Surgical lifestyles:

Balancing work and home
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charts course for improved system of care  
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### DEPARTMENTS

**From my perspective**
*Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director*

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**About the cover...**

This month’s cover helps to launch a new periodic series of articles in the *Bulletin* on “surgical lifestyles.” In the first features of this series (p. 22 and p. 28), we focus on how surgeons, particularly those who are married to other surgeons or physicians, have managed to maintain their devotion to both their patients and their families—despite the competing emotional, physical, and intellectual challenges. The second article in this series will be included in the July issue of the *Bulletin.*

(Stethoscope photo © Mitch Hrdlicka/PhotoDisc. Back cover photo by Chuck Giorno Photography.)
NEWS

Faculty Research Fellowships awarded by College

Resident Research Scholarships for 2003 awarded

Trauma meetings calendar

Task force explores practice-based learning and improvement

ACS releases 2002 NTDB™ annual report by Richard J. Fantus, MD, FACS

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have become increasingly convinced that achieving improvement of our health care system is, and will continue to be, dependent on the unification and cooperative efforts of medical and surgical organizations. Systemic health care problems in this country have plagued the profession and our patients for many years and persist at the present time. However, meaningful change will come about only when we recognize that each of the competing forces at play in our system has certain individual priorities, making radical change very difficult to achieve in the current environment. No matter how diligently we work, effecting reform will be a highly complicated process as long as the stakeholders continue to hold firmly to divergent views.

Listening to a range of perspectives and banding together to develop creative solutions to problems already are proving to be the most effective means of achieving at least incremental changes. Indeed, in the last couple of months, we’ve witnessed some important examples of how collaboration can stimulate improvement. While some surgeons may view these steps as being too small or narrow, I believe that they are just beginning stages of more expansive reform and signify just how far we’ll be able to take meaningful change if medical and surgical organizations unify their advocacy efforts.

**Physician reimbursement**

As many of you know, the 2003 Medicare physician fee schedule originally would have resulted in a projected 4.4 percent across-the-board payment reduction. This cut would have deepened the negative effects from last year’s 5.4 percent decrease. However, the additional Medicare payment reduction was averted due to the hard work of a coalition of medical and surgical organizations, including the College.

Indeed, Medicare reimbursement rose 1.6 percent for services provided on or after March 1 of this year because of the successful passage of the Omnibus Appropriations bill, H.J. Res. 2. When considered in combination with the 4.4 percent reduction that would have occurred without congressional action, the 1.6 percent update is producing payments that are a full 6 percentage points higher. For surgeons alone, this percentage translates into $751 million more in total payments in 2003. The legislation, which President Bush signed into law February 20, allows the Centers for Medicare & Medicaid Services to correct the errors it made when calculating the physician expenditure targets in 1998 and 1999. If you look at the collective payment for all physicians, the new law will boost total payments by about $54 billion over the next 10 years. While this increase may be too little for some surgeons, it clearly signals a change in the right direction and should greatly ameliorate a near-desperate situation for many members of the profession.

**Liability reform**

For the first time in several decades, real opportunities for the enactment of comprehensive federal tort reform have emerged. Again, this situation has arisen largely because the College and other like-minded organizations have exerted intense pressure on Congress. For instance, the ACS has led the Health Coalition on Liability and Access (HCLA) for more than a year now, and this
Thomas R. Russell, MD, FACS

group has done much to galvanize the medical profession with regard to this issue.

In mid-March, the House of Representatives approved H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act (HEALTH). This legislation is modeled after California's Medical Injury Compensation Reform Act (MICRA) and includes a $250,000 cap on noneconomic damages. Senate leaders plan to act quickly on the bill.

The next struggle will be achieving passage in the Senate, which, at press time, was about a dozen votes shy of reaching the majority required to enact similar legislation in that body. Given that the Senate rejected this type of reform bill last year, HCLA is leading an effort to conduct a serious marketing campaign aimed at the key Senators, which will be critical as this issue evolves.

As you know, President Bush has made a commitment to signing a tort reform measure. Should this legislation become law, it will help to resolve the ongoing malpractice insurance crisis that is making it so difficult for many surgeons to provide care to their patients.

Trauma

With homeland security being such an important issue these days, I am pleased to report that Washington has been demonstrating its support for various trauma bills. For fiscal year 2003, the Omnibus Appropriations bill mentioned previously in this column includes $3.5 billion in funding for the trauma grant program. Additionally, the Senate seems poised to pass legislation to reauthorize the Trauma Care System Planning and Development Act through 2008. Efforts in this area now shift to the House, where similar legislation is being drafted by the House Energy and Commerce Committee.

I can assure you that none of these legislative efforts would have come to fruition if not for the combined efforts of the College's Washington Office and other professional organizations.

Further change possible

In this column I have highlighted some examples of the incremental changes and improvements that are occurring as a result of the College's collaborative efforts on our members' behalf. Often these small movements go unnoticed, but the fact of the matter is they are real and tangible inroads toward improving the system in the near future.

In no way should these efforts be seen as ends; rather, they are the means to effecting true reform. Your continued support and willingness to bring to our attention the serious impact of issues like these on your practice are critically important. To further ensure that your voice is heard at the federal level, please remember to use our electronic Legislative Action Center (http://capwiz.com/facs/home), which allows our members to contact their legislators en masse with regard to critical issues.

Clearly, surgeons are becoming more politically involved, and this sort of activity is a key element of our recent successes.

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
A new category of membership in the American College of Surgeons has been created for medical students and was officially approved by the Board of Regents at their February 2003 meeting. Students in medical schools accredited by the Liaison Committee on Medical Education in the U.S. and in accredited Canadian medical schools are eligible to apply for Medical Student Membership. Benefits offered to medical students who are granted affiliation with the College through this category of membership include: free attendance at the annual Clinical Congress; discounts on selected Lippincott Williams & Wilkins textbooks; health, life, auto, disability, and loan payment insurance policies; online access to the Journal of the American College of Surgeons; an MBNA credit card; discounts on PDAs and computer software; use of the ACS travel agency; access to the “Members Only” area of the ACS Web site; representation on selected committees of the College; and an official membership card. A one-time application fee of $20 is required, but there will be no annual dues during the duration of medical school education. Details on the application process and an application form are available at http://www.facs.org/dept/fellowship/documents.html#application or by contacting ikulyk@facs.org.

ACS Executive Director Thomas R. Russell, MD, FACS, continues to spend considerable time visiting groups of importance to the College. In recent weeks, Dr. Russell attended the annual meeting of the Society of Gynecologic Oncologists, the Southeastern Surgical Congress, the Nathan Davis Award Dinner sponsored by the American Medical Association, the Pacific Coast Surgical Association, a meeting of the Health Coalition on Liability and Access in Washington, DC, the Presidents’ Forum sponsored by the AMA, and the Society of Gynecologic Surgeons, the Los Angeles Surgical Society, and the Pittsburgh, PA, Surgical Society. Dr. Russell also met with the chief residents and participated in grand rounds at the UCLA School of Medicine, he was a visiting professor at the Western Pennsylvania Hospital, and he attended the meeting of the Metropolitan Chicago Chapter of the College.

The Candidate and Associate Society of the American College of Surgeons (CAS-ACS) will launch its own quarterly electronic newsletter—CAS-ACS News—late this spring. The CAS-ACS was formed in 1997 to meet the needs of surgical residents and newly practicing surgeons and to benefit the surgeons of the future through involvement in the activities of the College. To facilitate this mission, CAS-ACS News will be a quarterly e-mail publication available to its own members, to Fellows of the College, and to other interested parties. If you haven’t signed up to receive the newsletter, please do so now so you’ll be sure you won’t miss the inaugural issue. To subscribe, simply send your name, e-mail address, and street address to cas-news@facs.org. If you have already signed up for the newsletter, you need do nothing because your information is already in the College’s subscriber database for the publication.
After more than two years of rigorous advocacy, the College applauded the House and Senate on February 14 for passing the Consolidated Appropriations Resolution 2003, which includes provisions to temporarily fix the Medicare physician payment crisis. Signed into law by President Bush on February 20, P.L. 108-7 allows the Centers for Medicare & Medicaid Services (CMS) to correct errors it made when calculating physician payments in 1998 and 1999. Due to the cumulative nature of the payment formula, these errors were producing a series of significant annual physician payment cuts, amounting to a 5.4 percent decrease in 2002 and a projected 4.4 percent cut in 2003. As a result of this congressional action, CMS increased Medicare payments to physicians by 1.6 percent for services rendered on or after March 1.

To accommodate the change, physicians had an additional 45 days, through April 14, to change their participation status. Physicians who change their status should begin preparing claims according to their new status as soon as they submit the necessary paperwork. Any claims that are processed incorrectly will be adjusted automatically after July 1.

Hugh H. Trout III, MD, FACS, testified on behalf of the College at a hearing held by the Practicing Physicians Advisory Council (PPAC) on February 10. During his testimony, Dr. Trout identified changes the College believes CMS should make in the 2004 Medicare fee schedule and emphasized the need for the agency to use its administrative authority to adjust the sustainable growth rate (SGR), which determines, in part, the annual updates to the fee schedule conversion factor.

Most of the College’s remarks centered on the refinement of malpractice relative value units (RVUs), a process that CMS is required to conduct at least once every five years. The College asked that CMS seek public comments on the appropriateness of refining the malpractice relative value units a year earlier than normally scheduled, that is, in 2004 rather than in 2005. PPAC included both of the College’s points in its recommendations to CMS.

A request for public comments is likely to be issued when the draft 2004 fee schedule is released in June, and a final version is expected on November 1. For additional details, please see Dr. Trout’s testimony at http://www.facs.org/dept/hpa/testimony/trout.html.

On March 13, the House passed the Help Efficient, Accessible, Low-cost, Timely Healthcare Act (HEALTH) of 2003, a comprehensive medical liability reform proposal introduced by Rep. Jim Greenwood (R-PA). The College, which actively supported the legislation, will now lead the charge in advocating for passage of medical liability reform legislation in the Senate.

Recently, the College-led Health Coalition on Liability and Access (HCLA) released the results of a nationwide poll indicating that 84
percent of those surveyed believe the availability and quality of the health care they receive may be compromised because of rising medical liability costs and the lack of liability insurance coverage in some states. In addition, three-quarters of the Americans surveyed favor a law that guarantees full payment for lost wages and expenses, places reasonable limits on awards for noneconomic damages, and limits the percentage of a client’s award a personal injury trial lawyer may receive. Full poll results can be found on at www.hcla.org.

Joint hearings held by the Federal Trade Commission and the Department of Justice on health care and competition law and policy began last month with Frank Opelka, MD, FACS, testifying on behalf of the College. The hearings examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying consumer preferences for high-quality, cost-effective health care.

"Without sufficient leverage, insurers offer surgeons a take-it-or-leave-it medical service agreement. Insurance companies set policies and prices for surgical care with little or no direct relationship to the actual costs of providing the service. In an increasing number of markets, physicians find themselves with very little left on the table to negotiate," Dr. Opelka said. His remarks addressed a number of issues, including consolidation of the health insurance industry, all-products clauses, undisclosed fee schedules, unilateral amendments by payors, delayed payments, and insurance antitrust exemptions.

The third set of hearings, to be held April 23-25 and April 30-May 1, will focus on issues involving health insurers. At the conclusion of the hearings, the commission will provide a report to Congress. A copy of Dr. Opelka’s remarks is available at http://www.facs.org/dept/hpa/testimony/opelka.html.

In 1988, Congress first designated May as National Trauma Awareness Month. To mark the 15th anniversary, the College is highlighting the accomplishments made in trauma systems planning, and is calling on Congress to increase funding for FY 2004 to ensure that these statewide networks are fully prepared to respond to emergencies or natural disasters. To urge your congressional representatives to support increased funding, please visit the College’s Legislative Action Center at http://capwiz.com/facs/home/

The College is also working with Senate and House committees to introduce and pass legislation to reauthorize the trauma system grant program administered by the Health Resources and Services Administration through FY 2008. The Trauma Care Systems Planning and Development Act of 2003, S. 239, was introduced by Senate Majority Leader Bill Frist, MD, FACS (R-TN), and Sen. Edward Kennedy (D-MA) in January and was recently approved by the Senate Health, Education, Labor, & Pensions Committee. A companion House bill is expected to be introduced later this spring.
What surgeons should know about...

Antitrust laws

by Jennifer Razor, JD, Government Affairs Associate, Division of Advocacy and Health Policy

With the Federal Trade Commission (FTC) stepping up its enforcement actions in the health care arena, a basic understanding of antitrust laws has never been more important for surgeons. FTC Chairman Timothy J. Muris has laid out an extensive blueprint for action, which began to take effect in February with hearings on health care and competition law and policy. The Department of Justice (DOJ) cosponsored the meetings.

This article is intended to offer surgeons a cursory explanation of how the federal government examines health care cost, quality, and access through the lens of competition.

Q. What are the origins of antitrust law?

A. The basis of antitrust law is statutory. In 1890, Congress passed the Sherman Antitrust Act. Then, to clarify and supplement that law, Congress passed the Clayton Act in 1914, which created the FTC and authorized private parties to sue for violations of antitrust laws. Today, the FTC’s Bureau of Competition and the DOJ’s Antitrust Division share responsibility for enforcing these laws.

Q. How is antitrust applied to physicians?

A. As members of a “learned profession,” physicians were immune for nearly a century from the normal rules of competition. In 1975, however, the U.S. Supreme Court declared that professional services are subject to antitrust laws. The Court held that anticompetitive activities by professionals could restrain commerce and that, while certain restraints imposed by professional associations might be judged to serve the public interest, all “commercial” restraints could be challenged as violations of antitrust laws.

Q. What are the basic antitrust principles?

A. The law indicates that certain practices, such as price fixing, are so inherently harmful to consumers that a detailed examination isn’t necessary to determine whether the practices are reasonable. The law presumes that these practices are per se violations and condemns them almost automatically.

Other practices demand closer scrutiny by the agencies. These cases are examined under a “rule of reason” analysis. Pursuant to the rule of reason, a practice is illegal if its procompetitive effects fail to outweigh the restrictions it places on competition. In theory, such anticompetitive practices are likely to harm consumers by driving up prices, reducing accessibility of services, decreasing the quality of service, or appreciably stifling innovation.

The rule of reason analysis is rarely clear-cut. Consider an agreement among physicians to adopt a practice standard for vaginal birth after cesarean delivery, limiting the procedure to institutions equipped to respond to emergencies with physicians immediately available. The agreement to adopt the standard is restrictive: the physicians have limited their own ability to perform the procedure. In practice, however, the agreement limits consumer choice, even though

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the agreement to adopt the practice standard may benefit consumers in that it provides assurances of safety.

**Q.** How does an agency or private party prove illegal business practices?

**A.** Violations of antitrust laws are typically described as either horizontal or vertical in nature. Agreement among competitors horizontally can trigger investigation if the competitors agree to restrict competition among them. Likewise, certain kinds of vertical agreements between buyers and sellers are also illegal.

Proving a violation in most cases depends largely on demonstrating that an agreement exists. In the absence of a smoking gun, however, the agency may rely on a combination of circumstantial evidence to prove an inferred agreement. Remember, it is the agreement itself that is illegal. Thus, the agreement need not even be implemented for a violation to result.

