readiness. The AHA believes hospitals must be prepared to handle mass-casualty terrorism in close coordination with police, fire, rescue, and other public safety services. The organization's other priorities include responding to the regulations stemming from the Health Insurance Portability and Accountability Act (HIPAA) regulations, reducing the regulatory burden on providers, resolving the nursing shortage, and improving quality of care. The AHA Washington office may be reached by phone at 202/638-1100 and online at *www.aha.org*.

Federation of American Hospitals

The Federation of American Hospitals is another organization representing for-profit hospitals, ambulatory centers, and other organizations involved in the delivery of health care services. Founded in 1966 with national offices located in Washington, DC, the federation is working to foster the public good through the creation and delivery of quality health care for all people. The organization shares many of the AHA's objectives but also has put structural payment reform for Medicare and Medicaid, mental health and rehabilitation services, and rural health on its agenda for this year. For more information call 202/624-1500 or visit *www.americashospitals.org*.

Association of American Medical Colleges (AAMC)

The AAMC was established in 1876 to work for reform in medical education. Originally charged with representing the interests of medical schools, the organization has evolved into an advocate for

400 major teaching hospitals and health systems, as well as 90 academic and professional societies. In its quest to improve the health of the public by enhancing the effectiveness of academic medicine, the AAMC concentrates its efforts on achieving adequate funding for the National Institutes of Health, biomedical research, and GME. Workforce issues concerning resident work hours and the nursing shortage continue to be organizational priorities. Since 1997, the AAMC has been successful in working to implement refinements in the Balanced Budget Amendment's provisions that center on reimbursement for teaching hospitals. The AAMC is headquartered in Washington, DC, and may be reached by calling 202/828-0400 or by visiting *www.hiaa.org*.

Insurance groups

Another category of health advocacy organizations comprises the insurance industry. Representative groups in this classification are as follows.

Health Insurance Assocation of America (HIAA)

The HIAA represents more than 300 private health care insurers. The HIAA is a diligent and often formidable advocate on both Capitol Hill and with the executive branch. In fact, it was listed in *Fortune's* top 25 most influential associations in America for the years 1999, 2000, and 2001. The HIAA's primary purpose is to advocate on behalf of the industry at the state and federal levels. It is also well known as a provider of self-study courses on health insurance and managed care.

Like other health insurance associations, the HIAA frequently represents a differing view on issues of importance to physicians. For example, the HIAA opposes legislation that would expand health plan liability and proposals to establish antitrust statute exemptions that would enable physicians to negotiate collectively with insurers. Additionally, the HIAA supports legislation that preserves the employer-based system of health coverage, choice in the marketplace, improvements in the Medicare+Choice program, access to care for the uninsured, and tax incentives for long-term care insurance. The HIAA is headquartered in Washington, DC, and can be contacted at 202/824-1600 or online at *www.hiaa.org*.

American Association of Health Plans (AAHP)

The AAHP is the principal association advocating for the managed care industry, including health maintenance organizations, preferred provider organizations, and utilization review organizations. The AAHP is headquartered in Washington, DC, and the group actively advocates managed care positions. It also provides communications programs, quality assessment/improvement programs for health plans, and research and educational programs on the latest developments in managed care. The AAHP shares many of the HIAA's views but also pursues prescription drug coverage, HIPAA reform, patient safety, and antidiscrimination laws and regulation as part of its agenda. The AAHP can reached by calling 202/778-3200 or by visiting their Web site at *www.aahp.org*.

Other surgical organizations

As regulatory intrusion into surgical practice intensifies and the resources required to address the associated problems are stretched increasingly thin, surgical organizations like the College are seeking more effective ways to garner congressional and regulatory attention and achieve appropriate action on pressing issues. The College can amplify its work through effective programs of alliance- and coalition-building, as well as through the cooperation of Fellows who are willing to help illustrate the implications of a proposed policy. In many cases, a majority of the health organizations in Washington are working toward a similar goal—the creation of an efficient, accessible, affordable, and high-quality health care system. The challenge remains in finding consensus and identifying a "win-win proposition" among diverse membership organizations and using that collective voice most effectively.

In addition to the organizations previously listed, the chart on pages 16-17 identifies surgical groups that are among the strongest allies of the College. Along with tracking their positions and advocacy efforts on their Web sites, Fellows are encouraged to periodically monitor the College's efforts, which are summarized on the ACS Web site in the Legislative Action Center at *http://capwiz.com/facs/home/*. Ω

Surgical residencies:

Are we still attracting the best and the brightest?

by Michael J. Zinner, MD, FACS, Boston, MA

I've spent the past 20 years as either a program director in general surgery or as chair of a department of surgery. Much has changed during that period of time. Residencies are not what they were—nor should they be.

Patients having cholecystectomies used to spend five days in the hospital; now they spend five hours. Patients with complex surgical conditions would be admitted to the hospital for preoperative preparation; now most are admitted the morning of surgery. Residents used to spend weeks in the hospital; now most residencies limit them to every third night call.

Managed care, with its push to lower costs, has influenced many of these changes. This pressure has led to some improvements and has forced us to reevaluate our training programs. Residency review committees have insisted that residents have a broader experience that includes preoperative, operative, and postoperative care of patients. Most of our surgical programs have made or are making this wise move. It ensures that residents see a full spectrum of surgical diseases and follow both hospital and outpatient cases.

As dramatic as these 20 years of change have been, the new millennium presents us with challenges that may prove even more difficult to solve. I am concerned about two areas: the medical student environment and the training of residents.

Medical students

Over the past decade, medical schools have changed dramatically. Nearly 50 percent of our graduates are women. Students are more diverse, and many are older and have taken nontraditional paths to medical school (see Table 1, p. 21). How-

ever, applications are down, indebtedness is soaring, and the relative attractiveness of surgical residencies is in question.

Medical school first-year positions have been stable for some time, but the number of medical school applicants has steadily fallen from a high of 46,968 in 1996-1997 to 37,092 in 2000-2001.[1] That is a 21 percent drop.

Why did this decline occur? There are several possible explanations. In the 1990s, the U.S. economy was robust, and the high-tech industry could have been more alluring to undergraduates than medicine. Many college-age entrepreneurs with little experience formed high-tech companies. Others joined start-up companies with little or no capital. Huge compensation at a young age was possible. During this time in medicine, however, we saw incomes in general, and surgical salaries in particular, remain flat or decrease.

Data from the Association of American Medical Colleges (AAMC) shows that the mean salary for associate professors in general surgery actually fell from $232,200 in 1996-1997 to $226,100 in 1999-2000.[2] General surgery incomes vary widely, ranging from $142,000 to $274,000, according to recent surveys by several groups (see Table 2, p. 22). At the same time, data from these groups showed higher salary ranges for radiology ($163,000 to $355,000), medical oncology ($162,000 to $334,000) and noninvasive cardiology ($158,000 to $327,000).[3] As a result of these salary decreases and variances, along with a variety of other factors, senior members of the medical establishment often said they would not recommend a medical or, in particular, a surgical career to their children. Virtually everyone in the field felt they were working longer and harder simply to maintain the same level of income. Young people noticed.

Now the economy has changed. Dot-com dreams have been dashed, and as New England's high-tech bubble has burst, the *Boston Globe* has reported a sharp increase in students reapplying to business schools for MBAs.[4] Medical school applications may also follow this upward trend. I certainly hope so, but we'll have to wait and see.

Another pressing issue for medical students is the huge educational loan debt they carry out of medical school and into their residencies. We have seen a striking increase in this financial burden over the past two decades. The AAMC reports that 83 percent of new graduates are in debt and that their average indebtedness is $95,000 (see Fig-

Table 1

Percent of U.S. medical school graduates from underrepresented minorities, other ethnic groups, and women

Year	White	Asian	African-American	Hispanic	Women
1979-1980	84.6%	2.7%	5.1%	3.0%	23.1%
1999-2000	66.5	18.1	7.0	6.7	42.5

Source: AAMC.[1]

Notes:

1. AAMC defines "underrepresented minority" to be only U.S. citizens with permanent visa; prior to 1981, only U.S. citizens were included.
2. "Asian" refers to AAMC definition of "Asian/Pacific Islander."
3. "Hispanic" refers to combined AAMC definition of "Mexican American/Chicano," "mainland Puerto Rican," "Commonwealth Puerto Rican," and "other Hispanic."

Table 2

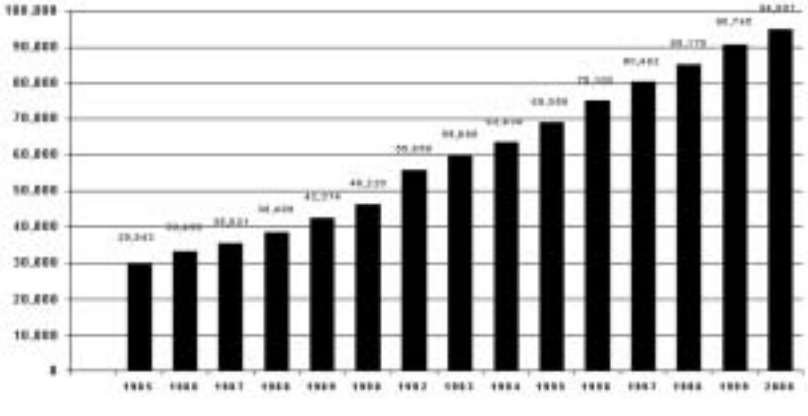
Compensation for general surgeons—2001

Group	Compensation
Medical Group Management Association	$274,037
Hospital & Healthcare Compensation Service	265,431
American Medical Group Association	257,139
Martin, Fletcher & Associates	250,000
Sullivan, Cotter & Associates	235,210
Warren Surveys	220,804
Merritt, Hawkins & Associates	216,000
Goddard Healthcare Consulting	210,000
Hay Group	190,400
Health Care Group	142,000

Source: *Modern Healthcare.*[3]

Figure 1

Average indebtedness of medical students



Source: AAMC.[1]

ure 1, this page); only 17 percent have no debt.

Saddled with this burden, students are asked to consider entering low-paying surgical residencies that last five to 10 years. Although the mean first-year house staff salary is only $35,728, residents are asked to start repaying their loans immediately upon graduation.[1] Directly or indirectly, the disparity between loan payments and potential income must affect career decisions.