**Q.** In what settings can antitrust issues arise?

**A.** Antitrust issues in health care may arise in many settings, including, but not limited to, the following:

- physician practice mergers.
- price-fixing by provider networks.
- physician unionization.
- provider standard-setting programs.
- exclusive contracts between payors and single groups of physicians.
- exclusive contracts between hospitals and physicians as to particular services rendered at the hospital.

**Q.** Can physician unionization exist within the antitrust laws?

**A.** Employed physicians may unionize to negotiate with employers. The antitrust laws, however, have been interpreted to prohibit physicians from unionizing to negotiate with health plans. To combat the increasing control that health plans have over the practice of medicine, physicians have long argued in favor of an exemption to antitrust laws allowing them to jointly negotiate.

To combat the increasing control that health plans have over how surgeons practice medicine, the House of Representatives is entertaining two pieces of legislation, H.R. 1247 and H.R. 1120. Rep. Ron Paul, MD (R-TX), introduced the Quality Health Care Coalition Act of 2003, H.R. 1247. The legislation aims to ensure and foster continued patient safety and quality of care by exempting health care professionals from the federal antitrust laws in their negotiations with health plans and health insurance issuers. H.R. 1247 is similar to legislation championed by former Rep. Tom Campbell during the 106th Congress.

Rep. Spencer Bachus (R-AL) and Rep. John Conyers (D-MI) introduced the Health Care Antitrust Improvements Act of 2003 (H.R. 1120). This legislation would change the standard of review under the antitrust laws when two or more physicians or other health care professionals attempt to negotiate with a health plan over contractual terms or plan policies. Additionally, the bill would establish demonstration projects in six states, which would have allowed physicians and other health care professionals to negotiate with health plans without violating antitrust laws. H.R. 1120 is considered to be a more moderate outgrowth of H.R. 1247. A Senate companion does not exist.

During the 108th Congress, the College is tracking this legislation to ensure that physicians and health plans are competing on a level playing field.
Q. Is antitrust scrutiny increasing?
A. The agencies’ focus on health care continues to sharpen. According to Chairman Muris, the FTC continues to see a wide variety of overtly anticompetitive practices in the health care marketplace. The FTC continues to bring cases against physicians for what it deems the most egregious violations, including “naked” price-fixing. During 2002, the FTC reached settlements with a number of groups of physicians in antitrust actions. Several of these new cases involve an unprecedented number of physicians and some consultants who allegedly coordinated the price-fixing under the guise of assisting in negotiations with payors.

Last September, the FTC and DOJ held a two-day workshop featuring presentations by academicians, providers, insurers, employers, and patient groups. The workshop focused on clinical integration, payor/provider issues, group purchasing organizations, generic and branded drugs, and direct-to-consumer advertising of pharmaceuticals.

The FTC indicates that during the course of the year the topics for the hearings will include hospital mergers, the significance of not-for-profit status, vertical integration, quality and efficiencies, market power, and the adequacy of existing remedies for anticompetitive conduct. In addition, the hearings are expected to explore the implications of the FTC’s consumer protection mandate with regard to the performance of the health care financing and delivery markets.

In addition to participating in the hearings, the College continues to meet with the FTC regarding the impact of competition on surgeons. Look for future updates from the College as the hearings continue throughout the year. For more information about this issue, contact Jennifer Razor at jrazor@facs.org.

Note: This article is an educational tool only and should not be construed as legal advice. Should a legal question arise regarding antitrust, Fellows should consult an attorney.

Bibliography

Office of Evidence-Based Surgery
charts course for improved system of care

by R. Scott Jones, MD, FACS, Director,
and Karen Richards, Administrative Director,
Division of Research and Optimal Patient Care
In 2000, the American College of Surgeons began a long-range strategic planning process, culminating in the reorganization of the College into four divisions: the Division of Advocacy and Health Policy, the Division of Education, the Division of Member Services, and the Division of Research and Optimal Patient Care. The Division of Research and Optimal Patient Care encompasses the cancer and trauma programs.

Additionally, in February 2001, the Board of Regents established the Office of Evidence-Based Surgery upon the recommendation of a special task force. This article primarily focuses on the new Office of Evidence-Based Surgery—its present responsibilities and its long-range goals, particularly in the realm of optimal patient care.

The new Office of Evidence-Based Surgery will provide the administrative support and infrastructure to support health services, clinical, and laboratory research. The office will foster the conduct of systematic reviews, clinical trials, and outcome studies. Another important goal of the office will be to provide practicing surgeons with easy access to the best evidence available to support best practices. This aim requires close collaboration with the Division of Education.

Background

All Fellows of the American College of Surgeons should concur that optimal patient care is the objective of each surgeon's professional life and of all facets of the medical profession. We all strive for optimal care, effective care, and high-quality care. If that is true, then we can all agree to work together to provide optimal, effective, high-quality patient care. We can define optimal patient care as a common goal.

While surgical care in North America is excellent, questions about quality frequently arise. Professionals, the government, and the public express concern about the safety of surgical care. The application of some operations, such as prostatectomy or coronary artery bypass grafting, varies by region and demographic groups. National morbidity or mortality rates for hospitals or for surgeons are unknown. Governments, public interest groups, and payors want quality indicators for medical and surgical care to assist in selecting surgeons and hospitals for their clients. Nationally, we currently lack scientifically valid, accurate, and useful measures of surgical quality.

The accomplishment of optimal surgical care throughout North America will require planning and direction, a road map. Perhaps the best word here is system. The achievement of optimal surgical care throughout our land will require an organized and integrated system of surgical care, one that is organized and operated by surgeons. This system of surgical care consists of four interconnected steps (see Figure 1, p. 13): (1) the establishment and maintenance of an accessible reservoir or repository of the best available scientific evidence for translation into everyday practice; (2) documentation of the results of surgical care with reliable outcome studies; (3) development of a disciplined process for introducing new technology and innovative practices into everyday practice; and (4) a well-organized and productive clinical trials program to expand the scientific evidence base and elevate the overall quality of scientific evidence.

While establishing a system of high-quality surgical care will be a sufficiently formidable task, we must accomplish at least one more objective: we must communicate. We must communicate with the public, we must communicate with our state and federal governments, and we must communicate with all other stakeholders in the health care system. Our communication must be based on accurate data; it must be timely, truthful, and crystal clear.

The evidence base

Before proceeding we should define evidence. According to *The Random House Dictionary of the English Language* (Random House, New York, 1969), evidence means “ground for belief; that which tends to prove or disprove something; proof.” This very definition provides a perfect prologue for the subject of this article. It implies a spectrum of confidence or rigor from “ground for belief” to “proof.” All surgeons, of course, practice evidence-based surgery. Hippocrates practiced evidence-based surgery. Today, the catch is that some types of evidence are more evidence than other types of evidence.

Scholars recognize a hierarchy of evidence and have developed taxonomy to describe best evidence. Sackett and others defined evidence-based medi-
cine as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. They went on to stress the value of the physician’s (or surgeon’s) clinical expertise and urged the integration of best evidence with clinical skill.

Let’s focus on “current best evidence.” Thoughtful surgeons seek “proof” to support their decisions and actions. Unfortunately, “proof” remains scarce in the complex reality of clinical practice. Often “ground for belief” is the best we can do. Surgeons should always seek the best evidence to support their decisions.

And, indeed, there is an evidence hierarchy. About 25 years ago clinical scholars began to focus on decision making in medical practice and observed that care was often based on individual experience, dogma, animal experiments, and outmoded information. This realization led to critical inspection of the evidence used in practice and a systematic ranking. The ranking has improved with time, culminating in the establishment of the Oxford Centre for Evidence-Based Medicine Levels of Evidence in May 2001 (see Figure 2, p. 14-15).

Today, the highest level of evidence is the systematic review of homogeneous randomized clinical trials. The next level is an individual randomized clinical trial with narrow confidence intervals. The 1c level of evidence, called “all or none,” occurs when all patients died before the treatment became available, but some live with the treatment; or when some patients died before the treatment, but none die after the treatment became available. Level 2 evidence includes systematic reviews of cohort studies, individual cohort studies, and outcomes research. Systematic reviews of case-control studies and individual case-control studies comprise level 3 evidence. Case series, poor-quality cohort, and case-control studies provide level 4 evidence. The lowest level of evidence, level 5, comes from expert opinion without explicit appraisal based on physiology, bench research, or first principles. The evidence hierarchy is clear. Figure 2 spells it out.

**Evidence-based medicine**

The evidence-based medicine movement has evolved more rapidly and effectively in medical disciplines than in surgical disciplines for many reasons. Prospective randomized clinical trials represent the highest level of evidence to support clinical practice. Because of federal regulations, pharmaceutical companies cannot enter new products into routine use without proof of safety. Clinical trials, therefore, became essential for the introductions of new drugs and devices, and pharmaceutical companies found it in their best interests to fund clinical trials. Clinical trials are relatively easy to carry out with drugs. Surgical clinical trials are very difficult, and most surgeons are unwilling to participate in trials because of the paperwork, the hassle, and the discipline required. Patients, too, are frequently unwilling to participate in trials. Furthermore, government imposes less stringent regulations on the introduction of new technology and new operations than for new drugs. For these reasons, surgeons have less understanding of clinical trials and less clinical-trial evidence upon which to base their practice than do nonsurgeons. Today, in North America, most surgical specialists base their practice on uncontrolled case series and uncontested expert opinion.

A surgeon seeking to apply the best evidence to the care of his or her patients certainly can do so, because much high-level evidence exists. Best evidence resides on the shelves and in the stacks of every hospital library and every medical center.
Figure 2. Oxford Centre for Evidence-Based Medicine—Levels of Evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Therapy/prevention, aetiology/harm</th>
<th>Prognosis</th>
<th>Diagnosis</th>
<th>Differential diagnosis/symptom prevalence study</th>
<th>Economic and decision analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>SR (with homogeneity) of RCTs</td>
<td>SR (with homogeneity) of inception cohort studies; CDR validated in different populations</td>
<td>SR (with homogeneity) of level 1 diagnostic studies; CDR with 1b studies from different clinical centres</td>
<td>SR (with homogeneity) of prospective cohort studies</td>
<td>SR (with homogeneity) of level 1 economic studies</td>
</tr>
<tr>
<td>1b</td>
<td>Individual RCT (with narrow confidence interval)</td>
<td>Individual inception cohort study with 80% follow-up CDR validated in a single population</td>
<td>Validating cohort study with good reference standards; or CDR tested within one clinical centre</td>
<td>Prospective cohort study with good follow-up</td>
<td>Analysis based on clinically sensible costs or alternatives, systematic review(s) of the evidence, and including multi-way sensitivity analyses</td>
</tr>
<tr>
<td>1c</td>
<td>All or none</td>
<td>All or none case-series</td>
<td>Absolute SpPins and SnNouts</td>
<td>All or none case-series</td>
<td>Absolute better-value or worse-value analyses</td>
</tr>
<tr>
<td>2a</td>
<td>SR (with homogeneity) of cohort studies</td>
<td>SR (with homogeneity) of either retrospective cohort studies or untreated control groups in RCTs</td>
<td>SR (with homogeneity) of level &gt;2 diagnostic studies</td>
<td>SR (with homogeneity) of 2b and better studies</td>
<td>SR (with homogeneity) of level &gt;2 economic studies</td>
</tr>
<tr>
<td>2b</td>
<td>Individual cohort study (including low quality RCT; e.g., &lt;80% follow-up)</td>
<td>Retrospective cohort study or follow-up of untreated control patients in an RCT; derivation of CDR or validated on split sample or databases</td>
<td>Exploratory cohort study with good reference standards; CDR after derivation, or validated only on split-sample or databases</td>
<td>Retrospective cohort study, or poor follow-up</td>
<td>Analysis based on clinically sensible costs or alternatives, limited review(s) of the evidence, or single studies, and including multi-way sensitivity analyses</td>
</tr>
</tbody>
</table>

SR = Systematic Review, RCT = Randomized Clinical Trial, CDR = Clinical Decision Rule.

library in North America. Surgeons who want to spend every night, every weekend, and every day off in the library can maintain a fair base of best evidence to support a practice. Of course, that level of activity is impractical.

Fortunately, computerized literature search capabilities are at the fingertips of every surgeon. Medline, Ovid, and PubMed are available at low cost, permitting access to the best evidence extant.

Nonetheless, practicing surgeons live under an avalanche of information about the diseases they treat. No one today can keep up with all the publications in all of the journals even in a small and focused specialty. Fortunately, we can turn to other
### Figure 2. Oxford Centre for Evidence-Based Medicine—Levels of Evidence (contd.)

<table>
<thead>
<tr>
<th>Level</th>
<th>Therapy/prevention, aetiology/harm</th>
<th>Prognosis</th>
<th>Diagnosis</th>
<th>Differential diagnosis/symptom prevalence study</th>
<th>Economic and decision analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>2c</td>
<td>“Outcomes” research: ecological studies</td>
<td>“Outcomes” research</td>
<td>Ecological studies</td>
<td>Audit or outcomes research</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>SR (with homogeneity) of case-control studies</td>
<td>SR (with homogeneity) of 3b and better studies</td>
<td>SR (with homogeneity) of 3b and better studies</td>
<td>SR (with homogeneity) of 3b and better studies</td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td>Individual case-control study</td>
<td>Non-consecutive study; or without consistently applied reference standards</td>
<td>Nonconsecutive cohort study, or very limited population</td>
<td>Analysis based on limited alternatives or costs, poor quality estimates of data, but including sensitivity analyses incorporating clinically sensible variations.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Case-series (and poor quality cohort and case-control studies)</td>
<td>Case-series (and poor quality prognostic cohort studies)</td>
<td>Case-control study, poor or non-independent reference standard</td>
<td>Case-series or superseded reference standards</td>
<td>Analysis with no sensitivity analysis</td>
</tr>
<tr>
<td>5</td>
<td>Expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principles”</td>
<td>Expert opinion without explicit critical appraisal, or based on physiology, bench research or “first principles”</td>
<td>Expert opinion without explicit critical appraisal, or based on physiology, bench research, or “first principles”</td>
<td>Expert opinion without explicit critical appraisal, or based on economic theory or “first principles”</td>
<td></td>
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</table>


Professional organizations have developed standardized methods for reviewing the literature to select the best scientifically disciplined publications into collections or other formats readily accessible to practicing physicians and surgeons electronically. Figure 3 (p. 16) lists the available excellent sources of best evidence. The Cochrane Library has been available for about 10 years and has set the standard for providing high-quality critically edited and evaluated summaries of prospective randomized trials. The British Medical Journal also sponsors a collection of excellent information on wide array of topics (www.clinicalevidence.org). Practicing surgeons...
entific method and the role of evidence in research and in clinical practice. But after a period of active surgical practice, even in research-oriented hospitals, surgeons are apt to make practice decisions based on their recollection of past experience, a recent journal article (usually an uncontrolled case series), or what they learned in residency from their chief many years ago.

The second problem is the lack of access to best evidence to support surgical care. Although excellent resources such as the Cochrane Collection are available, they fail to provide a wide array of information on surgical problems. While the Cochrane Collection has expert surgeons on its review panels and excellent reviews appear, generally we find carefully assembled information on can efficiently search these sources and find the best evidence.

These special sources of best evidence strive for high relevance and validity, with low work for the user. Slawson and others express this very clearly when they state: the usefulness of any source of information is equal to its relevance, multiplied by its validity, divided by the work required to extract the information.

The problems

So, what are the problems? The first problem is a pervasive lack of understanding and appreciation of the scientific method. Every medical school graduate has experienced instruction in the scientific method and the role of evidence in research and in clinical practice. But after a period of active surgical practice, even in research-oriented hospitals, surgeons are apt to make practice decisions based on their recollection of past experience, a recent journal article (usually an uncontrolled case series), or what they learned in residency from their chief many years ago.

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<th>Annual cost, $</th>
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<td>Clinical Evidence</td>
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<td><a href="http://www.ovid/products/cip/ebmr/cfm">http://www.ovid/products/cip/ebmr/cfm</a></td>
<td>1,275 (institutional price for one user)</td>
</tr>
</tbody>
</table>

asthma, heart failure, arthritis, arrhythmia, and so on. A wide selection of surgical topics is lacking—not absent for sure, but lacking. There are several possible reasons for this dearth of material. One explanation is that these important resources have been organized and are operated by nonsurgeons who, quite naturally, focus on matters they face regularly.

The third problem we face is the relative lack of high-quality, well-designed, and well-conducted prospective randomized clinical trials on surgical conditions. Surgical journals abound with case series alongside a paucity of clinical trials. Several factors impede the conduct of surgical clinical trials. Few surgeons have the knowledge, skills, and commitment needed to carry out clinical trials. Clinical trials require time, energy, and paperwork. Clinical trials in surgery are difficult to design and conduct. Patients are more reluctant to participate in surgical trials than in medical trials. And, importantly, clinical trials cost a lot of money, and because drugs usually are not involved, pharmaceutical companies generally are not involved, so funding for surgical trials must come from government sources or private funds.

Some surgical problems do not require prospective randomized clinical trials to guide proper treatment. Some surgical problems do not lend themselves to clinical trial investigation. We should strive to identify important surgical issues that need study with clinical trials.

The challenges

Implementation of the practice of evidence-based surgery poses several formidable challenges. The first and most important is to educate surgeons. This process should begin immediately in postgraduate training and continue for the remainder of the surgeon’s professional life.

The American College of Surgeons should include courses on evidence-based surgery at the Clinical Congress and the Spring Meeting. For several years, the College has provided an excellent annual clinical trials course. This year, the Clinical Congress will include a postgraduate course on evidence-based medicine. In addition to courses on the principles of evidence-based medicine, the College should insist that all courses, symposia, and other presentations at its official programs reflect the best available evidence.

Several authors have criticized various surgical journals for lacking scientific rigor and discipline. As mentioned previously, uncontrolled case series substantially outnumber the publication of randomized trials. Editors should strive to publish manuscripts of the highest scientific discipline that are relevant to current practice. Publications should provide new knowledge or insights that have the potential for changing surgical practice for the better. Slawson and others, in selecting material for an evidence-based source of information for family doctors, refer to good manuscripts as POEMS—patient-oriented evidence that matters.

The best work includes prospective randomized clinical trials. The patients in the trials should be reflective of the overall patient population, so that the results of the study can be applied broadly.

Proper clinical trials must employ concealed allocation of subjects to treatment or control groups. The study could be biased if investigators know or influence which group the subjects enter.

An accounting must be taken of all patients entering the trial. Patients who are lost during the trial and follow-up must be acknowledged. Studies with large drop-out rates should not be published. Most biostatisticians favor the intention-to-treat analysis. That is, if a subject is randomly assigned to a treatment or control group and subsequently refuses the therapy or control designation, or otherwise changes status, he or she will continue to be regarded as a member of the assigned group.

Studies work better if neither the subjects nor the investigators know if the subjects are in the experimental or the control group. These double-blind studies are frequently impossible in surgical research. The experimental and control groups must be similar. The randomization process must provide comparable groups. Dissimilar groups may introduce bias. A valid study must include enough subjects to permit confidence in the results. Statistical power is very important, particularly in negative studies.

Another important challenge facing surgeons is to expand the available pool of best evidence. Today, we face a shortage of 1a and 1b evidence in most surgical disciplines. Obviously, random-
ized clinical trials are not necessary for the treatment of many surgical diseases. Trials cannot answer all questions, but we should systematically identify those areas in which trials are needed and marshal the resources to conduct the trials. When we lack 1a and 1b evidence, experts and scholars in the field should recognize and communicate the best evidence available and encourage surgeons to incorporate best evidence into their practices.

Office’s response

A vision and long-term goal of the ACS Office of Evidence-Based Surgery is to establish and maintain a repository of best evidence for the practice of surgery. This database could be developed in partnership with an existing organization or independently as a service provided by the College. This project would require substantial resources and expertise but would greatly facilitate the quality of surgical practice. A best-evidence repository assembled through systematic literature searches and data from ongoing surgical trials would become the basis of guidelines to assist surgeons in their practices. Best evidence would shape high-quality surgical practice.

How can we ever know if best evidence will lead to high-quality surgical practice? We measure it. In 1994 the Veteran’s Administration (VA) Health System established the National Surgical Quality Improvement Program (NSQIP), the first and only prospective, risk-adjusted, validated database for quantifying 30-day surgical outcomes. A NSQIP nurse at each of 122 VA hospitals collects and verifies the data, then submits it electronically to the data coordinating centers. Feedback to the surgical services includes: (1) comparative, site-specific, and outcome-based annual reports; (2) periodic assessment of performance; (3) self-assessment tools; (4) structured site visits; and (5) dissemination of best practices. Since NSQIP’s inception, 30-day postoperative mortality following major surgery decreased by 27 percent and 30-day morbidity by 45 percent.

The investigators tested NSQIP in three nonfederal university hospitals: the University of Michigan, Ann Arbor; the University of Kentucky, Lexington; and Emory University Hospital, Atlanta, GA. In these three alpha sites NSQIP performed very well in general surgery and in vascular surgery.

Now NSQIP and the ACS, with support from a grant from the Agency for Healthcare Research and Quality (AHRQ) are testing NSQIP in 11 additional university hospitals, making 14 beta sites. Presently, the investigators are evaluating the data from the first year of this study. If NSQIP is valid in the beta sites, the VA and ACS in collaboration will work to establish NSQIP throughout the private sector as rapidly and efficiently as possible. Also, the investigators will expand the project to include quality-of-life measures and to continue measures beyond 30 days.

NSQIP has the potential to quantify surgical quality in every hospital in North America and beyond. This will be a great service and resource to patients, to the public, and to our profession. In addition, our profession must address the issue of surgical errors. Quantification is an important step in minimizing surgical errors. NSQIP can document errors and allow systematic and methodical approaches to their elimination. The NSQIP database will also direct attention to those areas of surgical care that have high priority for improvement and can therefore facilitate the planning of surgical trials.

The National Cancer Data Base (NCDB) represents another quality improvement tool at the College’s disposal. The Commission on Cancer and the American Cancer Society established the NCDB approximately 10 years ago. Reports from 1,500 hospitals in 50 states form this nationwide database, which contains information on more than 11 million cancer patients. The database includes detailed information about pathology, staging, treatment, and outcomes, including five-year survival. Currently the NCDB provides feedback information to the approved cancer centers. Soon the data in the NCDB will be available to Fellows through the College Web site. The NCDB is available for scholars to pursue research questions and to plan clinical research projects.

Another College repository, the National Trauma Data Bank™ (NTDB™), exists as a result of collaboration between the American College of Surgeons and 130 hospitals dedicated to the care of injured patients. This maturing resource owes its success to the leadership and the abundant energy and talent of the Committee on Trauma.
Improving software and attention to information technology contribute to improvement in the NTDB. From 1994 through 1999 data pertaining to 542,841 injured patients were included. The bank records 92 data points on each patient and covers demographics, diagnosis, procedures, outcomes, as well as injury scene and facility characteristics. The NTDB, therefore, represents an important resource for improving the quality of care of trauma victims by enabling outcome studies as well as a broader range of clinical research.

**Technological innovation**

The American College of Surgeons must play a leading role in the introduction of new technology into clinical practice. New knowledge and technology are growing and advancing at far faster rates than the medical profession can safely and effectively incorporate the changes into practice. In 1994, the College established the Committee on Emerging Surgical Technologies and Education (CESTE), which developed guidelines for emerging surgical technologies and their application to the care of patients. The Statements on Principles of the American College of Surgeons require early and continued institutional review board evaluation of the protocol, a full description of the procedure, and the informed consent of the patient. These guidelines are open to interpretation and are not restrictive.

Today uncertainty about what constitutes surgical innovation and surgical research remains in the minds of surgeons and in the minds of the editors of surgical journals. CESTE will take a leading role in resolving this ambivalence. The reason for mentioning this point is that after CESTE recognizes new technology and defines surgical research, we must facilitate the examination of new technology and innovations by prospective randomized clinical trials. Our profession must encourage innovation and encourage the development of new technology. No two surgical operations are identical, and surgeons often encounter unexpected findings. Innovation is fundamentally essential for successful surgical practice. When innovative change becomes research is difficult to define. Marked departures from prior practice deserve evaluation before acceptance.

The introduction of new technology presents a slightly different problem. Of course the introduction of new technology is essential to progress and improved care. But, new operations and new devices should be evaluated for safety and efficacy before they are introduced for general use. In addition, new operations and devices should be compared with current practice before general application. Our profession must protect the public from ineffective and potentially dangerous new devices and operations.

**Clinical trials**

Clinical trials provide the most important source of information recognized by evidence-based medicine scholars. In 1996, Samuel A. Wells, J r., MD, FACS, proposed to the Board of Regents that the American College of Surgeons establish a multicenter cooperative group to conduct prospective randomized clinical trials to evaluate the surgical management of patients with malignant solid tumors. With support from the College and the National Cancer Institute, a group of surgeons worked with Dr. Wells to develop a clinical trials program called the American College of Surgeons Oncology Group (ACOSOG). With five years' funding, ACOSOG began in May of 2000 as one of nine cooperative clinical trials groups funded by the National Cancer Institute. Of the nine groups, only ACOSOG has the primary responsibility of studying the surgical treatment of cancer.

Initially ACOSOG was based in the College's Chicago headquarters. As the program grew, however, the leadership of ACOSOG recognized that it would function better and develop faster if located in an academic environment. For that reason, ACOSOG moved to the Duke Clinical Research Institute (DCRI) at Duke University in Durham, NC, January 1, 2002. The DCRI possessed the personnel, the infrastructure, and proper research environment to provide optimal opportunity for ACOSOG's growth and development. ACOSOG's current success underscores and validates the wisdom in the decision for relocation into an established clinical research environment.

The DCRI provided abundant, well-designed offices and facilities to house the current staff of 50 individuals, including surgeons, biostatisticians, data managers, and other clinical research staff.
While the program is working well, it will need to increase in size substantially if it is to reach its anticipated level of productivity. It especially needs more personnel in statistics and in clinical trials management.

There are currently 3,079 members of ACOSOG and 643 active member participating groups. The membership includes surgeons in academic centers, surgeons in private practice, medical oncologists, radiation oncologists, diagnostic oncologists, and nurses. Members from Australia, Canada, and Ireland currently contribute actively to patient accrual. Surgeons in private practice enter a large proportion of patients into ACOSOG trials. This is a splendid opportunity for practicing surgeons of all venues and specialties to participate in important clinical research and to stay abreast or even ahead of new scientific and clinical concepts in cancer treatment. The program also provides an opportunity for practicing surgeons to learn how to perform new operations and to apply new techniques. We encourage Fellows of the College, whether in private practice or in academic practice, to join ACOSOG, to enter patients into trials, and to participate in the programs.

Today, ACOSOG manages 16 clinical trials investigating a wide range of neoplasms, including breast cancer, lung cancer, prostate cancer, melanoma, metastatic brain cancer, esophageal cancer, pancreatic cancer, gastrointestinal stromal tumors, and head and neck cancer. ACOSOG recently completed a trial testing the effectiveness of PET scanning in staging lung cancer.

ACOSOG meets twice a year, in November and June, to plan and review the activities of the group as well as to provide continuing education to the participants. The group devotes one afternoon to a basic science seminar for active and prominent scientists to present lectures and discussions of the latest research relevant to the pathogenesis, diagnosis, and treatment of solid tumors. During these meetings, 14 organizing committees meet to address such issues as ethics, membership, patient advocacy, nursing education, special populations, auditing, and basic science. Committees also address diagnostic radiology, international relations, quality of life, radiation oncology, and tumor registries. The Executive Committee reviews and directs the total activities of the group. The 10 Organ Site Committees develop topics for trials, prepare protocols for NCI review, and monitor the progress of open trials.

In addition to ACOSOG, the Office of Evidence-Based Surgery manages clinical trials in fields other than cancer. We are working to expand clinical trial opportunities in other disciplines. For example, the Committee on Trauma is currently focusing on conducting clinical trials upon which to establish guidelines for trauma care. Important questions abound in other disciplines such as vascular surgery, thoracic surgery, cardiac surgery, general surgery, and so on, which could be answered with clinical trials.

**Conclusions**

It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way—in short, the period was so far like the present period, that some of its authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only. (Charles Dickens, *A Tale of Two Cities.*)

Today, medicine in general and surgery in particular can cure more disease with greater effectiveness, with greater precision, and less pain than ever before. But, today, the rising cost of health care continues to erode the fabric of our society. Patients are suing physicians, patients are suing health insurance companies, physicians are suing health insurance companies, professional organizations are suing the government, governments are suing the pharmaceutical industry, the pharmaceutical industry is suing governments, physicians are going on strike, and union workers disgruntled about health care are going on strike. Lawyers cannot solve this problem; health insurance companies cannot solve this problem; government cannot solve this problem; a discontented public cannot solve this problem. The medical profession can and must solve this problem. The American College of Surgeons must work to solve this problem by systematically addressing the cha-
lenges of improving the quality of surgical care throughout North America.

The American College of Surgeons will promote a system of surgical care for the twenty-first century designed for safety and high quality. This article describes the loop of related sequential steps that provide the framework for the system: a system of quality improvement. The components of the system are in place today but will require support and management. The American College of Surgeons must do this.

Acknowledgment

The authors acknowledge the outstanding work and leadership of Olga Jonasson, MD, FACS; Margaret Mooney, MD; and Kathy Johnson, who established the Office of Evidence-Based Surgery of the American College of Surgeons.

Bibliography


Dr. Jones is Director of the Division of Research and Optimal Patient Care and Past-President of the College.
Dual-surgeon households strive to balance work, family, play
by Diane S. Schneidman, Senior Editor
The surgical population just isn’t what it used be, and neither is the lifestyle of the people who compose it. While the profession remains male-dominated, more women are choosing surgical careers and bringing with them their own sets of concerns. Further, two generations of individuals—the Baby Boomers and Generation X—now comprise a large share of the surgical workforce. Members of these generations have a different value system than that of their forebears, who were more likely to put their professional commitments before their personal lives.