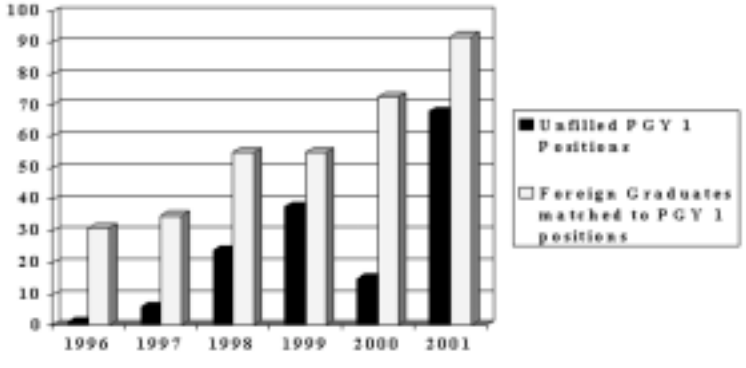
It is only anecdotal information, but medical schools are reporting a higher number of students leaving the profession to enter entirely different careers. Similar reports about surgical residents were offered during recent meetings of the Association of Program Directors in Surgery. Students and residents don't leave medicine solely for financial reasons, but money worries certainly contribute to their decision.

Last year, the National Residency Matching Program sounded a wake-up call for all of the country's surgical residency program directors.[5] For a long time, general surgery residencies have been among the most competitive programs. In 1996, there was only one unfilled position in general surgery. The number used to be virtually zero because there were always more students interested in surgery than there were surgical positions. By 2001, however, the number of unfilled positions surged to 69 even though the number of first-year spots remained stable at approximately 1,000.

In addition, a lack of U.S.-trained applicants has led to an

Figure 2

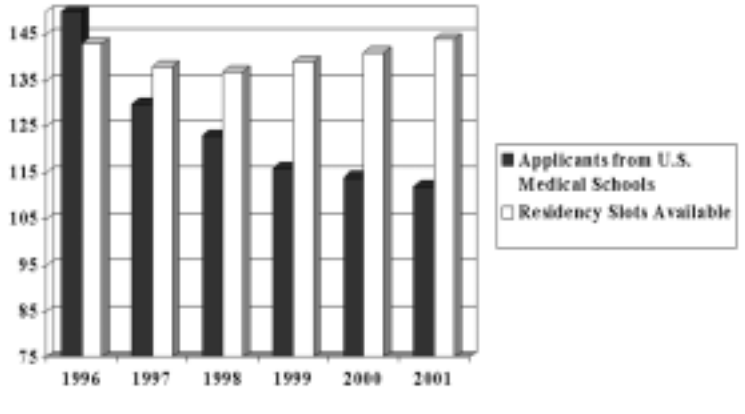
First year positions in general surgery



Source: AAMC.[5]

Figure 3

Matches to cardiothoracic residency positions



Source: AAMC.[5]

increase in graduates of foreign medical schools filling PGY-1 categorical positions (see Figure 2, this page). This change is even more dramatic among applicants for cardiothoracic training positions (see Figure 3, this page). Not long ago, cardiothoracic surgery positions were the most competitive surgical positions available. Now, there are fewer U.S. applicants than positions available, and there is an almost one-to-one ratio of total applicants (foreign and U.S.) to positions in the 2001 match (total number of applicants equals 149 and total number of positions equals 144).[6]

The number of entering medical students has dropped in other specialties as well. Anesthesia is a particularly distressed specialty, and most programs do not fill through the match. Last year, the total number of unmatched anesthesia positions rose again.

The cause of this descent isn't clear, but there does appear to be a shift away from surgery and anesthesia toward specialties that afford more controllable lifestyles. Two residency programs that are becoming increasingly popular and that have fewer unfilled positions are diagnostic radiology and emergency medicine. This trend may represent medical "market forces" or a desire for a controlled professional environment, particularly during early family-raising years.

Residents

State and federal governments hear the seductive call: Limit the number of hours a surgical resident can work, and limit the amount of call. Debate on this issue was sparked by the Institute of Medicine's November 1999 report on medical errors. Suddenly, the public was more aware of health care mistakes. Many concerned parties have tried to link errors to work hours and conditions, prompting the call to curtail the time residents spend in the hospital.

Current proposals to limit house staff work hours

draw inspiration from the report of the Bell Commission, which investigated the 1984 death of an 18-year-old woman admitted to New York Hospital with agitation and a high fever. She was taking an antidepressant, Nardil, and was given Demerol for sedation. Her reputed cocaine use was not reported. She died eight hours after admission. The family attributed her death to house staff fatigue and lack of supervision. Because her father was a well-known journalist for the *New York Times*, the case received a great deal of publicity. An ad hoc government advisory committee, chaired by Bertram Bell, MD, was formed to investigate the issue and advise the state. The committee made these recommendations:

1. Residents should be on call no more than 80 hours per week.
2. Residents should work no more than 24 hours in a row.
3. Residents' stints on duty should be separated by at least eight consecutive hours.
4. Residents should have one 24-hour period of nonwork time per week.

These suggestions were written into New York State regulations issued in 1986. After a professional disciplinary board had censured the residents who treated the patient, a state appeals court exonerated them. In a separate civil case, a jury found the physicians involved were negligent but split the negligence between the patient and the doctors.[7]

After the "405 Regulations" were first issued, training programs varied in their level of compliance until a series of investigative articles in the *New York Times* reported that many hospitals were not abiding by the rules. In March of 2000, the New York State Department of Health sent 12 teams of investigators into hospitals to do spot checks.[8] They interviewed residents, paged attendings, and reviewed charts on the wards. Fines were levied against institutions that failed to meet the requirements. Not surprisingly, nearly all of New York State's residencies were in compliance by the following year.

This past year, other state and federal regulatory agencies have shown increasing interest in work hours. In Washington, the Occupational Safety and Health Administration (OSHA) is holding hearings on resident work hours. Last year Ralph Nader's consumer and health advocacy group, Public Citizen, joined the OSHA petition to limit work hours for residents. Recently the AMA Board of Trustees weighed in, announcing that it, too, is looking into resident work hours. A succession of policies and bills followed. The new AAMC policy was published in October 2001 and was nearly identical but added "no more than 12 hours of continuous duty in high-intensity settings (that is, emergency rooms and critical care units)." In November 2001, Rep. John Conyers, Jr. (D-MI), introduced the Patient and Physician Safety Protection Act of 2001 into the House of Representatives, which included the same list of restrictive hours. Finally, at the end of November 2001, the Massachusetts Medical Society adopted the same policy to limit hours and called for drafting state legislation that would enforce hourly limits.

Unfortunately, it is overly simplistic to think that legislated work hours will solve all of the problems, including the occurrence of medical errors. No surgical residency director builds fatigue into his or her program as a rite of passage. What we do build into our programs is the crucial principle of continuity of care for one's own patients.

There is almost universal "pride of ownership" and high esprit de corps among surgical residencies. Many of the most vocal opponents to external limitations on surgical residencies are the residents themselves. Although we as educators teach judgment and a skill set about surgical diseases, the most important quality we impart is a sense of responsibility for the total care of our patients. This is the cornerstone of every surgical training program and must not be left out of the debate. When we limit work hours and convert care to shift work, we build in multiple hand offs between physicians.

Lost in public discussions is the link between these multiple hand offs and the possibility of errors. This discontinuity is a real problem. One of the few studies that addresses this key issue is by L.A. Petersen and others; its results are reported in "Does housestaff discontinuity of care increase the risk for preventable adverse events?"[9] This case-controlled study of more than 3,000 patients in an urban teaching hospital showed that yes, increasing hand offs increase errors. Researchers concluded that "patients who had potentially preventable adverse events were more than twice as likely to be covered by an intern from another team or the night float resident…as were matched con-

trol patients in adjacent beds (26% compared to 12% $p < 0.05$)." The problem of errors and cross covering has received very little attention from our own profession, and systems need to be developed to deal with this.

Limiting residents' work hours to 80 per week is not the definitive answer. It is only part of the solution. Work at my institution tells us that error reduction in surgery is a complex problem and that fatigue is only one of several factors. Cutting hours does not change the sad fact that residents are stuck performing noneducational and nonclinical tasks, such as unnecessary clerical work, scheduling patients, and drawing blood. We need to add hospitalwide systems, such as computer order entry, electronic medical records, and electronic signouts to reduce some of the administrative burdens.

Time for fresh approaches

Our profession has a long history of attracting the best and the brightest, and I think we still do. However, as surgical leaders we simply cannot ignore the changing environment. We must improve residents' work environments. We must add other health care professionals to handle nonmedical tasks, offering more time flexibility in our residency programs, and designing more integrated residencies in areas of added qualifications. These changes are going to be controversial, and in some cases costly, but are necessary.

The American College of Surgeons and the American Surgical Association set up the Study of Surgical Services for the United States (SOSSUS) 31 years ago to study the future of the profession.[10] The goal was to "objectively and dispassionately evaluate the distribution of services, the problems of manpower, and the interaction of surgery with other fields." It is time once again to act, to study the state of the profession, and to plan its future before someone else tries to do it for us. Ω

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Dr. Zinner *is Moseley Professor of Surgery and surgeon-in-chief, Brigham and Women's Hospital, Boston, MA.*

IN THEIR OWN WORDS

Serving on the Practicing Physicians Advisory Council

by AMILU ROTHHAMMER, MD, FACS, *Colorado Springs, CO*

In March 2000, I began a four-year term on the Practicing Physicians Advisory Council (PPAC), serving as the College's representative and the only Fellow on PPAC. I will become eligible for a second term in 2004. This article summarizes my experiences in this role and the functions of PPAC.

What is PPAC?

PPAC is an advisory group composed of physicians currently in practice throughout the country. It was formed by statute in 1990 to advise the Secretary of the Department of Health and Human Services (HHS) on Medicare and Medicaid policies that affect practicing physicians. Although technically PPAC advises the Secretary of HHS, its real job is to ensure that the administrator and staff of the Centers for Medicare & Medicaid Services (CMS) hear our views about the practicalities and potential impact of various policies and procedures.