These two factors—more women of childbearing age entering surgery and a new generational mind set—have combined to create a changed surgical lifestyle. Families headed by two surgeons or a surgeon and another physician are no longer rare. Like all dual-income families, those led by two surgeons face a constant struggle to balance work, child-rearing, and leisure. However, surgery’s emotional, physical, and time demands make the cultivation of a stable lifestyle even more complicated.

This article provides some information about the changing surgical workforce. It also examines some of the issues that are unique to dual-physician families, including concerns about time management and juggling work and home life. Surgeons offer their insights into the professional and personal advantages and disadvantages of being married to someone who also is in a similar profession. The surgeons interviewed for this piece reflect on how they have been able to maintain their enthusiasm for surgery and have the energy to raise children.

This article also discusses how the American College of Surgeons is working to respond to the needs of a more time-pressed and autonomous generation of surgeons.

Changing demographics and demands

According to the most recent available data, approximately 20 percent of currently practicing surgeons are women, and that number is likely to climb in the future, given that women represent about 27 percent of entering and more than 23 percent of graduates of surgical training programs.* So, while surgery remains a male-dominated profession, female surgeons are becoming a significant segment of the population.

Like their male counterparts, most women surgeons (more than 60%) marry, and 40 percent of women surgeons have children. Women surgeons who do wed tend to marry other professionals, such as attorneys and other physicians, who also deal with great professional demands.†

Meanwhile, graduates of the core surgical specialties are, on average, 33 years old, while the average retirement age of a surgeon is near age 63.* Although the experts on demographics disagree somewhat on the exact age range of the people who are in these two generations, they generally agreed that Baby Boomers currently range in age from their late-thirties to their late-fifties, and Generation Xers range in age from their mid-twenties to late-thirties. In other words, individuals in these two generations represent the largest share of surgeons currently in practice or in training.

Members of these generations tend to place greater emphasis on their personal lives and are less loyal to a specific cause than were members of the World War II generation. They want to have a good family life and time to explore their interests outside of work.

Nothing new

While surgeons have been marrying other members of the health care professions for years now (largely because they spend so much time in the hospital setting and rarely have time for purely social activities), the contrasts are notable between the expectations of the generations that comprise the current adult population. Until recently, women who worked in the health care environment and married surgeons would leave the profession to raise the children, or surgeons would seek out a spouse who preferred to be solely responsible for family matters.

For example, Andrew D. Burch, Sr., MD, FACS, a general and thoracic surgeon in private prac-

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tice in Mobile, AL, met his wife, Mary, when she was working as a dietician at the hospital where he was training. They produced a total of nine children—five girls and four boys. Almost needless to say, Mrs. Burch chose to be a stay-at-home mom. (For more details about Dr. Burch’s family and lifestyle, see the related story on page 28.)

Other women health care professionals decided to stick with their profession and raise a family at the same time. John Sawyers, MD, FACS, met his wife, Julia Sawyers, MD, while he was doing his surgical residency and she was in medical school at Vanderbilt University, Nashville, TN. Dr. Julia Sawyers said she grew up wanting to become a surgeon, like her father. However, when she was in college, surgery “maybe was not as kind and friendly to women surgeons as it is now,” she said.

Drs. John and Julia Sawyers had the first of their three children when she was a third-year medical school student. Dr. Julia Sawyers went on to complete her training in anesthesiology and to pursue a career in that field because it provided a more scheduled workload than did other medical professions. She was able to take six weeks of maternity leave with each of her children and was on call only one night per week when the children were growing up.

Even so, Dr. Julia Sawyers said that being a medical professional and mother at the same time often left her feeling “really kind of torn in half.” When she was at work, she would worry about the children, and when at home, she’d think about her patients. “Getting peace of mind was difficult,” she said.

The tension between work and home life wasn’t as pronounced for Dr. John Sawyers. “I always put professional demands first,” he said. “In retrospect, I wish I had spent more time with my family, but it really wasn’t an option at that time.”

“In those days [the 1950s through the 1970s], you did what you had to do, and your children accepted it,” added Dr. Julia Sawyers.

Drs. John and Julia Sawyers said that the key to balancing their professional careers with child rearing was finding responsible people to care for their children. They found two women who fit the bill. One was a mature woman whom they hired to stay with the children when they were very young, and the other was a college student who lived with the family for several years.

After many years of striving to raise a family and maintain a general surgery and anesthesiology practice, respectively, Drs. John and Julia Sawyers now enjoy retirement together.

Other ways the couple found to balance work and family commitments included mixing family trips with professional meetings. This practice also afforded them opportunities to cultivate some sort of social life. “We met a lot of our current friends through meetings,” said Dr. John Sawyers.

Many of these friends were from outside the U.S., because the Sawyers found that their lifestyles were more comparable. “A lot of European surgeons’ wives were physicians, so when we’d get together at meetings, we had a lot in common,” Dr. Julia Sawyers added.

Aside from international surgical meetings, Dr. Julia Sawyers found that the opportunities for social contact were much more limited. “I was pretty isolated from a social life at the time,” she said. “I didn’t see a lot of my friends.” Nonetheless, she said, “I would never regret what I did. When I
would be around the surgeons’ wives who did not work, they didn’t have anything to do. I suppose it would have been nice in some ways, but not very challenging. I had the best of both worlds.”

Drs. John Sawyers and Julia Sawyers both indicated that they have noticed a marked change in the attitudes of younger surgeons and physicians. “Now, there seems to be more equal sharing of the load in terms of raising family,” Dr. Julia Sawyers said. Additionally, “Younger surgeons are demanding more time for themselves and their families,” she said. “When we were practicing, if you were on call, you just accepted the responsibility.”

Willingness to compromise

Because there is indeed more equal sharing of family obligations, both partners in young-surgeon couples are likely to feel torn between hospital and home. “I don’t want to look back and think that I didn’t spend enough time with my kids,” said James B. Harris, MD, FACS, a general surgeon in Greenville, SC, and a father of two boys—Jeffrey, age nine, and William, age seven.

To help balance their time between work and family, some young surgeons are leaving behind the long work hours and on-call demands associated with private practice together for the more regimented world of academic medicine. Dr. Harris, and his wife, Karin L. Klove, MD, FACS, also a general surgeon, are among them.

Drs. Harris and Klove met when they were both in surgical residency at the University of Southern California. After completing their training, they went into private practice with two other surgical oncologists in Sacramento, CA, and started a family.

When their boys were preschoolers, Drs. Harris and Klove were able to schedule their childcare situation around their time providing patient care. But as the children began entering school, participating in extracurricular and athletic activities, and so on, the couple found that Jeffrey and William needed more of their time and attention. At the same time the demands of family life were growing, so were their professional pressures. “We had a hard time because with managed care coming in, we had to increase our patient load,” Dr. Harris said. “We were booked out seven or eight weeks in advance.”

To help simplify matters, in 1998, Drs. Harris and Klove decided to seek out a quieter way of life. They moved across the country to Greenville, SC, which was less populated and had a marketplace that was less managed care-driven. Additionally, the couple opted to pursue an academic career path, which offers a more practical work schedule.

“It allowed me to back off practice,” Dr. Klove said. “I’m often home when the boys get home from school, and I’m on call only half as much as before.”

“Academic practice does mean less pay, but you have to ask: Is it worth the extra bit of money to miss out on being there for your kids?” added Dr. Harris. “We have tried very hard not to let surgery control our lives. You have to control it, or it will control you. You’ve got to remember that the job doesn’t always love you back.”
Like Drs. Harris and Klove, James R. Korndorffer, MD, FACS, and Melanie Leopard Korndorffer, MD, FACS, Montgomery, AL, are both general surgeons and have two young children—Caroline, age six, and Charles, age two. The Korndorffers also met during residency, and they went into private practice after completing their training.

When Caroline was an infant, the Korndorffers lived in a rural community and found that juggling their careers with family life was difficult but not impossible. “We had a nanny. Being in a small town at the time, it was easy to find someone we knew and trusted to care for our daughter,” Dr. Melanie Korndorffer said. Also, “The nanny could bring the baby in to be fed between cases.”

Once Charles was born and Caroline entered school, the balancing act became more difficult. Dr. Melanie Korndorffer was in a five-person group practice, and some of the partners were fearful that she would put family before professional demands. Additionally, she experienced some complications during the second pregnancy. Given all these factors, she opted to take a few years off from practice.

“I’m very fortunate that she’s been willing to put her professional life on hold for a while for our benefit,” Dr. James Korndorffer said.

To help make it possible for his wife to return to practice within the next couple of years and for him to devote more time and energy to his young family, Dr. James Korndorffer is pursuing academic practice. Later this year, he will begin a two-year fellowship in advanced laparoscopy at Tulane University’s Center for Minimally Invasive Surgery in New Orleans, LA. After finishing that training, he hopes to enter academic medicine.

“Most academic practices are in larger cities, where more opportunities would exist for dual-surgeon families,” Dr. Melanie Korndorffer said.

**Rewards**

Although both couples have found themselves making some significant changes and sacrifices to keep their houses and careers in order, they agreed that marriage to another surgeon is highly rewarding.

“We both understand the stress that the other one is going through,” Dr. Harris said. “At least she can understand when I have to devote a lot of time to a complicated case. If your spouse is not in medicine, that could be a problem.”

In terms of being in academic practice together, Dr. Klove said she and Dr. Harris are “both stimulated by medicine and learning. We both appreciate the joy of teaching residents about surgical judgment and compassionate patient care.”

Other surgeons like the ability to consult with their mate. “I can go to her and get an immediate second opinion,” Dr. James Korndorffer said in reference to his wife. Further, “I have no question that she’s going to understand that dedication to the patient is a given.”

Additionally, both dual-surgeon couples indicated that they enjoy attending conferences together and sharing the knowledge they acquire at the meetings with someone who is truly interested.
in learning about the topic. Like the Sawyers before them, Dr. Harris and Dr. Klove and Drs. James and Melanie Korndorffer noted that attending surgical meetings together provides opportunities for them to work in leisure time with their children.

Problems and solutions
Although families headed by two surgeons find that meetings are helpful in terms of enhancing their professional knowledge and of opening gateways to traveling and spending time with their children, they find that many programs are not designed with their needs in mind. For example, the College’s Clinical Congress no longer includes child care. So, for families who have children who are in preschool, it is difficult for both parents to attend sessions at the same time or to locate child care in the cities where the meetings are held, young surgeons have said.

Further, some women surgeons still find that they are out of place at medical and surgical meetings. “I was the only woman at the last Alabama Chapter meeting,” Dr. Melanie Korndorffer said. “When I asked some of the women I know if they were going to the meeting, they said they didn’t have any interest in attending.”

Dr. Melanie Korndorffer also suggested that more of the sessions at meetings such as the Clinical Congress should be aimed at “real life” issues. “At one of the recent Clinical Congresses, there was one set of courses for married clinicians but one of the speakers just talked about finding a nanny and wearing the right-colored clothes.” Young, dual-surgeon couples would like to see more presentations about negotiating for less on-call time and improved maternity leave policies, dealing with the competitive marketplace, understanding contract negotiations, and changing one’s lifestyle without leaving the profession. The surgeons also said they would like the College to sponsor sessions that demonstrate the advantages of including women and part-time members in group practices.

The College recognizes that the number of dual-surgeon households is growing and that these families face unique challenges. The organization is working to help resolve some of their concerns. For instance, the College’s Committee on Women’s Issues is working with the Association of Women Surgeons to help draft maternity leave guidelines for institutional settings. Furthermore, the committee is planning to present a program at next year’s Clinical Congress focusing on the concerns of women surgeons and parenthood.

In addition, the College’s Committee on Diversity is examining resident work hours and how they can be modified to ensure that surgical residents receive the appropriate training but can still have time for leisure activities and a family life.

Overall, though, what seems to help dual-surgeon households maintain a positive perspective on balancing their personal and professional demands is simply focusing on why they chose a surgical career in the first place.

“Absolutely there are fields that are much more favorable for having a family life,” Dr. Harris said. “There is so much negative stuff—decreased payment, increased regulation—that you really have to find that component of general surgery that makes you happy” and that offers enough flexibility to enjoy the rewards of family life.
Andrew D. Burch, Sr., MD, FACS, and his progeny give a whole new meaning to the phrase “family practice.” Two of Dr. Burch’s four sons—Andrew D. Burch, Jr., MD, FACS, and Ernest G. Burch, MD, FACS—are in a general surgery group practice with him in Mobile, AL. Another son, Danny Burch, MD, is currently in the surgical residency program at the Ochsner Clinic in New Orleans, LA. When he finishes training, he will join his father’s practice as well.

Meanwhile, several other Burch family members are pursuing careers in the health care professions. Dr. Danny Burch’s twin brother, Tommy, is an anesthesiology resident at the University of Alabama, Birmingham. Tricia Burch is attending Tulane Medical School in New Orleans, LA, and is considering moving on to a surgical residency. Dr. Andrew Burch, Sr., said his daughter is doing very well in medical school and that if she decides to become a surgeon, she, too, will become part of the family’s practice.

All together, eight of Dr. Burch’s nine children are in health care-related fields. Susan is a chemical engineer in charge of science and technology policy at a major pharmaceutical company. Marianne is a nurse, and Cathy is a medical technologist. Barbara is a homemaker.

Childhood exposure

Dr. Andrew Burch, Sr., attributes his children’s career decisions to their upbringing, joking that he “started recruiting at the moment of conception.” More seriously, though, “They saw that their mother was happy and that we were happy together and that I enjoyed surgery,” Dr. Burch added.

Dr. Ernie Burch echoed his father’s sentiments. “I always knew he was happy, and that encouraged me to go into surgery,” he said.

Although Dr. Andrew Burch, Sr.’s wife, Mary, opted to be a homemaker and handle most of the child-raising responsibilities, Dr. Burch always made a point of taking time away from work to be with his family. He said it was and still is very important for surgeons with families to have “protected time off,” meaning at least one full day a week and one weekend every month when they can turn off their beepers and enjoy their personal lives.

Dr. Burch said he acquired the habit of taking this protected time off while working with Ernest DeBakey, MD, FACS. “When I needed to take a day or weekend to be with my family, I would tell Dr. DeBakey, and he’d cover for me. In return, I’d cover for him when he’d go to a meeting or on vacation,” Dr. Burch said.
During their protected time off, Dr. Burch and his children would hunt, fish, or otherwise spend time together. He noted that it was very important to him and his wife that their children see that raising a family was their top priority and that it was possible for a surgeon to be committed to both his family and his patients.

The tradition of giving his partner protected time off has carried over into the practice that Dr. Andrew Burch, Sr., and his sons run. "When you're in private practice, you have to be willing to and want to put in long hours," Dr. Ernie Burch said. "But we also make sure each of us gets one or two weekends off every month. You have to be able to clock off."

Dr. Andrew Burch, Sr., raised his children so that they could see both his role as a father and the professional side of his life. When they entered high school, his children would work in his office with plenty of time away from there to study and socialize. When they were in college, the children would work in the operating room as scrub technicians. "Actually being in the OR, it became obvious that I had interest and talent in [surgery]," Dr. Ernie Burch said.