PPAC has a diverse membership representing all areas of the country and practice settings. The statute requires that PPAC include both participating and nonparticipating Medicare physicians, as well as physicians practicing in rural and underserved urban areas. Most of the seats on PPAC are held by physicians, but up to four seats may go to those limited license practitioners who are designated as "physicians" under the Medicare statute (chiropractors, dentists, optometrists, and podiatrists). Currently 12 of the 15 seats are held by MDs and DOs.

Members' functions

As the College's representative, it has been my responsibility to ensure that the surgeon's voice is heard as the CMS considers changes in policy and procedures. Certainly, my experience as the Chair of the College's Board of Governors provided me with a unique perspective on the issues affecting surgeons and may have played a part in my appointment. I find it very important to have the input of many physicians so that we really know what is affecting them and ultimately their patients. Administrators need a surgeon's real world experience, no matter what his or her discipline, to be certain that good policies are crafted and reality tested.

I think we have a real impact on the Medicare program by concentrating on those policies that affect a physician's everyday activities. We have been able to accomplish a number of goals in the two years I have been on PPAC, including:

- We have made suggestions on a revised physician enrollment form that went into effect January 1, 2002. If the CMS follows through on their plans, physicians will need to re-enroll periodically so that eventually all physician offices will be expected to complete the new form.
- The CMS found that a few carriers were denying all preoperative testing on the grounds that it was a screening service. We pointed out how important it was that they write a directive to carriers making it clear that preoperative testing was covered.
- We reviewed the CMS's plans for documentation requirements for evaluation and management (E&M) services at important points in the process. This was prompted by the CMS's decision that it would be better to evaluate E&M services by using clinical examples rather than using the elaborate documentation requirements they had developed in 1995 and 1997. However, the development of the clinical examples became overwhelming, with a massive number of examples for each specialty. PPAC and other specialty societies recommended that the work on clinical examples stop and the CMS agreed. The *Current Procedural Terminology* (CPT) editorial panel now has a work group examining whether revisions can be made in CPT that would reduce the need for documentation guidelines.
- We have worked to simplify the revised advanced beneficiary notice and related instructions to physicians. My experience indicated that surgeons do not use this form very often, but signing the form shifts financial liability to the patient in the event Medicare chooses not to cover a procedure that is usually covered.

2002 fee schedule

We also try to review all directives to physicians from Medicare to prevent misunderstandings from occurring. However, we were unable to review the letter that was sent to physicians regarding the changes in Medicare reimbursement for 2002 because our meeting in late September 2001 was canceled.

We do not generally provide advice on matters that will be settled in the political arena because other players, such as the President and Congress, take the lead. However, we did make an exception regarding the flawed update for physician services. Our meeting in December 2001 occurred two weeks after the CMS announced the negative update for physicians for 2002. Our meeting provided an early opportunity to speak about the issue. Although there are a number of problems with the update, the major error is using the gross domestic product in the calculation of the update. This number has nothing to do with the need for physician services.

We recommended that the Secretary not oppose a statutory "fix" for the problem. The President's budget for fiscal year 2003, which was announced in early February and begins October 1, 2002, calls for the development of a new "budget neutral" update factor. Having the problem of the flawed update factor mentioned in the budget was certainly a surprise, but the physician community will have to see what the phrase "budget neutral" means as events play out in the legislative arena.

Meeting procedures

The agenda for our meetings is developed jointly by the CMS with input from PPAC. The CMS places some topics on the agenda because they want our input, while council members identify issues of concern to their constituency. For example, we plan to hold sessions on a number of topics including Medicare's oversight of carriers. Some items appear only once on our agenda, but others are on it more than once so we can review

the issues at various points in their development. It looks as though we may become even more involved in CMS operations with the appointment of a new chair of PPAC. Tom Scully, the administrator of the CMS, has appointed Michael J. Rapp, MD, to serve as chair, because he is from the Washington, DC, area and can personally participate frequently in the work of the agency.

Typically we meet once each quarter for a day. Usually there are four to six items on the agenda, which is published in the *Federal Register* about a month before the meeting so that the medical societies are able to prepare written or oral testimony. Agenda materials, consisting of what the CMS has prepared and any public testimony, are delivered to our hotel the evening before the meeting.

At the meeting, we first hear from one or two CMS representatives who are working on a project identified in the agenda. They usually make a presentation about the program or process and answer any questions from the council members. Next, we hear any oral testimony and have a chance to ask questions of the presenter. We then discuss what we have heard and make our recommendations. A formal transcript of the meeting, containing all of the discussion and recommendations, is produced. At the end of each year, a report that captures our recommendations and the actions taken is prepared.

The atmosphere of these meetings is more informal and interesting than a dry recitation of briefing notes. Members of the council and some of the CMS staff have worked closely through the years and have developed collaborative relationships. There usually is an audience of about 20 to 30 people, including specialty society representatives and CMS employees. Sometimes these members present clarifying information or even ask questions. Finally, one or two top officials from the CMS are usually present during portions of the meeting to provide their views on items of current interest.

In many ways PPAC functions like the Medicare Carrier Advisory Committees (CACs), although the subject matter is different. The CACs' primary purpose is to provide clinical advice on proposed local medical review policies, whereas PPAC provides advice on a broad range of issues that will be implemented nationwide.

Expanding territory

So far I have only discussed Medicare, but the committee also has responsibility for examining the Medicare+Choice and Medicaid programs. We have not done a great deal with either program yet. There does not seem to be much interest in Medicare+Choice, probably because network administration is left largely to the plans.

Although it has not been a part of the formal agenda, Medicaid has been addressed at each of the meetings. Some members of PPAC practice in economically disadvantaged areas, so they have a great deal of experience with Medicaid and can cite many areas in the program that could be improved. However, states have responsibility for administering the program as long as they meet some rather broad federal criteria. Nonetheless, we plan to receive an overview of the Medicaid program to see just what opportunities exist for PPAC to be of assistance. It certainly would do a lot to ease the pressures many physicians encounter if we could fix some of the problems.

Ultimately, I believe it is my responsibility to help the leadership and staff of the CMS understand the real-world implications of policies and processes that stand in the way or add unnecessary complications as physicians attempt to provide quality care for their patients. I think it is important that the College insist upon our continued representation on PPAC after my term is completed. Ω

Dr. Rothhammer *is a general surgeon in private practice in Colorado Springs, CO. She is Second Vice-President-Elect of the College and is a Past-Chair of the Board of Governors.*

Ten specialty boards report accomplishments and plans: Part I

Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the *Bulletin* to keep Fellows abreast of any changes in the procedures of the various boards. The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the *Bulletin* contains the reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Orthopaedic Surgery, the American Board of Otolaryngology, and the American Board of Urology.

The April issue of the *Bulletin* will feature the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, American Board of Plastic Surgery, the American Board of Surgery, and the American Board of Thoracic Surgery.

American Board of Neurological Surgery

by Dennis D. Spencer, MD, FACS, New Haven, CT

Resident numbers

There are 94 neurosurgical training programs in the U.S. In January 2001, we had 289 registrants with 219 rank lists. Of these individuals, 211 were ranked and 142 matched compared with 134 in January 2000. The U.S. Medical Licensing Examination digit score was 227 for matched students versus 206 for those unmatched. This score has been stable for the last three years it has been tracked. There are 861 residents currently training in U.S. neurosurgical programs. There were 147 graduates in the spring of 2001.

Primary examination

The 2001 primary exam was administered March 31 in 102 test centers to 475 examinees. There were 199 candidates for certification and 276 for self-assessment. A total of 504/520 questions were scored with a 27 percent failure rate for all certification candidates. An extramural writing committee was formed in the spring of 2000 consisting of individuals from each of the American Association of Neurological Surgeons/ Congress of Neurological Surgeons joint specialty sections. This committee supplements the primary examination committee and will focus on generating clinical questions for the recertification cognitive examination.

Oral examination

Seventy-three candidates sat for the oral exams in November 2000 with a 12 percent failure rate. In May 2001, 73 candidates were examined and 19 percent failed.

Subspecialization and fellowships

The American Board of Neurological Surgery (ABNS) does not issue subspecialty certificates. The Society of Neurological Surgeons has begun the task of establishing criteria for subspecialty fellowships. Neurosurgical programs are then encouraged to meet these training standards. Formalization of this program will provide a mechanism then for the residency review committee in neurosurgery to assess the impact of fellowship training on the core residency education.

Recertification/maintenance of certification

This process was a major focus of discussion at the ABNS meetings this past year. Since 1999, the ABNS has issued 10-year time-limited certifications. The recertification process will involve a written examination, continuing education credits, and a practice data log for the prior year. The written exam will be offered beginning in 2006 with the first recertifications possible in 2007.

Since developing this plan, it has become clear that maintenance of certification must be part of our long-range planning to meet the general requirements of the ABNS: evidence of professional standing, lifelong learning and self assessment, cognitive expertise, and practice performance. The six core competencies must be assessed within these four general components. The ABNS is developing guidelines for the boards to consider. The ABNS believes strongly that neurosurgery should develop these criteria with the other surgical specialties within an initiative from the American College of Surgeons. Everyone will benefit from a uniform plan.

ABNS directors/officers

At the May 2001 meeting, Steven Giannotta, MD, FACS; H. Richard Winn, MD, FACS; and Donald P. Becker, MD, FACS, completed their productive six-year terms. The newly elected directors were Marc Mayberg, MD, FACS; Richard Morawetz, MD, FACS; and Robert Solomon, MD, FACS. The new officers of the board are Dennis Spencer, MD, FACS, chairman; Charles Hodge, MD, vice-chairman; and Arthur Day, MD, FACS, treasurer. Ralph Dacey, MD, FACS, remains as secretary.

American Board of Ophthalmology

by John G. Clarkson, MD, Miami, FL

Examinations

The fall oral examination and meeting of the American Board of Ophthalmology (ABO) was held November 17-19, 2000, in San Francisco, CA. The date of the next annual meeting will be Friday, October 26, 2001, in Cambridge, MA.

The future dates for examinations are as follows: written qualifying examination, April 26, 2002, and April 11, 2003. Oral examination, 2001, October 26-28, in Cambridge, MA; 2002, June 7-9 in San Francisco, and November 8-10 in San Francisco; 2003, June 6-8 in Philadelphia, PA, and October 24-26 in Cambridge, MA.