This is the same sort of exposure and opportunity that sparked Dr. Andrew Burch, Sr.'s, interest in surgery when he was young. His father was a golf pro, and Dr. Burch worked as a caddy at the course where his father worked. "One of my father’s best friends was a general surgeon, and he took me into the operating room," he said. "I saw what he was doing in the OR, and I thought it looked like something I could do."

**Togetherness and trust**

Drs. Ernie and Andrew Burch, Jr., and Sr., spend much of their workday together, either operating together on major cases or giving each other guiding support. Both Drs. Ernie and Andrew Burch, Sr., say that the biggest advantage of working together as a family unit is an unflagging level of mutual faith in and respect for each other’s capabilities.

"I don’t think there’s any question in their minds but that I’m here to help them, and they’re here for me,” Andrew Burch, Sr., said. “My sons do not work for me. We work together.”

"It’s obvious that they have my best interests at heart, and I have theirs at heart,” added Dr. Ernie Burch. “If I have a question about a case, I know I can pick up the phone and they’ll be there” to offer wise counsel.

Nonetheless, the three surgeons rarely question each other’s best professional judgment. “Dad, I think, sometimes fears that he’s going to get too involved in our cases,” Dr. Ernie Burch said. “He wants us to feel like his equal in the OR, so he won’t really make a lot of suggestions unless we ask for his help. Andy and I have a happier medium. If we see something from the other side of the table, we’ll tell each other about it.”

Another advantage of working with family, according to Dr. Ernie Burch, is that it eliminates many worries about the division of time and money. “There’s an unwritten amount of trust,” he said.

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*Dr. Andrew D. Burch, Sr., (center with plaque) is flanked by his family after receiving the 2001 Paul W. Bryant Alumni-Athlete at the University of Alabama. Dr. Burch played football for the University of Alabama as an undergraduate student. Pictured to the left of Dr. Andrew D. Burch, Sr., are (left to right): Catherine E. Burch, Patricia L. Burch (seated), Dr. Andrew D. Burch, J r., and Dr. Daniel C. Burch. Pictured to his right are (left to right): Mary H. Burch, Dr. Thomas M. Burch, Barbara Burch Mjor, Marianne Burch Haas (seated), Susan Burch Waltman, and Dr. Ernest G. Burch.*
Prospects for the 108th Congress

by Susanne R. Bell, Legislative Assistant  
Health Policy and Advocacy Department, Washington Office

Changes in the composition of the 108th Congress present significant leadership changes that may affect the outcome of health care legislation. The midterm elections shifted the control and agenda of both houses to the Republicans. Perhaps one of the most promising developments for surgery was the election of Sen. Bill Frist, MD, FACS (R-TN), by his colleagues to serve as the majority leader.

The individuals described in this article are the new leaders of important congressional committees that have jurisdiction over national health care issues. Hence, they will be the focus of many of the College’s education and outreach efforts.
Senate Majority Leader

Sen. Bill Frist, MD, FACS (R-TN)

Dr. Frist, a thoracic and transplant surgeon, was elected in 1994 and is the first practicing physician to hold office in the Senate since 1928. His initial assignment to the influential Health, Education, Labor and Pensions (HELP) committee gave Senator Frist frontline responsibility for developing and implementing health care policies and reforms for the nation. As chair of the HELP Subcommittee on Public Health, he provided important direction in the following areas: the Trauma Care Systems Planning and Development Act, medical savings accounts, reform of the Food and Drug Administration, the Ryan White CARE Act for the treatment and support of AIDS patients, and organ donation.

His experience was most helpful in drafting legislation requiring health plans to allow at least 48-hour hospital stays for mothers and newborns and in the formulation of the Health Insurance Portability and Accountability Act (HIPAA). He was also a member of the National Bipartisan Commission on the Future of Medicare, which explored how the nation would respond to a growing number of beneficiaries in the next 20 years. His Republican colleagues selected Senator Frist to serve as majority leader when Sen. Trent Lott (R-MS) resigned his position in December 2002.

Senate Health, Education, Labor and Pensions Committee

The Senate HELP Committee is responsible for all federal programs administered by the Public Health Service, including the National Institutes of Health, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality. The new leadership of the full committee has shifted the responsibilities of the Subcommittee on Public Health to the full committee.

Sen. Judd Gregg (R-NH)

As the new chair of the HELP Committee, Senator Gregg has outlined several goals, including preserving access to health insurance, improving access for the uninsured, expanding medical research, and increasing the number of community health centers. Before joining the Senate in 1993, he served two terms as governor of New Hampshire and as a member in the U.S. House of Representatives.

Sen. Edward Kennedy (D-MA)

Senator Kennedy has been an active and vocal advocate of health care reform throughout his 30 years in the Senate. Last year, he joined Dr. Frist in drafting essential bioterrorism response legislation. From 1987 to 1994, he chaired the Senate Labor and Hu-
man Resources Committee (now the HELP committee). Senator Kennedy, with former Sen. Nancy Kassebaum (R-KS), cosponsored and successfully secured the passage of HIPAA. He has long supported a Medicare drug benefit and opposed medical liability reform efforts.

**Senate Finance Committee**

The Senate Finance Committee is responsible for all legislation that governs revenue, trade, customs, and health care programs authorized by the Social Security Act and financed by taxes and trust funds, including Medicare Part A and Medicare Part B. This committee also provides global direction for Medicaid policy. Actual implementation of the Medicaid program remains the responsibility of the states. Due to the smaller size of the Senate, most of the substantive work of the panel is conducted at the full committee level.

**Sen. Charles Grassley (R-IA)**

Senator Grassley reassumes his position as chair of the Finance Committee. He is an advocate for health care equality for rural areas, including increased support for the nation’s small-town hospitals and physicians. His previous experience as chair of the Senate Aging Committee has continued with active involvement in health care issues of concern to elderly people.

**Sen. Max Baucus (D-MT)**

Senator Baucus resumes his role as Ranking Minority Member of the Finance Committee and continues his active support for cancer prevention and treatment legislation. He has continued efforts to update the Balanced Budget Act, seeking financial relief for rural hospitals and physicians. He was elected to the Senate in 1978 following a career in law, the Montana State Legislature, and the U.S. House.

**Sen. John (Jay) D. Rockefeller IV (D-WV)**

Sen. Rockefeller, the Ranking Minority Member of the Senate Finance Subcommittee on Health Care, has been a leader in health care delivery and financing issues for nearly 20 years. He was a principal architect of the Omnibus Budget Reconciliation Act of 1989 (OBRA), which introduced the Medicare physician fee schedule. He has a long history of reviewing Medicare reform options, having served on the National Bipartisan Commission on the Future of Medicare in the 1990s and, in the early 1980s, the Pepper Commission, which examined possible solutions to the problems of health care delivery in the future. Before his election to the Senate, Senator Rockefeller served as governor of West Virginia and as a member of the State House of Delegates. He assumed his role in the Senate in 1985.
House Committee on Ways and Means

One of the oldest congressional committees, the Ways and Means Committee has responsibility for all tax measures, Internal Revenue Service oversight, trade, and national trust funds, including the Medicare Trust Fund. The Subcommittee on Health formulates legislation that addresses issues such as Medicare reimbursement for hospitals and physicians.

Rep. William (Bill) Thomas (R-CA)

As chair of the committee and as a member of it for more than 25 years, Representative Thomas has been a leading force in the development of the Balanced Budget Act of 1997, which expanded health care delivery options for Medicare beneficiaries. Congressman Thomas recently played a pivotal role in negotiating a fix to the baseline errors in the Medicare physician payment formula. His continued dedication to a long-term solution helped to secure $54 billion in funding. Before his election to the Congress, he served as a California State Assemblyman and as a professor of American government at Bakersfield College in California.

Rep. Charles Rangel (D-NY)

Representative Rangel began his work as the Ranking Minority Member of the committee on Ways and Means in 1997. As a senior member of that committee, the congressman has continually fought against cuts in the Medicare programs and in the federal welfare system. Faithful to his New York teaching hospital constituency, he also has been an outspoken advocate for continued support of graduate medical education. Before his tenure in the House of Representatives, Representative Rangel served four years in the New York State Assembly.

Ways and Means Subcommittee on Health

Rep. Nancy Johnson (R-CT)

As chair of the Ways and Means Subcommittee on Health, Representative Johnson has been a stalwart supporter of health care providers. During the 107th Congress she introduced legislation that would stop any further cuts in the Medicare fee schedule. As a long-time member of the subcommittee, Representative Johnson has been very active in health care reform issues and has demonstrated her commitment by introducing legislation that would extend Medicare coverage to pay for cancer clinical trials. Representative Johnson founded the House Republican Task Force on Health Care in an effort to develop legislative proposals that would control costs and ensure universal access to affordable care. Before her election to Congress, Representative Johnson served as a member of the Connecticut State Senate.
Members of the Senate health care committees

Health, Education, Labor and Pensions Committee

Judd Gregg (R-NH), Chair
Bill Frist, MD, FACS (R-TN)
Mike Enzi (R-WY)
Lamar Alexander (R-TN)
Christopher Bond (R-MO)
Mike DeWine (R-OH)
Pat Roberts (R-KS)
J eff Sessions (R-AL)
J ohn Ensign (R-NV)
Lindsey Graham (R-SC)
J ohn Warner (R-VA)
Edward Kennedy (D-MA), Ranking Minority Member
Christopher Dodd (D-CT)
Jim Webb (D-VA)

Finance Committee

Charles E. Grassley (R-IA), Chair
Orrin G. Hatch (R-UT)
Don Nickles (R-OK)
Trent Lott (R-MS)
Olympia J. Snow (R-ME)
J ohn Kyl (R-AZ)
Craig Thomas (R-WY)
Rick Santorum (R-PA)
Bill Frist, MD, FACS (R-TN)
Gordon Smith (R-OR)
J im Bunning (R-KY)
Max Baucus (D-MT), Ranking Minority Member
J ohn D. Rockefeller IV (D-WV)
Tom Daschle (D-SD)
J ohn Breaux (D-LA)
Kent Conrad (D-ND)
Bob Graham (D-FL)
J ams j effords (I-VT)
J eff Bingaman (D-NM)
J ohn F. Kerry (D-MA)
Blanche L. Lincoln (D-AR)

Members of the House health subcommittees

Committee on Ways and Means
Subcommittee on Health

Nancy L. Johnson (R-CT), Chair
Jim McCrery (R-LA)
Phil Cr. Crane (R-IL)
Sam Johnson (R-TX)
Dave Camp (R-MI)
Jim Ramstad (R-MN)
Phil English (R-PA)
Jennifer Dunn (R-WA)
Fortney H. (Pete) Stark (D-CA), Ranking Minority Member
Gerald D. Kloorczyk (D-WI)
J ohn Lewis (D-CA)
J im McDermott (D-WA)
Lloyd Doggett (D-TX)

Committee on Energy and Commerce
Subcommittee on Health

Michael Bilirakis (R-FL), Chair
Joe Barton (R-TX)
Fred Upton (R-MI)
J ames C. Greenwood (R-PA)
Nathan Deal (R-GA)
Richard Burr (R-NC)
Ed Whitfield (R-KY)
Charlie Norwood (R-GA), Vice-Chair
Barbara Cubin (R-WY)
Heather Wilson (R-NM)
J ohn B. Shadegg (R-AZ)
Charles (Chip) Pickering (R-MS)
Steve Buyer (R-IN)
J oseph R. Pitts (R-PA)
Ernie Fletcher (R-KY)
Mike Ferguson (R-NJ)
Mike Rogers (R-MI)
W. J. (Billy) Tauzin (R-LA), ex officio
Sherrod Brown (D-OH), Ranking Minority Member
Henry A. Waxman (D-CA)
Ralph M. Hall (D-TX)
Edolphus Towns (D-NY)
Frank Pallone, J r. (D-NJ)
Anna G. Eshoo (D-CA)
Bart Stupak (D-MI)
Eliot L. Engel (D-NY)
Gene Green (D-TX)
Ted Strickland (D-OH)
Lois Capps (D-CA)
Bart Gordon (D-TN)
Diana DeGette (D-CO)
Christopher J ohn (D-LA)
J ohn Dingell (D-MI), ex officio
Rep. Fortney H. (Pete) Stark (D-CA)

Representative Stark has been a leader within the Committee on Ways and Means since 1985, when he became chair of its Subcommittee on Health. In 1995, when Republicans gained a majority of the House, Representative Stark was named Ranking Minority Member of the committee. During his tenure as chair, Representative Stark was one of the principal architects of OBRA ’89, which mandated the implementation of a Medicare physician fee schedule using a resource-based relative value scale. He also authored laws that limited patient referrals to services in which the physician holds a vested interest. Before Representative Stark was elected in 1972, he founded the Security National Bank in Walnut Creek, CA. He also served as director of Common Cause, a citizen’s lobbying group that works for reform in federal and state government.

House Energy and Commerce Committee

The House Committee on Energy and Commerce has statutory authority for those health programs financed by general revenues (as opposed to trust funds). Their jurisdiction includes: Medicare Part B and physician payment issues, as well as Medicaid; agencies of the Public Health Service, including the Food and Drug Administration; the Centers for Disease Control and Prevention; and the National Institutes of Health.

Rep. Billy Tauzin (R-LA)

Representative Tauzin, known for his leadership on energy policy issues, continues his position as chair of the House Committee on Energy and Commerce. His health care priorities this year include passage of a prescription drug benefit for seniors and medical liability reform. He has served more than 12 terms in Congress.

Rep. John Dingell (D-MI)

Representative Dingell has served in the House since 1955. As one of the most senior members of Congress, he has continued to be an outspoken supporter of health care reforms for Medicare beneficiaries. He served as member of the National Bipartisan Commission on the Future of Medicare. He was chair of the Committee on Energy and Commerce for 14 years before becoming the Ranking Minority Member of the Commerce Committee in 1995. In the 106th Congress, both he and Rep. Charles Norwood (R-GA) introduced the Patients’ Bill of Rights, a comprehensive managed care reform proposal that passed the House with bipartisan support. Before his tenure in the House, Representative Dingell was an assistant prosecutor in Michigan.
Subcommittee on Health

Rep. Michael Bilirakis (R-FL)
As chair of the Subcommittee on Health since 1995, and the representative of a district predominately composed of senior citizens, Representative Bilirakis has been a leader in the development of some of the most important health care legislation in recent years. His knowledge of Medicare and the nation’s health care delivery system led to his appointment to the National Bipartisan Commission on the Future of Medicare. His efforts on the Energy and Commerce Committee have meant passage of key health care bills, such as HIPAA, the Ryan White CARE Act, and the Trauma Care Systems Planning and Development Act. Representative Bilirakis, before being elected to Congress in 1982, was an attorney and held county and municipal judicial positions.

Rep. Sherrod Brown (D-OH)
Representative Brown, the Ranking Minority Member on the Health Subcommittee, was elected in 1992 and immediately devoted a great deal of attention to health care issues. He has authored and supported patient protection legislation for Medicare patients enrolled in managed care plans and is known for his efforts to increase federal support for cancer research, screening, and treatment. Before his election to Congress, Representative Brown was a member of the Ohio State House and served as Ohio’s Secretary of State.
Ten specialty boards report accomplishments and plans:

Part II

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 Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Ophthalmology, the American Board of Surgery, and the American Board of Urology.