The total number of diplomates certified at the November 2000 San Francisco and May 2001 Chicago, IL, oral examinations was 457 (232 in San Francisco, 225 in Chicago). Seventy-three failed the examination and must repeat all six subjects.

The 2001 written qualifying examination was held Friday, April 20, at three sites in the U.S. The questions in this examination were prepared by the written examination committee of the American Board of Ophthalmology and the ophthalmic knowledge assessment program committee of the American Academy of Ophthalmology. It is the responsibility of the written examination committee to review and approve the final questions.

Of the 760 registered for the 2001 written qualifying examination (WQE), 683 took the examination, 217 failed (31.77%), and 466 passed. Of the 217 who failed, 120 (55.30%) failed previously. Of the 683 candidates who took the examination, 208 (30.45%) were repeaters, and of these, 120 (57.70%) failed again.

International medical graduates constituted 13.32 percent (91 candidates) of the examination and 44 failed (48.35%). U.S./Canadian graduates constituted 86.68 percent (592 candidates) and 173 (29.22%) failed. Of the 208 candidates repeating the WQE, 44 (21.15%) were international medical graduates and 164 (78.85%) were U.S./Canadian graduates.

The candidates who passed the 2001 WQE plus the repeaters from previous oral examinations provide a potential pool of 238 candidates for the October 2001 oral examination in Cambridge, MA, and 228 potential candidates for the June 2002 oral examination in San Francisco.

Recertification

The future dates for examinations are as follows: certificate renewal examination, written (CREW), February 1 through March 31, 2002 (this is a take-home examination with two months to complete); office record review (ORR), January 1-31, 2002, and July 1-31, 2002 (given twice a year with one month to complete).

The 2001 CREW examination was administered as a take-home examination from February 1 through March 31, 2001. Of the 309 registered for this examination, 304 completed the examination with 288 passing (94.74%) and 16 failing (5.26%).

The ORR was administered July 1-31, 2000, and January 1-31, 2001. Of the 60 registered for the July 2000 examination, 60 passed the review. At the January 2001 examination, 195 were registered with 189 passing and six incomplete.

Representation

The representative to the American College of Surgeons for 2001 is Lee R. Duffner, MD, FACS. The board's representatives to the residency review committee (RRC) for the year 2001 are: Susan H. Day, MD; Richard P. Mills, MD; and M. Bruce Shields, MD, FACS.

At its June 16-17, 2000, meeting, the RRC for ophthalmology considered 28 agenda items. The results of this meeting are as follows: 11 programs received continued full accreditation status; one program was given full accreditation; one program received provisional accreditation, while one program had continued provisional accreditation; one program voluntarily withdrew and seven progress reports were reviewed; six administrative decisions were made.

At its December 8-9, 2000, meeting, the RRC for ophthalmology considered 26 agenda items. The results of this meeting are as follows: 17 programs

received continued full accreditation status; one program voluntarily withdrew; three progress reports were reviewed; four administrative decisions were made; and one proposed probationary status was given.

Officers and board directors

The following directors became officers of the board for 2001: John G. Clarkson, MD (chair), and Lee R. Duffner, MD, FACS (vice-chair).

The two new board directors who took office January 1, 2001, are Gregory L. Skuta, MD, and James S. Tiedeman, MD.

The voting representatives to the American Board of Medical Specialties (ABMS) for 2001 are: Edward G. Buckley, MD; John G. Clarkson, MD; Richard P. Mills, MD; and Charles P. Wilkinson, MD. Denis M. O'Day, MD, FACS, has been elected to the executive committee of the ABMS.

General information

In an effort to provide quality eye care to the public, the American Board of Ophthalmology continues to define and characterize the elements and components of quality eye care. To assist in this role, the ABO has elected a public member to the board. It is hoped that this individual will assist in addressing the ABO's role in the future.

The board continues to seek new ways to increase the reliability of its examinations. The next administration of the oral examination will incorporate two new examining concepts—essential actions and paired topics. Essential actions are key elements that a candidate must perform in order to pass a patient management problem. In the past, the ABO examined in six separate topic areas. These six topic areas will move into three combined sections. This examination combination is the first phase in the elimination of subject headings in order to better simulate the doctor/patient encounter.

In order for time-limited certificate holders to achieve recertification, they must pass both a practice assessment and knowledge assessment pathway. The written knowledge assessment pathway is currently a take-home written examination but the board has voted to change this to a closed book proctored examination, which will be achieved no earlier than 2004.

The ABO continues to discuss the change in the process of recertification to one of maintenance of certification. Future long-range planning meetings will develop the timeline and the contents of this continuous verification of competency.

The American Board of Orthopaedic Surgery

Stuart L. Weinstein, MD, Iowa City, IA

The American Board of Orthopaedic Surgery (ABOS) is pleased to report to the American College of Surgeons the following information regarding its recent activities.

Exams

The initial certification process of the American Board of Orthopaedic Surgery (ABOS) involves three steps: a written examination, a peer review process, and effective achievement in the oral examination.

To be admitted to the written examination, a candidate must have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education and have attestation from the program director that the candidate has performed satisfactorily and is an ethical physician. The written examination undergoes continuous scrutiny and content domain is adjusted by the written examination committee and the staff of the National Board of Medical Examiners. This year, 789 candidates sat for the exam, of which 607 (77%) passed and 182 (73%) failed. Of the 627 examinees who were taking the examination for the first time, 547 (87%) passed and 80 (13%) failed. The reliability and validity of

the examination remains extremely high.

The oral examination is a practice-based examination, which is generally recognized as the most valid form of testing available for professionals. The board has implemented many changes in the oral examination over the past two years in response to an intense three-year review. The board's goal is to ensure that every candidate has the same opportunity to successfully complete the exam. Also, in response to the needs of the candidates, the board spent considerable time and resources in the development of a computerized case list. This year, the case list will be collected and submitted to the ABOS in an online computerized format. This process should make the task of case list preparation less onerous for the candidates and provide the board with a better way to assess the candidate's practice for case selection. It has also provided the board with a database on the practice of orthopaedic surgery, which will guide future direction. This year, 725 candidates sat for the oral exam; 621 (86%) passed and 104 (14%) failed.

Certification

Like the 23 other member boards of the American Board of Medical Specialties (ABMS), the ABOS is committed to transforming its current recertification program into a maintenance of certification program.

As the ABOS looks to the future in addressing the issues of maintenance of certification, one can be assured that, as it has done since 1934, the ABOS will continue serving the best interests of the public and the medical profession. The public and the medical profession should be able to count on the fact that every individual certified by the ABOS is both current and competent.

The ABOS subscribes to the definition of the "competent physician" adopted by the ABMS Assembly in September 1999. Currently the ABOS is looking at the six general competencies adopted by the ABMS Task Force on Physician Competence. The ABOS is currently evaluating whether all the competencies are relevant to orthopaedic surgery, making certain that there are valid assessment tools for each skill. Finally, the ABOS is looking to see how practice variations can be accounted for in measuring these competencies.

The ABOS has already incorporated many of the four required elements of the ABMS's maintenance of certification program into its recertification program. With respect to the first element, evidence of professional standing, the ABOS currently requires a full and unrestricted license to practice medicine. These criteria eventually require further in-depth investigation with state licensing boards. In addition, the ABOS recertification process has always involved peer review. Peer review is used in the review of application letters, letters of recommendation, and other relevant information by the ABOS credentials committee. The current credentials process is also being reevaluated by the ABOS.

With respect to the second mandate, lifelong learning, currently the ABOS requirement is for 120 hours of continuing medical education credits in the three years prior to application for recertification. No doubt, this requirement will change to ensure that the process is continuous and accompanied by periodic self-assessments.

With reference to the third requirement, evidence of cognitive expertise, the ABOS has always been cognizant of the increasing variability of orthopaedic practice. In the current recertification process, the ABOS has provided multiple pathways to recertification. These include: the general clinical written examination administered during the annual meeting; the written examination; and the computer-administered practice profile examinations in general orthopaedics, adult reconstruction, sports medicine, and spine surgery. These tests are currently available at more than 300 U.S. medical centers.

An additional option for this component of the recertification process is the practice-based oral examination, administered each year in conjunction with the certifying oral exam. The candidate is tested on 10 cases from their practice and evaluated by six practicing orthopaedic surgeons with the same practice profile. This pathway also addresses the fourth required element, performance in practice.

The recertification written and computer-administered examinations are knowledge-based tests. Most questions are written at the taxonomy (problem-solving) level. These examinations are all psychometrically valid, both with respect to content validity and reliability. Most educators would agree that lack of cognitive knowledge leads to incompetence, but having cognitive knowledge does not

always lead to competence. The ABOS has evaluated the correlation between cognitive knowledge and competence for the last 10 years in considering its initial certification process. We have found that performance on the written examination does not predict performance on the oral exam. The written exam tests knowledge, while the practice-based oral examination tests the candidate's ability to apply the knowledge appropriately and safely. While the oral examination is an excellent way to evaluate performance in practice, the board is currently engaged in a pilot project with the Maine Medical Assessment Foundation to link outcomes to the process.

Although more than 90 percent of surgical specialists are board-certified (in orthopaedic surgery there is a 97% compliance rate), concerns still exist within the profession about the certification process. Surgeons are unhappy about any "examination," particularly a proctored examination, and are justifiably concerned about costs, time away from practice, and compliance requirements.

The maintenance of certification program mandates that boards and specialty societies cooperate to address the issues relating to continued competence of physician specialists. The maintenance of certification program provides a unique opportunity for the ABOS and the American Academy of Orthopaedic Surgeons and other specialty societies to work together in the development and implementation of continuing competence assessment programs. As the recertification process transitions to maintenance of certification, the ABOS will continually look to ensure that the process is reliable, clinically valid, and economically feasible.

American Board of Otolaryngology

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

The American Board of Otolaryngology (ABOto) is pleased to report the following details regarding its recent activities.

Examinations

The ABOto continues to administer a two-part examination. Candidates must first pass a written qualifying exam and then pass an oral examination to become certified. In October 2000, 319 candidates took the written examination, which was offered in five locations: New York, NY, Chicago, IL, Charlotte, NC, Houston, TX, and San Francisco, CA. Of those individuals, 303 became candidates for the oral examination.

The oral examination was conducted by approximately 120 individuals, including ABOto directors, senior examiners, and guest examiners on April 21-22, 2001, in Chicago. A total of 324 candidates were examined, and 303 passed the exam and become certified.