The March issue of the Bulletin featured the reports of the American Board of Neurological Surgery, the American Board of Orthopaedic Surgery, the American Board of Otolaryngology, the American Board of Plastic Surgery, and the American Board of Thoracic Surgery.
Past and future meetings
The American Board of Colon and Rectal Surgery (ABCRS) held its most recent annual meeting September 22, 2002, and its most recent interim meeting March 24, 2002, in Chicago, IL. Future meetings and examinations were scheduled be held in Chicago through 2005. The schedule is as follows:

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<th>Written examination/interim meeting</th>
<th>Oral examination/annual meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 20-21, 2004</td>
<td>October 1-3, 2004</td>
</tr>
<tr>
<td>March 19-20, 2005</td>
<td>September 23-25, 2005</td>
</tr>
</tbody>
</table>

Officers and members of the board
The board is composed of 14 members. Nominations to fill vacancies are from the board and five other sponsoring organizations. The ABCRS nominates four members; the American Society of Colon & Rectal Surgeons (ASCRS) nominates four; the American College of Surgeons nominates two; the American Medical Association nominates one; the Association of Program Directors for Colon and Rectal Surgery (APDCRS) nominates two; and the American Board of Surgery nominates one. Board members normally serve two four-year terms, a total of eight years.

The board’s current officers are: Robert D. Fry, MD, FACS, president; James W. Fleshman, MD, FACS, vice-president; and Herand Abcarian, MD, FACS, executive director (at pleasure of the board). Current members of the board are: Richard P. Billingham, MD, FACS; Terry C. Hicks, MD, FACS; Vendie H. Hooks, MD, FACS; Ian C. Lavery, MD, FACS; Martin A. Luchtefeld, MD, FACS; Robert D. Madoff, MD, FACS; Patricia L. Roberts, MD, FACS; John P. Roe, MD, FACS; Alan G. Thorson, MD, FACS; Marshall M. Urist, MD, FACS; and Bruce G. Wolff, MD, FACS.

The board is pleased to announce that at its September 22, 2002, meeting, Drs. Billingham, Hooks, and Roe were re-elected and are serving their second four-year terms.

Proposal to increase board membership
At the September 22, 2002, meeting, the board voted to increase its membership from 12 to 14 members. The decision was reached because it has become increasingly difficult for the board to carry out its internal responsibilities, as well as to meet its demanding outside obligations, with 12 board members. The ABCRS and the APDCRS were each designated to provide an additional member, bringing ABCRS representation up to four members and the APDCRS up to two members. Filling the new slots were Dr. Luchtefeld, the new APDCRS representative, and Dr. Roberts, the new ABCRS representative.

Associate examiners
The board maintains a slate of associate examiners whose terms rotate at different intervals. Currently there are 16 associate examiners: Marcus J. Burnstein, MD, FACS; Charles P. Orsay, MD, FACS; W. Donald Buie, MD, FACS; Janice F. Rafferty, MD, FACS; Jose R. Cintron, MD, FACS; Jan Rakinic, MD, FACS; Richard M. Devine, MD, FACS; Thomas E. Read, MD, FACS; Brett T. Genlo, MD, FACS; Clifford L. Simmang, MD, FACS; Tracy L. Hull, MD, FACS; Michael J. Stamos, MD, FACS; Neil H. Hyman, MD, FACS; Mark L. Welton, MD, FACS; Ann C. Lowry, MD, FACS; and Richard L. Whelan, MD, FACS.

Five associate examiners completed their terms this September, and the board is grateful for their excellent service. They will be placed in the ranks of senior examiners and periodically invited to serve in the oral examination process. They are: P. Sue Beckwith, MD, FACS; Theodore J. Saclarides, MD, FACS; Frank J. Harford, MD, FACS; Judith L. Trudel, MD, FACS; and Bruce A. Orkin, MD, FACS.
Examination committee activities

The ABCRS oral examination committee, under the direction of Dr. Hicks, is focusing its attention on standardizing the oral examination process. Its goal is to change the oral examination from one that merely tests candidates’ recall knowledge to one that tests their cognitive knowledge. The committee began this task by editing existing oral case scenarios, making all the options clear, focused, and consistent. The process requires all examiners to test on the same material and to gather responses in key elements from each can-

<table>
<thead>
<tr>
<th>Year</th>
<th>Participants</th>
<th>Passed</th>
<th>% Failed</th>
<th>%</th>
<th>Maximum</th>
<th>Minimum</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>43</td>
<td>42</td>
<td>98%</td>
<td>1</td>
<td>2</td>
<td>94%</td>
<td>59%</td>
</tr>
<tr>
<td>2001</td>
<td>24</td>
<td>23</td>
<td>96%</td>
<td>1</td>
<td>4</td>
<td>90%</td>
<td>69%</td>
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<tr>
<td>2000</td>
<td>16</td>
<td>13</td>
<td>81%</td>
<td>3</td>
<td>19</td>
<td>90%</td>
<td>59%</td>
</tr>
<tr>
<td>1999</td>
<td>68</td>
<td>62</td>
<td>91%</td>
<td>6</td>
<td>9</td>
<td>94%</td>
<td>61%</td>
</tr>
<tr>
<td>1998</td>
<td>46</td>
<td>44</td>
<td>96%</td>
<td>2</td>
<td>4</td>
<td>93%</td>
<td>57%</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>184</td>
<td>93%</td>
<td>13</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Passing score: 70 Percent

<table>
<thead>
<tr>
<th>Written exam - March 23, 2002 (65 candidates)</th>
<th>Oral exam - September 21, 2002 (70 candidates)</th>
</tr>
</thead>
<tbody>
<tr>
<td># Fail rates</td>
<td>%</td>
</tr>
<tr>
<td>----------------</td>
<td>---</td>
</tr>
<tr>
<td>Total candidates</td>
<td>65</td>
</tr>
<tr>
<td>First-time takers</td>
<td>56</td>
</tr>
<tr>
<td>Repeat candidates</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total current diplomates</th>
<th>Male</th>
<th>%</th>
<th>Female</th>
<th>%</th>
<th>All</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active U.S.</td>
<td>1,009</td>
<td>72.90</td>
<td>106</td>
<td>7.66</td>
<td>1,115</td>
<td>80.56</td>
</tr>
<tr>
<td>Active international</td>
<td>66</td>
<td>4.77</td>
<td>5</td>
<td>0.36</td>
<td>71</td>
<td>5.13</td>
</tr>
<tr>
<td>Retired U.S.</td>
<td>184</td>
<td>13.29</td>
<td>2</td>
<td>0.14</td>
<td>186</td>
<td>13.44</td>
</tr>
<tr>
<td>Retired international</td>
<td>5</td>
<td>0.36</td>
<td>0</td>
<td>0.00</td>
<td>5</td>
<td>0.36</td>
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<tr>
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<td>0.36</td>
<td>0</td>
<td>0.00</td>
<td>5</td>
<td>0.36</td>
</tr>
<tr>
<td>Expired certificate holders</td>
<td>2</td>
<td>0.14</td>
<td>0</td>
<td>0.00</td>
<td>2</td>
<td>0.14</td>
</tr>
<tr>
<td>Total</td>
<td>1,271</td>
<td>91.84</td>
<td>113</td>
<td>8.16</td>
<td>1,384*</td>
<td>100.00</td>
</tr>
</tbody>
</table>

*This figure excludes diplomates who are deceased.
The intention is to make the oral process more objective and to provide a mechanism that will better identify the areas in which candidates fail.

Thirty-eight cases were preselected for this year’s oral examination, 19 for the morning session and 19 for the afternoon session. Photos and line drawings were also added. In general, the new process was well accepted and well executed by examiners. This year’s failure rate was 19 percent, compared with 22 percent in 2001. The decrease cannot be attributed to the new process, but future failure rates will be compared to previous examinations. New case scenarios will be added in 2003 and some format changes will be made.

Recertification activities
The last recertification examination was given June 4, 2002, in Chicago. Forty-three diplomates participated; 42 passed and one failed. The results and statistical summaries for the last five years are provided in Table 1 on page 39.

Examination results
The most recent written examination (Part I) was given March 23, 2002; 65 candidates were examined. The most recent oral examination (Part II) was given September 21, 2002; 70 candidates were examined. The pass/fail rates are shown in Table 2 on page 39.

Geographic/gender distribution
As of September 22, 2002, the board has a total of 1,384 diplomates; 1,186 in active practice and 198 retired/inactive, and two with expired certificates. Table 3 on page 39 provides the male/female and international distributions.

American Board of Obstetrics and Gynecology
by Norman F. Gant, M.D., Dallas, TX

Oral exam case collection
Commencing with residents graduating in June 2002, the length of time between successful completion of the written examination and the oral examination was shortened by one year. Specifically, after completion of the written examination on the last Monday in June, the candidate may begin collection of cases on July 1. Individuals who have not completed their residency before August 31 will not be allowed to begin case collection until the following July.

Implementation of this new policy will require a transitional phase-in period of three years. For the winter year examinations for 2003-2004, 2004-2005, and 2005-2006 one additional oral examination session will be scheduled for February. Unfortunately, it is unlikely that all candidates wishing to accelerate their certification process can be accommodated. Therefore, up to one-third of residents graduating in the years 2002, 2003, and 2004 will be allowed to enter this accelerated process each year. Of those eligible (that is, those who pass the June written examination), the application process is the same as other candidates, but case collection should begin immediately after completion of the written examination.

A lottery system will be used to select up to 450 eligible applicants from the graduating classes of 2002, 2003, and 2004. No late applications will be accepted, and all deadlines and requirements must be met in order for candidates to participate in the transitional program. For those persons not selected in the lottery process, application fees will be refunded and case collection may be continued for the following year’s examination. For those persons selected for the process, application fees will not be refunded if the process is canceled or not successfully completed.

Exams
The principal written examination was administered on June 25, 2001, at multiple sites. A total
of 1,711 candidates applied for the exam. Of them, 1,218 were new applicants, 1,138 were U.S. medical school graduates (USMGs), 80 were international medical school graduates (IMGs), and 493 were reapplying. Of those persons reapplying, 343 were USMGs and 150 were IMGs.

Of the individuals who took the written exam, 1,214 (76%) passed, and 389 (24%) failed. Of the USMGs, 1,134 (80%) passed, and 278 (20%) failed. Among the IMGs, 71 (39%) passed and 111 (61%) failed. First-time takers included 1,103 individuals (91%) who passed the test, and 114 (9%) who failed. U.S. graduates accounted for 1,040 (91%) of the individuals who took the exam for the first time and passed; however, 99 (9%) of the first-time USMGs failed. Among those who reapplied for the exam, 111 (29%) passed, and 275 (71%) failed.

The principal oral examination was administered in November and December 2001 and January 2002 in Dallas, TX. A total of 1,469 candidates applied for the oral exam: 16 were disapproved ad hoc; five were disapproved based on case list; 67 turned in incomplete-no fee applications; four were no-shows; 44 withdrew from the exam; and 1,333 took the exam. Of the individuals who took the exam, 1,132 (85%) passed, and 201 (15%) failed. Of the candidates who passed the exam, 1,061 (86%) were USMGs, 71 (76%) were IMGs, and 977 (88%) were USMGs who took the test for the first time. Of the individuals who failed the exam, 179 (14%) were USMGs, 22 (24%) were IMGs, and 132 (12%) were USMGs who took the test for the first time.

The pass rates for the principal written examination in obstetrics and gynecology have remained in a narrow range for more than a decade. For U.S. graduates of American medical schools taking the examination for the first time, the pass rate has ranged between 87 and 95 percent. For the entire examination, the pass rate has ranged between 66 and 76 percent.

The number of applicants for the written examination peaked in the mid-1990s. Since 1997, however, the number of applicants has decreased through the year 2001.

The pass rates for all candidates for the principal oral examination in obstetrics and gynecology have varied from 83 to 87 percent for the past decade. The number of applicants for the principal oral examination was constant between 1996 and 1999 (range: 1,650-1,686). This number dropped abruptly by more than 100 to 1,543 in the year 2000 and to 1,469 in 2001. This finding likely reflects the decreasing total number of applicants for the principal written examination first noted in the years 1997 and 1998.

Subspecialty exams

The written examinations in maternal-fetal medicine (MFM) and reproductive endocrinology/infertility (REI) were administered June 25, 2001, at multiple sites.

Of the 124 individuals taking the MFM written exam, 108 (87%) passed and 16 (13%) failed. Of those persons who passed the exam, 83 (98%) were first-time takers and 25 (64%) were reapplicants.

Of the 68 persons taking the REI written exam, 58 (85%) passed and 10 (15%) failed. Of those persons who passed the exam, 42 (89%) were first-time takers and 16 (76%) were reapplicants.

Subspecialty oral examinations were administered April 17-19, 2001. In the subspecialty of REI, 64 individuals took the oral exam, and 47 (73%) of them passed. A total of 852 physicians are board-certified in REI to date. In the subspecialty of MFM, 76 individuals took the oral exam, and 65 (86%) of them passed. A total of 1,419 are board-certified in MFM to date. In the subspecialty of gynecologic oncology (GO), 33 individuals took the oral exam and 28 (85%) passed. A total of 690 physicians are board-certified in GO to date.

Trends/written exams: The number of applications, those individuals approved to take the examinations, and the actual number who took the subspecialty written examinations in MFM and REI have declined for the past two years. This finding likely reflects the marked decrease in applicants for these fellowship positions first noted three years ago. The pass rates for the written examinations in MFM and REI have remained stable since the mid-1990s: between 75 and 90 percent.

Trends/oral exams: The pass-fail percentage rates for the oral subspecialty examinations are listed by year from 1990 to 2001 (see table, page 42).

A total of 2,961 diplomates have been issued subspecialty certificates (GO, MFM, REI), of whom approximately 2,690 are currently in practice.
This number represents approximately 7.8 percent of the total of 34,158 actively practicing diplomates.

**Maintenance of certification**

Certificate renewal/voluntary recertification written exams were administered February 26, 2001, at multiple sites. Of those physicians seeking to renew their certificates in obstetrics/gynecology (ob-gyn), 146 (98%) passed, and three (2%) failed. Of those physicians voluntarily renewing their certificates in ob-gyn, five (100%) passed. Of those individuals certified in ob-gyn and GO who were up for certificate renewal, two (100%) passed. A total of 15 persons certified in MFM and ob-gyn sought to renew their certificates and one voluntarily sought recertification. All passed. A total of 10 individuals sought to renew their certificates in ob-gyn and REI; nine passed and one failed.

A maintenance of certification exam in ob-gyn was administered August 27, 2001, in Dallas, TX. Of 46 physicians seeking to renew their certificates, 45 (98%) passed, one failed. Two physicians voluntarily sought recertification, and both passed.

A total of 5,485 individuals applied for annual board certificate (ABC) renewal and voluntary recertification for 2001. Of the ob-gyn applications, 4,789 were approved, 11 were disapproved, eight were withdrawn, and 252 were incomplete. There were 383 MFM applications, of which 380 were approved, one was disapproved, two withdrew, and 20 were incomplete. There were 171 REI applications, of which 169 were approved, one was disapproved, one was withdrawn, and 14 were incomplete.