The otolaryngology training exam (previously the annual otolaryngology exam) was conducted on March 3, 2001, in more than 100 international locations. This is the fourth year the exam has been prepared and conducted by the ABOto. More than 1,200 residents and practitioners participated in the exam.

Elections

Officers will continue in their posts. Michael E. Johns, MD, FACS, serves as president; David E. Schuller, MD, FACS, serves as president-elect; and the author serves as executive vice-president. In addition, H. Bryan Neel III, MD, FACS, was elected to a second three-year term as treasurer, while Charles W. Cummings, MD, FACS, was elevated to senior counselor in recognition of his many years of dedicated service to the ABOto. No new directors were elected to the board.

Senior examiners

Senior examiners serve as the core group of experienced oral examiners, along with ABOto directors. Senior examiners are elected to a five-year term and are eligible for reelection to one additional term after a three-year hiatus. To be

elected to a senior examiner position, an individual must have served as an ABOto examiner at least twice. He or she must be prominent in the specialty, especially in the areas of patient care and medical education, and must demonstrate interest and ability in the creation of educational and test materials.

The following senior examiners completed their terms of service after the 2001 annual meeting: Karen H. Calhoun, MD, FACS; Richard L. Goode, MD, FACS; Kenneth M. Grundfast, MD, FACS; Jeffrey P. Harris, MD, FACS; Paul R. Lambert, MD, FACS; W. Frederick McGuirt, MD, FACS; J. David Osguthorpe, MD, FACS; Ira D. Papel, MD, FACS; Stanley M. Shaphshay, MD, FACS; and J. Regan Thomas, MD, FACS. The following individuals were elected to serve as their successors: Shan R. Baker, MD, FACS; John G. Campbell, MD, FACS; Newton J. Coker, MD, FACS; Elise C. Denneny, MD, FACS; M. Jennifer Derebery, MD, FACS; Peter A. Hilger, MD, FACS; Donald A. Leopold, MD, FACS; Craig S. Murakami, MD, FACS; William Russell Ries, MD, FACS; and Richard J. Smith, MD, FACS.

American Board of Medical Specialties

The American Board of Medical Specialties (ABMS) is the umbrella organization of the 24 recognized certifying boards in the U.S. Otolaryngology representatives to the ABMS assembly in 2001 included: Dr. Johns, Dr. Schuller, and the author. Alternate representatives were: A. Julianna Gulya, MD; Robert H. Ossoff, MD, FACS; and Dean M. Toriumi, MD, FACS. Charles J. Krause, MD, served on the ABMS Task Force on Competence and represented the Council of Medical Specialty Societies in the ABMS assembly.

2000-2001 exams

The 2001 written examination was conducted on Monday, September 24, in four cities: Chicago, Boston, MA, Houston, and San Francisco. The subsequent oral examination will be conducted on April 27-28, 2002, in Chicago. The next otolaryngology training exam be administered on Saturday, March 2, 2002.

American Board of Urology

by Martin I. Resnick, MD, FACS, Cleveland, OH

The American Board of Urology (ABU) is pleased to present the following 2001 report to the American College of Surgeons.

Exams

The certification process of the ABU incorporates a qualifying examination and a subsequent certifying exam. Admissibility to the qualifying examination requires that the applicants have completed or be within six months of satisfactorily completing a urology residency program approved by the American Council on Graduate Medical Education. To be eligible for the certifying examination, candidates must have passed the qualifying examination, have 18 months of clinical practice experience in a single community, submit an acceptable practice log, and receive satisfactory peer reviews.

On June 28 and 29, 2001, 393 candidates completed the qualifying examination, which consists of three components: an imaging portion, a pathology section, and the qualifying examination. All three tests are presented in booklet form and are cognitive, multiple-choice examinations. Of the three components: 393 sat for the imaging portion, which 385 passed and eight failed; 384 sat for the pathology section, with 378 passing and six failing; and 343 sat for the written qualifying examination, which 271 passed and 72 failed. As has been true in other years, practitioners, U.S. and foreign educated, who previously failed the examination had a high failure rate upon reexamination.

For the past 10 years, the pass level for the qualifying examination has been set by the criterion reference method, equated to a previous bench-

mark test using the Rasch model. The passing score will vary according to the difficulty of the examination for any year. Thus, although examination may vary in difficulty from year to year, the probability of passing is based solely on the ability of the candidate pool in any given year. This is a fair and defensible methodology, which does not impose an arbitrary pass/fail point.

The 2001 certifying examination included tests in urological imaging and uropathology, as well as a standardized oral examination. The imaging and pathology examinations presently administered at the certifying level are projected examinations. During 2000 and 2001, the board made the transition to administering these examinations only in booklet form at the qualifying examination level. In 2001, these examinations were offered at both levels until the shift was complete.

In February 2001, 331 candidates took the certifying examination; 288 (87%) passed and were certified, while 43 (13%) failed, resulting in a pass rate higher than that of recent years. The board uses a modified Rasch model for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. Consistent with the board's commitment to continually improving its evaluation processes, in 1995 the board applied a dual scoring system for the oral examination protocols. Separate grades are utilized for information gathering and diagnosis and for problem solving and patient management. This system has resulted in a significant increase in statistical reliability. The board is pleased with this scoring technique for the oral examination.

Certification

The board requires completion of certification within five years of completing a residency program approved by the Accreditation Council for Graduate Medical Education; extensions are granted for approved fellowship training. Failure to complete certification within the time allotted requires reentry into the certification process at the qualifying exam level after first passing a preliminary examination.

In 1992, the board began its mandatory recertification process for all diplomates with 10-year time-limited certificates, which have been issued since 1985. Currently, all trustees of the ABU recertify during their tenure on the board. The process consists of multiple components, which provide diplomates with different opportunities and ways to document their competence. A modular, written, open-book exam consists of five subject areas from which diplomates choose three for testing. Other components include peer review, a surgical log review, and a continuing medical education requirement. In addition, at the board's discretion, hospital/office chart reviews, an oral interview or examination, and/or a site visit may be required. Diplomates may enter the recertification process up to three years before expiration of the primary certificate. Upon successful recertification, diplomates are issued a certificate valid for 10 years from the date of expiration of the original certificate. In November 2000, 248 diplomates sat for recertification; 245 diplomates (98.8%) successfully completed the recertification process.

Currently, the ABMS member boards are discussing plans to require maintenance of certification, which would entail ongoing monitoring of physicians by the certifying boards. The ABU is actively discussing the issue, but the trustees have significant concerns regarding the implementation of the proposal.

Officers

Current officers and trustees are: John M. Barry, MD, president; the author, president-elect; Fray F. Marshall, MD, FACS, vice-president; Paul F. Schellhammer, MD, FACS, secretary-treasurer; Michael E. Mitchell, MD, FACS; Robert M. Weiss, MD, FACS; Michael J. Droller, MD; Joseph A. Smith, Jr., MD, FACS; Robert C. Flanigan, MD, FACS; Mani Menon, MD, FACS; Linda M. Shortliffe, MD, FACS; and Peter C. Albertsen, MD, FACS. Ω

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San Diego,
La Jolla, CA

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C. N. Woodward Chair in
Surgery; professor and head,
division of thoracic surgery,
University of British Colum-
bia Faculty of Medicine
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Harvard Medical School,
and chairman of surgery,
Beth Israel Deaconess
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Boston, MA

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Professor of surgery,
department of surgery,
University of Colorado
Denver, CO;
Interim Director, Division of
Research and Optimal
Patient Care, American
College of Surgeons

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Otorhinolaryngology
Otolarynogologist-in-chief,
Children's Hospital
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Attending surgeon, Baylor University Medical Center
Dallas, TX

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Orthopaedic surgery
Wayland, MA

Maurice J. Webb
Gynecology (oncology)
Gynecologic oncologist, Mayo Clinic
Rochester, MN

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 a secure ordering facility, is available by visiting *www.acssurgery.com/learnmore.htm*. ACS Fellows, Associates, and Candidates: Please read the inset box below for a special notice regarding a change in your access to *ACS Surgery*.

Continue to keep current

As an ACS member, you have enjoyed complimentary online access to *ACS Surgery: Principles and Practice* since October 2000, when the reference was first launched on WebMD. Starting Monday, April 1, online access will be restricted to paying subscribers. While we realize that this change may be disappointing, we hope that you have enjoyed this extended free-trial period and that you have come to appreciate the high standards of quality that this College-sponsored resource represents.

For ACS Fellows, Associates, and Candidates who do not subscribe to the print or CD versions of *ACS Surgery*, we are pleased to offer a $50 limited-time discount on subscriptions to the online version of the reference. This offer expires on March 31, 2002. Please go to *www.acssurgery.com/learnmore.htm* for more information and to save $50 on the online version.

Subscribers to the print and CD-ROM versions of *ACS Surgery* can continue to get free online access to the monthly updates and full text by visiting *www.acssurgery.com*. You will need your nine-digit account number, which can be obtained by calling 800/545-0554 or 914/962-4559 (outside the U.S.), by faxing 914/962-5076, or by e-mailing samed@dwcweb.net. Updates are also 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.

IV. Trauma

9. Injuries to the Great Vessels of the Abdomen. David V. Feliciano, MD, FACS. Injuries to the great vessels of the abdomen are caused by penetrating wounds in 90 percent to 95 percent of cases. They are, of course, often accompanied by injuries to multiple intra-abdominal organs, including those in the gastrointestinal tract. The findings on physical examination generally depend on whether a contained hematoma or active hemorrhage is present in patients who have injuries to the great vessels of the abdomen. In the case of contained hematomas around the vascular injury in the retroperitoneum, the base of the mesentery, or the hepatoduodenal ligament, the patient often has only modest hypotension in transit or on arrival at the emergency center. This hypotension can be temporarily reversed by the infusion of fluids and may not recur until the hematoma is opened at the time of laparotomy. This is usually the situation when an abdominal venous injury is present. In the case of active intraperitoneal hemorrhage, the patient typically has significant hypotension and may have a distended abdomen on arrival. Another physical finding that is occasionally noted in association with an injury to the common or external iliac artery is intermittent or complete loss of a pulse in the ipsilateral femoral artery. This finding in a patient with a transpelvic gunshot wound is pathognomonic of an injury to the iliac artery.

In his updated chapter, Dr. Feliciano reviews repair techniques for injuries in zones one, two, and three of the retroperitoneum and in the porta hepatis or retrohepatic area, as well as damage control laparotomy.

Subscribers may view the full text of "Injuries to the Great Vessels of the Abdomen" at *www.acssurgery.com*.

V. Cost-Effective Nonemergency Surgery

4. Fast-Track Surgery. Henrik Kehlet, MD, PhD, and Douglas W. Wilmore, MD, FACS. In their new chapter, the authors discuss the various techniques necessary to implement a fast-track surgery program and describe how to anticipate the complications specific to such an approach. Fast-track surgery involves a coordinated effort to combine (1) preoperative patient education; (2) newer anesthetic, analgesic, and surgical techniques designed to reduce surgical stress responses, pain, and discomfort; and (3) aggressive postoperative rehabilitation, including early enteral nutrition and ambulation. It also includes an up-to-date approach to general principles of postoperative care (for example, use of tubes, drains, and catheters; monitoring; and general rehabilitation) that takes into account the revisions to traditional practice mandated by current scientific findings. It is believed that by these means, fast-track surgery can shorten the time required for full recovery, reduce the need for hospitalization and convalescence, and lower the incidence of generalized morbidity related to pulmonary, cardiac, thromboembolic, and infectious complications. For an accelerated recovery program of this type to succeed, proper organization is essential. In general terms, fast-track surgery must be based on a process of multidisciplinary collaboration that embraces not only the surgeon, the anesthesiologist, the physiotherapist, and the surgical nurse but also the patient.

Subscribers may view the full text of "Fast-Track Surgery" at *www.acssurgery.com*.

VIII. Common Clinical Problems

3. Skin Lesions. Alan E. Seyfer, MD, FACS. The clinical assessment and treatment of skin lesions can be challenging, because some are capricious in their biologic behavior. In his updated chapter, the author reviews key characteristics of basal cell carcinoma, squamous cell carcinoma, and malignant melanoma. He also describes the surgical techniques necessary for biopsy of suspicious lesions. In the surgeon's approach to these lesions, history is of great importance. Recent changes in the appearance of a lesion usually indicate active growth, which increases the chance that the lesion is malignant. Likewise, a history of chronic sun exposure—particularly in a patient who has a fair complexion—multiplies the patient's risk of malignancy. Certain congenital lesions must also be viewed with suspicion, even though the incidence of malignancy in such lesions can be extremely variable. Any history that departs from the natural history of a simple nevus should raise suspicion of malignancy. In general, nevus tissue becomes apparent at four or five years of age. Nevi often darken with puberty and pregnancy and fade in the seventh to eighth decades of life. Malignancies usually differ from the characteristic clinical pattern of a simple nevus.

Subscribers may view the full text of "Skin Lesions" at *www.acssurgery.com*.

Looking ahead

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

- "Pancreatic Procedures," by John L. Cameron, MD, FACS, and Keith D. Lillemoe, MD, FACS.
- "Outpatient Surgery," by Richard B. Reiling, MD, FACS, and Daniel P. McKellar, MD, FACS.
- "Risk Stratification, Preoperative Testing, and Operative Planning," by Nicolas V. Christou, MD, FACS; Douglas W. Wilmore, MD, FACS; Alden H. Harken, MD, FACS; and Jyoti Arya, MD.
- "Open Esophageal Procedures," by Richard Finley, MD, FACS, and John Yee, MD.
- "Renal Failure," by Anthony A. Meyer, MD, FACS; Bruce A. Cairns, MD; and Renae Stafford, MD.
- "Jaundice," by Jeffrey Barkun, MD, FACS, and Alan Barkun, MD.
- "Emergency Department Evaluation of the Patient with Multiple Injuries," by Felix Battistella, MD, FACS.
- "Molecular Mediators of Inflammation," by Vivenne M. Gough, MB, ChB; Constantinos Kyriakides, MB, ChB; and Herbert B. Hechtman, MD, FACS.
- "Thoracoscopy," by Valerie W. Rusch, MD, FACS, and Raja Flores, MD.
- "Esophageal Procedures: Minimally Invasive Approaches," by Marco G. Patti, MD, FACS, and Carlos A. Pellegrini, MD, FACS. Ω

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

College news

ACS executive staff welcomes Dr. Hoyt

ACS Executive Director Thomas R. Russell, MD, FACS, has appointed David B. Hoyt, MD, FACS, to the executive staff of the College as Medical Director of Trauma Programs.

As Medical Director of the College's Trauma Programs, Dr. Hoyt will oversee the College's efforts to improve all phases of the management of the care of the injured patient, including improvement in emergency care at the scene, transportation of the injured, care in the emergency department and hospital, teaching of the surgery of trauma (undergraduate, graduate, and continuing education), rehabilitation, injury prevention, and the practice of the surgery of trauma. As part of that activity, Dr. Hoyt will ensure that the College engages in active cooperation with other national organizations having similar strategic goals to augment its effectiveness in improving trauma care.

Dr. Hoyt is The Monroe E. Trout Professor of Surgery and vice-chairman of the department of surgery at the University of California (UC), San Diego, and is on the staff at the Veterans Administration Medical Center in San Diego and at Thornton Hospital in La Jolla, CA.

A Fellow since 1987, Dr. Hoyt has been active in a number of College activities. He is Chair of the ACS Committee on Trauma (COT) and a member of the COT Executive Committee. He is a member of the Board of Governors' Committee on Blood-Borne Infection and Environmental Risk.

CHUCK GIORNO PHOTOGRAPHY

Dr. Hoyt

Dr. Hoyt has served on the ACS Program Committee (2001), the Regents' Committee on Informatics (1995-1996), the Southern California Credentials Committee (1994-present), and the Regional Committee Organization-Trauma (1993-1998). He served as Chair of the Trauma Registry from 1994 to 1998, and has been on the ATLS® National Faculty since 1992. Dr. Hoyt was Chairman, Trauma Registry Subcommittee, NATIONAL TRACS®, and National Trauma Data Bank™ from 1994 to 1997.

Dr. Hoyt obtained his medical degree from Case Western Reserve University, Cleveland, OH, in 1976. He was intern (1976-1977), resident (1977-1979), research fellow (1979-1980), and senior and chief resident (1982-1984) at the UC San Diego School of Medicine. He has served as director of the ICU at UC San Diego Medical Center since 1985, and director of the division of trauma, burns, and critical care at the Center since 1989. Dr. Hoyt also served as assistant professor of surgery (1984-1989), associate professor of surgery (1989-1995), and professor of surgery (1995-present) at UC San Diego School of Medicine.

Dr. Hoyt is president-elect of the American Association for the Surgery of Trauma and past-president of the San Diego Society of General Surgeons. He served as president of the Trauma Research and Education Foundation from 1993 to 1996.

Dr. Hoyt holds membership on the editorial boards of the *Journal of Trauma*, *Shock*, the *Journal of Surgical Outcomes*, *The Journal of Critical Care Nutrition*, the *Pan American Journal of Trauma*, and *The Journal of Trauma Nursing*. He is also a reviewer for the *Journal of the American College of Surgeons*.

Left to right: Robert J. Freeark, MD, FACS, Dr. Ganske, ACS Regent Mary H. McGrath, MD, FACS, and ACS Regent Paul E. Collicott, MD, FACS.

Representative Ganske speaks in Chicago

In early January, Congressman Greg Ganske, MD, FACS (R-IA), addressed a joint meeting of the Metropolitan Chicago Chapter of the American College of Surgeons and the Chicago Surgical Society, which took place at the University Club in Chicago, IL.

Representative Ganske recounted for the audience how he became involved in the political arena following a successful plastic and general surgery practice in Des Moines, IA.

He spoke on "Challenges facing health care: A federal perspective," and reviewed current efforts in Congress regarding such issues as Medicare regulatory relief, tort reform, the National Practitioner Data Bank, and the Patients' Bill of Rights.

"It's good to have a 'doctor in the House,'" Dr. Ganske said, "and I hope that more surgeons would take a proactive interest in our legislative system. They have much to offer."

In memoriam

Jonathan Evans Rhoads: 1907-2002

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

On January 3, 2002, in the Hospital of the University of Pennsylvania, where he had worked uninterruptedly for some seven decades, Jonathan Evans Rhoads died of gastric carcinoma.

Probably the most honored surgeon of his generation, he stood astride the twentieth century like that wonder of the ancient world, the Colossus of Rhodes, as he was appropriately labeled by his admiring college classmates. With his great height, his incredible accomplishments, and an imperturbable gravitas leavened by a rare sense of humor, he was a paragon of the virtues that comprised his Quaker heritage.

No attempt will be made here to outline the multifarious achievements that marked him (as one of his many citations noted) as a clone of Benjamin Franklin, who founded the University of Pennsylvania two-and-a-half centuries earlier. In a Festschrift volume recording the felicitations of a worldwide collegial group on his eightieth birthday, editor Clyde Barker admirably captured both the vast extent of his work and the warm, admiring esteem that he so uniquely merited.

The definitive biography by John Rombeau, MD, FACS, and Donna Muldoon sets out the varied roles he played and the unmatched recognition he earned on the local, national, and international stages. He was a pillar of strength in the International Federation of Surgical Colleges, where an endlessly renewed Honorary Presidency symbolized his legendary effectiveness in that worldwide body.

Dr. Rhoads

Following the death of his beloved first wife, Terry Folin Rhoads, MD, with shocking suddenness after the 1987 birthday Festschrift, he married Katharine Evans Goddard, MD, who survives him after 11 happy years, marked by the indefatigable, joint world travels that were the characteristic hallmark of his long career. He leaves as well six children, 12 grandchildren, and five great grandchildren.

In the American College of Surgeons, as in so many other organizations he adorned, his outstanding record included the Presidency in 1971-1972, membership on the Board of Regents from 1961 to 1969, and the chairmanship of that board from 1967 to 1969. Under his chairmanship, I was privileged to assume a full-time administrative position in the College from 1969 to 1986. That term of service, plus an equivalent later period of intimate contact with the College, provided the opportunity to work closely with Jonathan Rhoads for the final third of his incomparable career. It was an inspiring encounter with genius.