For the obstetrics and gynecology portion of the ABC process several points are obvious.

Approval of applications in the years 1998, 1999, 2000, and 2001 was 97.5 percent, 99.8 percent, 99.7 percent, and 99.6 percent, respectively. The number of applications in 1999 (3,292) was decreased from 1998 (4,098). This decrease of 20 percent likely is explained by individuals who did not complete the process in 1998 and did not apply in 1999, plus the attrition of those persons who simply did not wish to continue the process for a variety of reasons. The increase back to 4,092 in 2000 and 4,808 in 2001 almost certainly represents the influx of another group of diplomates with time-limited certificates choosing this method of certification maintenance.

The percentage of diplomates who did not complete the process decreased from 30 percent in 1998 to 11 percent in 1999. In 2000, this number had decreased to 8 percent, and in 2001 this number was 5 percent. As mentioned previously, this improvement likely represents the loss of those who failed to complete the process in 1998. Also, this number likely includes a new group of diplomates with time-limited certificates and a better understanding of the process. More than 70 percent of diplomates using the ABC process in 1998 and 1999 did so voluntarily. This percentage fell in 2000 to 57 percent and in 2001 this number was 50 percent, as expected, due to the entry of more diplomates with time-limited certificates.

Analysis of the subspecialties after three years reveals several similarities to the ABC process in obstetrics and gynecology. Approvals of applications have been 100 percent and 98.5 percent in 1999 and 2000 respectively, and 99 percent in 2001. Since 1999, those failing and/or not completing the subspecialty ABC process appear to be decreasing. The reasons for this decrease are simi-
lar to those associated with the maintenance of certification examination in obstetrics and gynecology. Specifically, the attrition in 1999 likely resulted from those diplomates who did not understand the process or who discovered they did not wish to continue this form of recertification. The numbers of subspecialists actually entering the ABC subspecialty examination process in 1999 (686), 2000 (510), and 2001 (671) certainly support this conclusion. The subspecialists, using the ABC process in obstetrics and gynecology, are doing so slightly more often voluntarily. The 1999 voluntary rate was 77 percent, the 2000 voluntary rate decreased moderately to 61 percent, and in 2001 this rate was 55 percent.

Officers and directors
The ABOG officers for the year ending June 30, 2002, were: Gerson Weiss, MD, president; Michael T. Mennuti, MD, vice-president; Ronald S. Gibbs, MD, treasurer; Robert C. Cefalo, MD, PhD, chairman of the board; Norman F. Gant, MD, executive chairman; and William Droegemueller, MD, director of evaluation. Directors included Haywood L. Brown, MD; Larry J. Copeland, MD, FACS; Alan H. DeCherney, MD, FACS; Philip J. DiSaia, MD, FACS; Sherman Elias, MD, FACS; Wesley C. Fowler, Jr., MD, FACS; Larry C. Gilstrap III, MD; Frank W. Ling, MD; Roy T. Nakayama, MD; Kenneth L. Noller, MD; Valerie M. Parisi, MD; Nanette F. Santoro, MD; and Morton A. Stenchever, MD.

In addition, the following individuals served as the directors and representatives of the subspecialty divisions: Dr. Copeland, division of GO; Dr. Parisi, division of MFM; and Dr. Santoro, division of REI. Dr. Stenchever is the director and representative for female pelvic medicine and reconstructive surgery.

American Board of Ophthalmology
by Lee R. Duffner, MD, FACS, Golden Beach, FL

Certification examinations
The fall oral examination and meeting of the American Board of Ophthalmology (ABO) was held October 26-28, 2001, in Cambridge, MA. The annual meeting was held Friday, November 8, 2002, in San Francisco, CA.


The total number of diplomates certified at the October 2001 Cambridge and June 2002 San Francisco oral examinations was 456 (217 in Cambridge; 239 in San Francisco). Eighty-five failed the examination and must repeat all six subjects. The 2002 written qualifying examination was held April 26, 2002, at three sites in the U.S. The questions in this examination were prepared by the written examination committee of the ABO 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 730 registered for the 2002 written qualifying examination (WQE), 658 took the examination, 227 failed (34.5%), and 431 passed. Of the 227 who failed, 133 (58.5%) failed previously. Of the 658 candidates who took the examination, 206 (31.30%) were repeaters, and of these 133 (64.56%) failed again.

International medical graduates constituted 12.31 percent (81 candidates) of the examination and 44 failed (54.32%). U.S./Canadian graduates constituted 87.69 percent (577 candidates) and 183 (31.72%) failed.

Of the 206 candidates repeating the WQE, 40
(19.42%) were international medical graduates and 166 (80.58%) were U.S./Canadian graduates. The candidates who passed the 2002 WQE plus the repeaters from previous oral examinations provide a potential pool of 261 candidates for the November 2002 San Francisco oral examination and 263 potential candidates for the June 2003 Philadelphia oral examination.

Recertification examinations
The future dates for examinations are as follows: Certificate renewal examination, written (CREW), February 1 through March 31, 2003 (this is a take-home examination with two months to complete); Office record review (ORR), January 1-31, 2003, and July 1-31, 2003 (given twice a year with one month to complete).

The 2002 CREW examination was administered as a take-home examination from February 1 through March 31, 2002. Of the 351 registered for this examination, 346 completed the examination with 334 passing (96.53%) and 12 failing (3.47%).

The ORR was administered July 1 through July 31, 2001, and January 1 through January 31, 2002. Of the 42 registered for the July 2001 examination, 39 passed the review and three were incomplete. At the January 2002 examination, 243 were registered, with 241 passing and two incomplete.

Representation
The representative to the American College of Surgeons for 2002 was Lee R. Duffner, MD, FACS. The board's representatives to the residency review committee for the year 2002 were: Susan H. Day, MD, Richard P. Mills, MD, FACS, and James S. Tiedeman, MD.

In 2002, the residency review committee for ophthalmology reviewed 52 of 122 accredited ophthalmology residencies, with 23 receiving full reviews and the remainder partial reviews (either progress reports or requests for change in numbers of residents); of the fully reviewed programs, 20 were granted continued full accreditation, one proposed probation, one confirmed probation, and one deferred until the June 2002 meeting.

The following directors became officers of the board for 2002: chairman, Dr. Duffner, vice-chairman, and M. Bruce Shields, MD, FACS.

The two new board directors who took office January 1, 2002, were Martha J. Farber, MD, and David Tse, MD, FACS.

The voting representatives to the American Board of Medical Specialties (ABMS) for 2002 were: Edward G. Buckley, MD, FACS; Dr. Mills; Dr. Shields; and Charles P. Wilkinson, MD. Denis M. O'Day, MD, FACS, is on the executive committee of the ABMS.

General information
The American Board of Ophthalmology continues transitioning the recertification process into a program of maintenance of certification (MOC). MOC will be a continuous process that is part of a physician’s professional life and will be based on the following four components: evidence of professional standing; evidence of commitment to lifelong learning and involvement in self-assessment; evidence of cognitive expertise; and evidence of evaluation of performance in practice.

In addition to the four components, MOC will contain six domains of competence. These are patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Ophthalmology has added a seventh competency in surgery.

Each of the six domains of competence has guidelines developed by ABMS committees. This is an outgrowth of the committee formed a couple of years ago to evaluate medical school performance in the competencies. Not only will these competencies be used at the MOC level, but they will also be part of the final resident evaluations sent to the ABO. At the completion of an individual’s residency, the board will require a satisfactory performance rating in these seven competencies before he or she may sit for boards. To assist the process at the residency level, the ABO has taken the initiative of working with ophthalmology program directors to form a task force on competency.

The certificates for the first group of time-limited certificate holders expired December 31, 2002. These individuals received their certificates in 1992 and they are time-limited for 10 years.
American Board of Surgery

by Frank R. Lewis, Jr., M D, FACS, Philadelphia, PA

The following report summarizes the events of the 2001-2002 academic year, which has been a full one for the American Board of Surgery (ABS). A number of these issues should be of interest to the Fellows of the College.

New initiatives in education

The board held a retreat in January 2002 on the subject, “Graduate Surgical Education: Present Trends, Future Initiatives.” The purposes of the retreat were: (1) to examine the changing demographics of applicants for residency positions in surgery and its specialties; and (2) to examine the concepts of contracted training and tracking in an effort to make the process more efficient, effective, and less time-consuming. In addition to the ABS directors (who provided representation from the American Board of Thoracic Surgery, American Board of Plastic Surgery, and American Board of Colon Rectal Surgery), broad representation was present from the American College of Surgeons, the residency review committee for surgery (RRC-S), and the Association of Program Directors in Surgery. All members of the Boards of Vascular Surgery and Pediatric Surgery of the ABS and the Surgical Oncology Advisory Council (SOAC) were also included.

There was general agreement that numerous indicators pointed to a downward trend in the size (and possibly the quality) of the applicant pool for surgery for approximately the last five to seven years. These issues have become more visible with the failure of categorical surgical residency positions to fill completely during the last four years. For the last two years, 68 and 58 positions, respectively, of categorical positions did not fill. Mirroring the trend in general surgery, residencies in thoracic surgery and vascular surgery have also noted a declining pool of applicants, such that the number of applicants to available positions is approaching one to one. This issue, in part, led the American Board of Thoracic Surgery in October 2001 to abandon the requirement for holding an ABS certificate before entering thoracic surgery residency, and instead opening the possibility of entering thoracic residency after only three years of general surgical training.

Factors identified as causative in this declining interest were the following:

• Lifestyle issues. The perception exists of adverse working conditions in surgical residency, with work weeks in excess of 100 hours, excessive service requirements without educational value, and disaffected surgical faculty. Generation Xers have different values from earlier generations, and want more balance between professional and personal life as well as greater control of their personal time; they are not willing to spend time in the hospital while neglecting personal interests and family.

• Gender issues. Women constitute roughly 50 percent of medical school classes, but only 15 percent of surgical residents. Residencies must consider issues specifically addressed to women, such as child care provisions and more realistic maternity policies.

• Image of surgery issues. Surgery is often perceived as not being on the cutting edge of new knowledge, and of becoming progressively less relevant in the face of new technology (for example, endovascular, robotics). In addition, many of the practical issues of practice—decreased reimbursement, decreased autonomy, and increased administrative hassles—have made a surgical career less attractive. In most medical schools, time spent on surgical rotations has been significantly reduced in the last two decades, and medical students often have little or no exposure to the best and brightest of surgical faculty.

• Personal indebtedness. The degree of indebtedness has risen dramatically in the last 10 years, and is now a factor in specialty selection because of the effect on personal lifestyle and family security.

The issues and problems were discussed extensively. Ultimately, the directors adopted the con-
cept of initiating a pilot program for the specialties that are essential content areas (also known as primary components) of general surgery; if successful, such a program would allow shortening of total training by one year. It was considered essential that the validity of the basic ABS certificate be maintained. The core of the proposal would allow residents to enter specialty training after four years of general surgery, spend the fifth year in the specialty, and then one or two additional years to complete specialty training. The fifth year would count as the fifth year of general surgery as well as the first year of specialty training.

Following the retreat, a request was directed to the American Board of Medical Specialties for approval of the above concept, in which the fifth year could count toward two different ABS certificates. That approval was granted, and a committee was appointed—the ad hoc committee for the early specialization program (ESP).

Further discussion ensued at the June ABS meeting and additional directives were provided to the committee to clarify the charge. The committee met August 5, 2002, and developed a draft report which is currently being circulated to all ABS directors and RRC-S members. There was a relative unanimity in favor of the ESP, and a recommendation that it be extended to vascular and pediatrics, but not critical care or hand. Specialties that have independent boards—thoracic surgery, plastic surgery, and colon and rectal surgery—may also be interested in this paradigm, but the approval process for any combined program will be different, and will have to go through the ABMS as a formally combined residency program. Initiatives in that area will be explored in the future.

The report will be reviewed extensively and revised as necessary. It was to be presented to the ABS directors in January for adoption, and if successful, the ESP program would be implemented shortly thereafter. The committee report has emphasized that the success of these programs must be judged by the ability of ESP graduates and other residents in programs where ESP is initiated to maintain the same pass rates on the qualifying exam and certifying exam as their peers. It is also considered essential that all minimums currently mandated by the RRC-S be maintained for future graduates of these programs. These will initially have to be evaluated on a year-to-year basis.

**IT/SBSE suspicious matches**

Three years ago, the ABS purchased software designed to detect cheating on multiple-choice examinations, and initially used this to examine the results in the In-Training/Surgical Basic Science Examinations (IT/SBSE) from 1997 to 1999. The software makes it possible to detect suspicious “matches” in the selection of the same answers on two or more examinee’s answer sheets and to compare these. In general, when there are matches in the correct answers, one cannot detect cheating, since the argument is easily made that those examinees with a high percentage of identical right answers were simply well-informed and there is only one right answer for each question. Hence, the software compares matches of wrong answers. Since there are four possibilities of being wrong per question, a substantial match of wrong answers throughout an exam argues highly that the answers were copied from one to the other.

The software can be set at various levels of significance, and obviously detects more suspicious matches the lower the significance level is set. We have chosen to use it very conservatively, and have only identified suspicious episodes when the statistical probability of a “chance” occurrence is less than one in a million. (p < 0.0000001)

When this software was first applied to the 1997-1999 IT/SBSEs, 65-70 programs per year were found to have episodes of suspicious matches identified. Most of these were single pairs of examinees, but a few were notable for having “trios,” in which three-way matches were identified. After the 1999 IT/SBSE, program directors were notified of the findings and asked to proctor their subsequent examinations more closely. A year later, in 2000, they were notified that if the ABS detected cheating for three years sequentially in a program they would withhold the IT/SBSE from that program subsequently. In 2000, the number of programs identified fell to 45, and in 2001 to 27. In 2002 the number rose again to 38 programs. This is the second year of results under the new policy, so no program has yet faced recision.
This software has also been used to compare the incidence of suspicious matches on the qualifying examination and the recertification examination, both given to 1,100-1,500 individuals yearly, which are proctored closely by board directors to avoid the possibility of copying. There have been rare instances of matches identified, never more than two pairs per year in either of these exams.

For the past two years, both the qualifying and recertification examinations were printed in two versions with the same questions, but placed in a different sequence in the two books. Proctors were instructed to alternate versions of the booklet with alternate examinees. With this modification, no matches of answer sheets occurred in either examination.

At its meeting on June 24-25, 2002, the ABS discussed this phenomena, and felt that stronger action needs to be taken to reduce the number of these occurrences on the IT/SBSE. The following plan was adopted:

1. At the first identification of any suspicious matches in a program, the program director and chair of surgery will be notified of the occurrence and asked to make some specific changes in the conduct of the examination (assigned seating, closer proctoring, escorts for those leaving room).

2. If the same program has a suspicious occurrence in the next year, the program director, chair of surgery, and medical education director for the institution will be notified. The medical education committee for the institution will be asked to submit a written plan to correct the problem.

3. If the same institution has a suspicious match for a third year, the previously mentioned individuals will again be notified, and the IT/SBSE will be withheld for at least one year. The procedure for regaining entrance to the examination has not yet been determined but will be developed in the next six months. The RRC-S will also be notified that the program will not be allowed to receive the IT/SBSE.