CDC releases assessment of World Trade Center injuries

The Centers for Disease Control and Prevention (CDC) recently reviewed the trauma response to the World Trade Center injuries from the September 11 attacks.

The terrorist attacks killed and injured more people than any previous attack on a civilian target in the U.S. In the first 48 hours, 790 injured were seen at New York City emergency departments; 77 percent of them were treated and released. More than half of the injuries were inhalation-related due to smoke, dust, debris, and fumes; eye damage; and lacerations and sprains.

Twenty-nine percent of treated patients were rescue workers, including firefighters, police officers, and emergency medical service personnel. For more information and statistics on injuries sustained due to the World Trade Center attacks, visit *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5101a1.htm*.

Correction

The January 2002 *Bulletin* article on personal data assistants made a statement (p.15) that the American Board of Surgery (ABS) has made available an option to collect operative information on a hand-held device. Although such a device might be useful for the stated purpose, the ABS has no such device nor is the Board aware of where the software might be obtained.

ACS launches CME Joint Sponsorship Program

The Office of Continuing Medical Education of the American College of Surgeons has announced the launch of a CME Joint Sponsorship Program. The program will be conducted by the ACS as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for the CME programs and meetings.

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

Summer fellowship program targets talented minority students

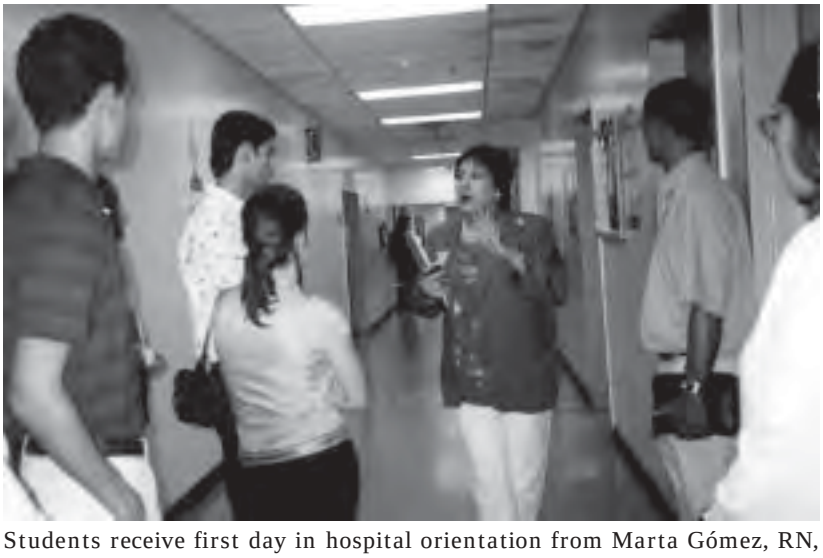
by Raúl García Rinaldi, MD, PhD, FACS, Maura Tapia, MD, and Teresita Ibarra, San Juan, PR

We enjoyed reading an article in the July 2001 *Bulletin* that highlighted a day at the ACS Clinical Congress for minority youths. The program directly addresses the needs of minority students who are very underrepresented in the graduating classes of surgery programs. The mentoring program that includes a day at the Clinical Congress has yielded excellent results, attracting minority students to the American College of Surgeons.

The Fundación Dr. García Rinaldi in San Juan, Puerto Rico, has addressed the mentoring problem in a slightly different way. We sponsor a Summer Fellowship Program for talented students in college or medical school. The students are chosen using a well-structured selection process that evaluates various parameters. Among these parameters are: grade point average, letter of recommendation from the dean of the college or medical school, letter of recommendation from two professors, a letter of intent, and a personal interview. By assigning a numerical score to all parameters, a reasonably objective method of selection is achieved.

The students—36 in the summer of 2001—are divided into two equal groups. Each group spends one month in the "hospital program" while concomi-

Group seminar with mentor Dr. García Rinaldi (center).



Students receive first day in hospital orientation from Marta Gómez, RN, head of the nursing department.

tantly the other group rotates with mentors of various specialties, including general surgery, vascular surgery, cardiac surgery, internal medicine, family medicine, rheumatology, and orthopaedics. At the end of the month, the groups switch.

Students in the hospital program rotate through the medical and surgical intensive care units, echocardiography, and noninvasive vascular laboratories, invasive radiology, catheterization laboratory, and surgery (vascular, general, thoracic, and cardiac).

At certain scheduled times the groups join to visit medical device manufacturing companies, receive instruction in CPR, aquatic rescue, electrocardiography, and echocardiography, and are invited to the entire annual meeting of the Puerto Rican Society of Cardiology.

The students are required to prepare a research paper on a topic of their choosing. The paper is presented at the conclusion of the program during a monitored session.

The mentoring program, which has had over 250 participants since its inception, has been a remarkable success. The majority of the students reaffirm their desire to pursue a career in medicine. All participating students have improved their grades and all have been matched with the residency program of their choice. The majority of individuals have returned to their mentors for advice and counsel regarding their education, academic performance, and career plans.

Group of students in their rotation through cardiovascular surgery.

Day for lessons on aquatic rescue.

A most pleasant finding has been the willingness of the students to remain as volunteers of the foundation long after completing their fellowship. Here they participate in charitable activities, seminars, health fairs, and wellness programs.

The physician mentors have thoroughly enjoyed the experience with the students during the fellowship program. Many mentors have participated in as many as five years consecutively—a clear example of their dedication to the students and this program.

Mentors have accepted the unique responsibility to teach and to motivate these students, as well as serve as role models.

Lastly, and perhaps due to our Latin heritage, the Summer Fellowship Program becomes a family affair. Parents, grandparents, and other relatives of the students become "participants" in the program as they enjoy the experience of their loved one and observe the metamorphosis that occurs during the summer fellowship.

At the conclusion of the summer program, a graduation is held that is attended by students, relatives, and close friends. A diploma, signed by the officers of the foundation and the Advanced Cardiology Center, is presented to each participant.

There are many ways to decisively have an impact on minority students, particularly if they have a desire to better themselves and overcome economic, cultural, and language barriers. The foundation's fellowship program allows these individuals to experience life as a physician in the company of exceptional role models who inspire these students to pursue academic excellence and practice compassionate medicine.

For further information regarding the Summer Fellowship Program for talented students, contact the foundation at *www.fundaciondrgarciarinaldi.org,* or e-mail fgr@fundacion drgarciarinaldi.org.

Commission on Cancer expands data-sharing system

The Facility Information Profile System (FIPS) was originally established as a benefit to approved programs as a collaborative effort between the American Cancer Society and the American College of Surgeons' Commission on Cancer (COC). Today, more than ever, cancer patients and the public are actively seeking information about treatment facilities and are making informed decisions about their options in cancer care. Cancer program staff at COC-approved cancer programs have access to FIPS—a secure, password-protected page on the American College of Surgeons' Web site *(www.facs.org).* Facility information provided to the American Cancer Society includes medical oncology services, diagnostic imaging services, radiation oncology services, support programs, facility participation in clinical trials, other services offered either at the facility or by referral, and 1999 annual caseload data provided to the COC National Cancer Data Base.

As of February 5, 2002, 581 approved programs have agreed to participate in this data-sharing project. In addition, 240 of these facilities have also agreed to release their caseload data. Individuals can now locate facility information in the COC Hospital Locator section of the American Cancer Society Web site, *www.cancer.org.*

This program is in keeping with the College's mission to increase consumer-based education to the general public and local communities. Fellows at approved programs are encouraged to work with their cancer committees to ensure that their programs are participating in this worthwhile program. Based upon the feedback from users, COC staff will be working to continually improve the FIPS project, primarily to encourage approved programs to take advantage of this wonderful free opportunity to market their cancer care services to the public. If you have any questions about the program, please email FIPS@facs.org, or contact Lina Patel-Parekh, FIPS Administrator, at 312/202-5401.

SYLLABI SELECT

Postgraduate course syllabi now available on CD-ROM

A CD-ROM containing select postgraduate course syllabi from the 2001 Clinical Congress is now available for purchase through the College's Web site at https://secure.telusys.net/commerce/current.html or by calling 312/202-5474.

Twenty courses are included on the CD-ROM, which is available for $35. There is an additional charge of $12 for shipping and handling for international orders.

The CD-ROM contains syllabi from the following postgraduate courses:

- *Professional Liability and Risk Management in a Changing Health Care Environment*
- *Head and Neck Surgery*
- *Diseases of the Liver, Biliary Tract, and Pancreas*
- *Vascular Surgery*
- *Thoracic Surgery*
- *Current Controversies in Cancer Management*
- *Gastrointestinal Disease*
- *Minimal Access Surgery*
- *Clinical Update in Trauma*
- *Cardiac Surgery*
- *Laparoscopy and Urology*
- *Surgical Infection and Antibiotics*
- *Breast Disease*
- *Pre- and Postoperative Care (Nutritional Support)*
- *Anesthetic Innovations for Improving Surgery and Postoperative Pain Control*
- *Practical Operating Room Management for Surgeons*
- *Complex Hemangiomas and Vascular Malformations*
- *Perioperative Care of the Anemic Patient*
- *Colon and Rectal Surgery*
- *The Anatomy and Surgical Correction of Groin and Abdominal Wall Hernias*

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Letters

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

Rural surgery

Thank you so much for your kind comments regarding the article in the *Bulletin* (May 2001) about the changing face of rural surgery. It was quite an honor for me to be included in the article and especially to be honored on the front cover.

I would hope the comments made in the article would have a positive rather than a negative effect on the young surgeons considering rural surgery.

Thank you for all you are doing to help further the cause of the Fellowship on the national scene.

James H. Lindsey, MD, FACS

Medical practices/update

I appreciate the interest generated by my article in the November 2001 issue of the *Bulletin* on survival strategies for surgeons' practices. I wanted to apprise you of the next step our group is taking in an effort to influence the continuing decline in reimbursement that we are seeing on the federal side with Medicare and also the state-mandated Medicaid organizations.

As you know, many of the private insurers use the Medicare relative value scale system to assign physician reimbursement schedules. The Medicare system continues to deteriorate with the anticipated 5.4 percent reduction that the intended 2002 schedule will create for general surgery. This amounts to an 8 percent reduction if one considers cost-of-living increases and increased costs of doing business for physicians. I understand that there are two bills pending in Congress—namely, S. 1707 and the H.R. 3351—which may help to overturn this short-term additional drop in Medicare reimbursement to physicians.

It is clear that many physicians, myself included, have already started to limit access to Medicare patients. My own practice has included peripheral vascular surgery, a mostly Medicare-reimbursed group of patients. Because of the dramatic reductions in reimbursement for vascular surgery over the last five years, up to 25-30 percent in many cases, I have made a simple choice to limit my involvement with peripheral vascular procedures and dialysis access procedures. It is this kind of access limitation that ultimately many physicians will be forced to make.

I also wanted to apprise you of the next step that our group is making in order to create additional contracting ability and economies of scale. On January 1, 2002, our general surgery group of 40 surgeons will merge with a group of 80 orthopaedists in western Washington State, covering essentially the same footprint as our group. I don't have to tell you that the combination of general surgery and orthopaedic surgery makes up over 50 percent of the surgical procedures in any hospital. This combination will give us an even greater market share for dealing potentially with access to care for Medicare patients.

None of us desires to limit access to care for the elderly, or for any patient for that matter. It seems, however, that access to care is the only message that our federal representatives seem to understand.

I am hopeful that we can convince our state and federal legislators of the importance of improving the federal reimbursement system. Short of that, it may become necessary to create an access to care issue with the Medicare population in order to force a solution to the problem.

I will keep you posted of future developments as they occur.

Robert L. Howisey, MD, FACS

9/11/01

Thank you for recognizing the efforts of all the professionals who responded to the attacks on September 11. We received a tremendous number of calls in the department of surgery at Walter Reed Army Medical Center from retired and former military surgeons and civilian surgeons who were willing and ready to freely give of their time and talents as needed.

I would echo your comments that surgeons stay actively engaged in preparing, rehearsing, and exercising hospital and community disaster and emergency preparedness plans. More importantly, surgeons must become experts at recognizing the signs and symptoms of chemical and biological casualties.

The military community is fond of saying that we should fight the way we train. We, the surgical community, need to adopt the same motto. As the terrorist events highlighted, it does not matter who you are or where you practice, you could be at the center of a mass casualty event and in a position of responsibility quickly. Our ability to triage and treat casualties will surely be tested again, and it is incumbent upon us to be educated and prepared for conventional, chemical, biological, and combined casualties.

Again, thank you for your kind words. My colleagues in uniform appreciate it.

Lt. Col. James M. Goff, Jr., MD, FACS

American College of Surgeons at www.facs.org

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Just go to www.facs.org, and go to the Members Only button. There you can Access the Fellowship Database by entering your eight-digit Fellowship ID number (found on your Fellowship ID card) and your last name.

There's no need to contact the American College of Surgeons– your membership record is automatically updated for all ACS mailings, including the *Bulletin* and the *Journal of the American College of Surgeons*.

You can also pay your dues online and search for contact information on other Fellows in the database.

ACGME honors 10 residency program directors

The Accreditation Council for Graduate Medical Education (ACGME), responsible for evaluating and accrediting residency programs in the U.S., selected 10 residency program directors for the Parker J. Palmer "Courage to Teach" Award. This is the first award of its kind given to program directors by the ACGME. The award was presented to the program directors during a special awards dinner last month at the Hotel Sofitel in Rosemont, IL.

The recipients were: Robert W. Block, MD, Tulsa, OK; Virginia U. Collier, MD, Newark, DE; George C. Curry, MD, Dallas, TX; Alfred D. Fleming, MD, Omaha, NE; William H. Hester, MD, Florence, SC; Earl D. Kemp, MD, Sioux Falls, SD; Gail A. McGuinness, MD, Iowa City, IA; Claude H. Organ, Jr., MD, FACS, Oakland, CA; Keith D. Wrenn, MD, Nashville, TN; and Nikitas J. Zervanos, MD, Lancaster PA. Photographs and information about the award recipients may be found on the ACGME Web site at *www.acgme.org*.

"The ACGME recognizes that program directors face many challenges in administering a residency program. Those finding innovative ways to teach residents and to provide quality health care in this harsh environment should be celebrated," said David C. Leach, MD, ACGME executive director and himself a former program director.

Parker J. Palmer is a highly respected writer and traveling teacher who works independently on issues in education, community, spirituality, and social change. He is author of the book, *The Courage to Teach*, and his promotion of the concept of "living divided no more" has proven relevant to teaching in academic health centers. Criterion for selection included a demonstrated commitment to education with evidence of successful mentoring, program development, and improvement.

For more information about the Parker J. Palmer "Courage to Teach" Award program, contact Marsha Miller, ACGME, 515 N. State St., Chicago, IL 60610; tel. 312/464-4940, or visit the ACGME Web site.

ACS joins Medem® network

The American College of Surgeons has recently partnered with Medem®, the secure patient-physician e-health network founded by leading medical societies and the American Medical Association.

Medem's network services allow Fellows of the College to create their own practice Web sites with credible and trusted health care information from leading medical societies. This ACS membership benefit can improve your operations by increasing practice efficiencies, enhancing your Web presence, and offering improved electronic patient communications. This service includes:

- An-easy-to-build, customizable, template-driven practice Web site that is Health Insurance Portability and Accountability Act-compliant.
- A single place to access services that streamline daily communications and tasks like ordering medical supplies, accessing health plan information, and obtaining specialty-specific resources for your practice.
- Secure messaging for your office to communicate with patients, with unique features, including appointment reminders, prescription refills, patient-specific on/off features, and role-based access.
- A trusted library of clinical content with over 5,000 articles from leading medical societies.
- Access to a broad base of patients and consumers using the Medem network as one of the nation's trusted health Web portals.

To find out how the Medem network can help you and your practice, visit *http://www.facs.org/members/acs-medem.html*.

CT trauma conference addresses terrorism

The Fourth Annual Connecticut Trauma Conference will be held April 4-5 at the Foxwoods Resort Casino, Grand Piquot Tower, Ledyard, CT. The theme of the conference, sponsored by the Connecticut State Committee on Trauma, is "Trauma: Challenges from Terrorism to Reimbursement." Lenworth M. Jacobs, MD, FACS, will serve as moderator for the conference.

Program objectives are: to become knowledgeable about the evolving field of bioterrorism and weapons of mass destruction, to understand the professional role and personal impact of terrorism on caregivers, to provide insight into the management of challenging trauma cases from the surgical and nursing perspective, to understand the difficulties and challenges in the care of pediatric and elderly trauma patients, to learn new airway management techniques from the classroom to the bedside, and to become knowledgeable about trauma reimbursement issues.

Topics and presenters include: National Disaster Medical Service to NYC Ground Zero, by Susan Briggs, MD, FACS; NYC: Personal Reflections from the Scene, by Robert Fuller, MD, and Ronald Gross, MD, FACS; State of Connecticut's Response to Terrorism and Weapons of Mass Destruction, by Brian Cooper, MD, Charles McKay, MD, and Marie Wilson, RN; Keynote Address—Military and Civilian Trauma: Is There Any Difference? by Basil Pruitt, MD, FACS; Golden Hour/Golden Years: Challenges of the Elderly Trauma Patient, by J. Wayne Meredith, MD, FACS; Issues in Trauma Reimbursement, by Samir Fakhry, MD, FACS, and Heidi Frankel, MD, FACS; Keynote Address—Weapons of Mass Destruction: A Reality, by Donald Trunkey, MD, FACS; and China: Medical Response for Spy Plane Retrieval, by Jared Zelman, MD.

For more information, contact Jacqueline McQuay, RN, Trauma Nurse Coordinator, Hartford Hospital, 80 Seymour St., Hartford, CT 06102; tel. 860/545-1538, fax 860/545-5132, e-mail jmcquay@harthosp.org.

Trauma/Critical Care 2002 scheduled for June

The Eastern States Committees on Trauma will present Trauma and Critical Care 2002-Point/Counterpoint XXI, June 3-5, in Atlantic City, NJ. The Tropicana Casino and Resort will be the site for the program, which will bring together internationally recognized authorities to address difficult and controversial trauma and critical care issues. The course will take a broad look at some of the current issues in contemporary trauma care.

The objectives of the course are:

- to provide a review of the latest developments in the care of the acutely injured patient;
- to re-examine current approaches to diagnosis and treatment;
- to gain a greater understanding of the potential threat of weapons of mass destruction and how to react individually and as a medical community in the event of an attack;
- to challenge both the faculty and audience with case management scenarios and offer advice regarding difficult diagnostic, therapeutic, and technical challenges;
- to gain a better understanding of the principles of documentation and coding of trauma services in order to maintain adequate compensation for providing clinical care to the injured;
- to improve care of the patient in the ICU by anticipating problems that affect the critically ill and initiating early and appropriate therapy;
- to learn what is new in trauma, both in diagnosis and treatment, and determine whether these changes are adaptable to your own trauma care practice;
- to gain a greater familiarity with certain technical ap-

proaches to injuries through video-based learning and critical discussions by invited faculty;

- to learn how to minimize the occurrence and the consequences of missing injuries at the time of admission and how best to recognize specific injuries that present the greatest difficulty in early diagnosis;
- and to develop skills both in determining when initial nonoperative management is ineffective and how to optimize delayed operative management.

The scientific program committee consists of Kimball I. Maull, MD, FACS, course chair; Charles C. Wolferth, MD, FACS, course co-chair; L.D. Britt, MD, MPH, FACS; David V. Feliciano, MD, FACS; Lenworth M. Jacobs, Jr., MD, MPH, FACS; and Michael Rhodes, MD, FACS.

Complete course information can be viewed on the American College of Surgeons' Web site at *http://www.facs.org/dept/trauma/cme/traumtgs.html*. For further information about the course, contact the Trauma Office at 312/202-5342.

Next month in *JACS*

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

Original Scientific Articles:

- Limb-Sparing Resections of the Shoulder Girdle: A Long-Term Followup Study
- Unexpected Findings in Trauma Patients Dying in the Intensive Care Unit: Results of 153 Consecutive Autopsies
- Topical Perioperative Antibiotic Prophylaxis for Minor Clean Inguinal Surgery

Collective Review

- Optimizing the Use of Blood Cultures in the Febrile Postoperative Patient

Palliative Care Series:

- Symposium: Palliative Care by the Surgeon: How I Do It