The ABS is also debating whether it would be useful to print two or more versions of the examination booklet for the IT/SBSE, as this has not been done to date. Subsequent to the ABS action described, the issue was presented to the RRC-S, and they strongly supported the actions that had been taken.

**Competence initiative**

The ABS has previously adopted the maintenance of certification (MOC) initiative of the ABMS, and has implemented some of its requirements. The program has four basic components: (1) evidence of professional standing; (2) evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process; (3) evidence of cognitive expertise; and (4) evidence of evaluation of performance in practice.

The first of these components is evaluated by the requirement for a full and unrestricted license in all jurisdictions where licenses are held by a diplomate, and by personal reference requirements from the chief of surgery and the chair of the credentials committee in the hospitals where the diplomate practices.

The second requirement is met by demonstration of 100 hours of CME activities in the two years prior to recertification application, of which 60 hours must be Category I. The third requirement is met by taking and passing the recertification examination of the ABS. The fourth requirement is met in part currently by the reference letters of the chief of surgery and the chair of the credentials committee, but it is felt that more objective criteria are needed, which specifically would address the practice experience of an individual diplomate.

Currently, initiatives have been undertaken by the Vascular Surgery Board of the ABS (VSB-ABS), the Pediatric Surgery Board of the ABS (PSB-ABS), and the SOAC, which are geared to obtaining outcomes measures that could be used in the MOC process.

The VSB-ABS has initiated a program to measure specific outcomes of three index procedures: carotid endarterectomy, elective repair of infrarenal aortic aneurysms, and infrainguinal bypass. Under the leadership of Pat Clagett, MD, FACS, the VSB-ABS has moved ahead with planning for implementation of this program in the last year, and it is anticipated that it will be initiated during the recertification process for vascular surgeons seeking recertification in 2003.

The PSB-ABS, under the leadership of Brad Rodgers, MD, FACS, had adopted a similar approach and has identified seven conditions that will be utilized as index conditions for evaluat-
ing outcomes. They have been working with the clinical trials center of the American Pediatric Surgical Association in developing a short form in which a practitioner could compare his or her own results with regional or national norms in a confidential way.

Finally, the SOAC, chaired by Timothy Eberlein, MD, FACS, has explored the possibility of using the National Surgical Quality Improvement Program (NSQIP), developed by Shukri Khuri, MD, FACS, in the Veterans Affairs Hospital System. Dr. Eberlein and the members of the council have explored using data collected as part of the NSQIP process where it applies to the outcomes of surgical oncology procedures, and using these as the index of practice performance.

These three initiatives are all moving forward, and will be evaluated for effectiveness and acceptability to diplomates. Ultimately, a method will have to be found that is applicable to general surgery diplomates, but the ABS felt that the smaller number of practitioners in the above areas and the more homogeneous nature of the practices would allow us to more quickly identify effective and workable methods to meet MOC requirements.

Independent vascular surgery board

The American Board of Vascular Surgery has moved ahead with an application to the ABMS for creation of an independent board, which was filed in early June 2002. (The full application can be viewed online at www.vascularweb.org.) The application will be reviewed first by the Liaison Committee for Specialty Boards (LCSB), which is appointed jointly by the ABMS and the AMA. Initial review was scheduled for December 2002.

The membership of the LCSB consists of:

ABMS: David L. Nahrwold, MD, FACS; Harvey Meislin, MD; Joel A. DeLisa, MD; and John S. Strauss, MD.

AMA: Richard Allen, MD; James L. Borland, Jr., MD; Emmanuel G. Cassimatis, MD; Rebecca J. Patchin, MD; and Barbara Burzanski, PhD.

The ABVS application makes a good case for a vascular certificate, but such a certificate has existed under the aegis of the ABS for more than 20 years. The ABS strongly opposes the initiative for an independent board. It appears from reading the application that an intent of the independent board is to limit the vascular surgical experience of general surgery residents and direct these cases instead to vascular surgical trainees. Since experience in vascular surgery is essential to several content areas of general surgery, it is impossible for ABS to abandon this area as an essential content area.

If the action of the LCSB is to deny the application, it will move no further at this time. If it is approved, it will move to the ABMS executive committee, and if approved there, to the ABMS assembly.

Naming of new executive director

A search committee consisting of Patricia Numann, MD, FACS (chair); Mark Malangoni, MD, FACS; and J. David Richardson, MD, FACS, initiated the search process for a new executive director after Wallace P. Ritchie, Jr., MD, FACS, indicated in April 2001 his intent to retire in June 2002. The search committee interviewed all directors, several senior directors, and ABS office staff to determine views on the current status of the ABS, its future directions, and the characteristics needed in a future executive director. An RFP was widely disseminated in the summer of 2001, and widespread interest in the position was expressed. Ten candidates were interviewed, and final recommendations were submitted to the board at its January 2002 meeting. Frank R. Lewis, Jr., MD, FACS, was selected by the board after the search committee presented its recommendations and he shortly thereafter accepted the position. Overlap of approximately six weeks with Dr. Ritchie was scheduled, and on July 1, 2002, Dr. Ritchie officially retired and Dr. Lewis assumed the executive director responsibilities.

New and retiring members

The board would like to express its thanks for the dedicated service and excellent counsel of the following individuals who retired in 2002: (ABS directors) Robert W. Barnes, MD, FACS; Robert D. Fry, MD, FACS; Donald L. Kaminski, MD, FACS; Dr. Numann (chair, 2001-2002); (VSB-ABS) Keith D. Calligaro, MD, FACS; and (SOAC) Daniel G. Coit, MD, FACS.
American Board of Surgery:
Summary of 2001-2002 examinations

<table>
<thead>
<tr>
<th>Examination</th>
<th>Number of examinees</th>
<th>Pass rate</th>
<th>Diplomates to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifying</td>
<td>1,287</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Certifying</td>
<td>1,168</td>
<td>83%</td>
<td>47,367</td>
</tr>
<tr>
<td>Recertification</td>
<td>1,370</td>
<td>93%</td>
<td>12,991</td>
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<tr>
<td>Vascular surgery qualifying</td>
<td>123</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Vascular surgery certifying</td>
<td>120</td>
<td>83%</td>
<td>2,154</td>
</tr>
<tr>
<td>Vascular surgery recertification</td>
<td>138</td>
<td>94%</td>
<td>1,137</td>
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<tr>
<td>Surgical critical care certification</td>
<td>83</td>
<td>95%</td>
<td>1,939</td>
</tr>
<tr>
<td>Surgical critical care recertification</td>
<td>163</td>
<td>91%</td>
<td>687</td>
</tr>
<tr>
<td>Pediatric surgery qualifying</td>
<td>68</td>
<td>96%</td>
<td>N/A</td>
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<tr>
<td>Pediatric surgery certifying</td>
<td>69</td>
<td>87%</td>
<td>877</td>
</tr>
<tr>
<td>Pediatric surgery recertification</td>
<td>67</td>
<td>94%</td>
<td>498</td>
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<tr>
<td>Hand surgery certification</td>
<td>5</td>
<td>100%</td>
<td>223</td>
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<tr>
<td>Hand surgery recertification</td>
<td>12</td>
<td>92%</td>
<td>63</td>
</tr>
<tr>
<td>Pediatric surgery ITE</td>
<td>72</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>IT/SBSE</td>
<td>7,336</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>12,081*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N/A - Not applicable.

*4,745 examinees, excluding the IT/SBSE and pediatric surgery ITE.

New appointees elected in April to replace the above individuals, and the appointing organizations, are the following:

(ABS directors): Richard H. Bell, Jr., MD, FACS, American Surgical Association; James W. Fleshman, Jr., MD, FACS, American Board of Colon and Rectal Surgery; Russell G. Postier, MD, FACS, American Medical Association; and Steven C. Stain, MD, FACS, Western Surgical Association.


(SOAC): Fabrizio Michelassi, MD, FACS, Society of Surgical Oncology.

We want to welcome all of them enthusiastically, and look forward to working with them.

The board would also like to gratefully acknowledge the dedicated service of the following individuals who retired from active examiner status during the past year: Robert W. Barnes, MD, FACS; Edward M. Copeland III, MD, FACS; Haile T. Debas, MD, FACS; Josef E. Fischer, MD, FACS; Peter C. Pairolero, MD, FACS; and Donald D. Trunkey, MD, FACS.

Necrology

It is with great regret that we report the deaths of the following individuals during the past year: Jonathan E. Rhoads, MD, FACS (January 3, 2002); Jack Cole, MD, FACS (June 2002); Victor Richards, MD, FACS (July 13, 2002); David Tapper, MD, FACS (July 23, 2002), and C. James Carrico, MD, FACS (July 25, 2002).
Exams

The certification process of the American Board of Urology (ABU) incorporates a qualifying examination (Part I) and a subsequent certifying examination (Part II). Admissibility to the qualifying examination requires that the applicants have completed or be within six months of satisfactorily completing an Accreditation Council on Graduate Medical Education (ACGME)-approved urology residency program. Admissibility to the certifying examination requires that the candidates have passed the qualifying (Part I) examination, have 18 months of clinical practice experience in a single community, submit an acceptable practice log, and receive satisfactory peer reviews.

On June 27 and 28, 2002, 351 candidates completed the qualifying (Part I) examination, which consists of three components: An imaging examination, a pathology examination, and the qualifying (Part 1) examination. All three examinations are given in booklet form and are cognitive, multiple-choice examinations. Of the three component examinations: 286 sat for the imaging examination, 282 passed and four failed; 283 sat for the pathology examination, 276 passed and seven failed; and 329 sat for the written qualifying (Part I) examination, 270 passed and 59 failed.

As has been true in other years, practitioners—U.S.- or foreign-educated—who have previously failed the examination had a high failure rate on re-examination. For the past 10 years, the pass level for the qualifying examination has been set by the criterion reference method, equated to a previous benchmark 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 (pass rate) 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 2002 certifying (Part 2) examination is a standardized oral examination that consists of six protocols on which the candidate is tested. In February 2002, 277 candidates took the certifying (Part 2) examination; 262 (95%) passed and were certified; 15 (5%) failed, a pass rate much 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 completion of an ACGME-approved residency program; extensions are granted for approved fellowship training. Failure to complete certification within the time allotted requires reentry into the certification process at the qualifying examination (Part I) 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. These various components provide the diplomat with different opportunities and ways to document his or her competence. A modular, written, open-book examination consists of five subject areas from which the diplomat will choose three with which he or she is most comfortable. Each module has 20 questions, for an individual examination of 60 questions. Other components include peer review, a surgical log review, and a CME requirement. In addition, at the board’s continued on page 58
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. See the box below for a special announcement for ACS Fellows, Associates, and Candidates.

Keeping current in 2003 with ACS Surgery: Principles and Practice

ACS Surgery 2003 is now available. Receive a free three-month trial to www.acssurgery.com (a $50 value) by ordering your copy today. For only $199 you can be among the elite group of surgeons that subscribe to the continually updated surgery textbook, ACS Surgery. Updated monthly online and annually in print, the ACS Surgery 2003 volume features 40 percent new and updated information to provide you with the most contemporary views on best practice and technique. Minimize complications, lower expenditures, and increase patient satisfaction with this unique reference. Call 1-800/545-0554 today to reserve your copy, and be sure to request offer number S34S8G1C.

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II. Common presenting problems

12. Open wound requiring reconstruction. Joseph J. Disa, MD, FACS, and David A. Hidalgo, MD, FACS. In the update to their chapter, Drs. Disa and Hidalgo describe evaluation and initial treatment of the open wound and the selection of coverage procedure, as well as specific issues, such as small localized scar, shortage of subcutaneous tissue, and complex defects. They also discuss key postoperative management issues.

The level of bacterial contamination has been shown to be a significant predictor of outcome in wound closure by either skin-graft or flap-coverage techniques. According to the golden-period principle of wound closure, a minimum time interval is necessary for bacteria to proliferate to a certain threshold level. Contaminated wounds take a mean time of about five hours to reach a bacterial count of 10⁵/g of tissue. Attempts to close wounds that have counts higher than 10⁵/g of tissue will fail 75 percent to 100 percent of the time, whereas wounds with lower counts are successfully closed more than 90 percent of the time. β-Hemolytic streptococci are an exception in that much lower concentrations of these organisms consistently result in failed wound closure. When a β-hemolytic streptococcus is the dominant isolate, the wound should generally be treated openly until cultures become negative.

Part of the discussion of optimal closure of a small localized scar focuses on Z-plasty. When reconstruction is indicated for a small localized scar, soft tissue coverage is generally sufficient and poses no threat of breakdown leading to exposure of important structures. Instead, the reconstructive problem is generally functional in nature. An example is a tight scar band across a flexion crease, commonly seen after a burn injury. A local procedure that rearranges the existing tissue can relieve the tension by making more tissue available in one direction, though the amount of tissue in the area is not actually increased.
The Z-plasty is an example of such tissue rearrangement. Two triangular flaps are designed to have a common, or central, limb aligned in the direction that needs to be lengthened. Each of the other two limbs is equal in length to the central limb and diverges from it at an equal angle varying from 30° to 90°. After the flaps are transposed, length is gained in the desired direction, and the original Z is rotated 90° and reversed. An angle of 60°, which is commonly used, will result in a 75% gain in length along the central limb. In theory, the maximum gain in length is achieved by using the greatest angle possible, but practical limitations are imposed by the nature of skin elasticity. Important considerations with this procedure include the proper length of the central limb and the proper orientation of the limbs so that the new central limb formed after transposition is parallel to the skin tension lines. Multiple Z-plasties or other procedures, such as W-plasty, may be useful for some localized scars. Subscribers may view the full text of this chapter at www.acssurgery.com.

IV. Preoperative preparation

7. Perioperative considerations for anesthesia. Steven B. Backman, MDCM, PhD; Richard M. Bondy, MDCM; Alain Deschamps, MD, PhD; Anne Moore, MD; and Thomas Schricker, MD, PhD. In their new chapter, the authors offer a current perspective on perioperative considerations for anesthesia in the adult patient with the goal of facilitating dialogue between the surgeon and the anesthesiologist and thereby helping to minimize patient risk.

The medications the patient is taking can have a substantial impact on anesthetic management. Generally, patients should continue to take their regular medication up to the time of the operation. It is especially important not to discontinue medications whose abrupt cessation may result in withdrawal or rebound phenomena (such as beta blockers, alpha agonists, barbiturates, and opioids). With some medications (such as oral hypoglycemics, insulin, and corticosteroids), perioperative dosage adjustments may be necessary. Angiotensin-converting enzyme inhibitors have been associated with intraoperative hypotension and may be withheld at the discretion of the anesthesiologist. Drugs that should be discontinued preoperatively include monoamine oxidase inhibitors and oral anticoagulants.

Many surgical patients are taking antiplatelet drugs. Careful consideration should be given to the withdrawal of these agents in the perioperative period because of the possibility that discontinuation may lead to myocardial infarction. If increased bleeding is a significant risk, longer-acting agents (that is, aspirin, clopidogrel, and ticlopidine) can be replaced with shorter-acting agents. Typically, these drugs are given for 10 days, stopped on the day of surgery, and then restarted six hours after operation. Platelet transfusion should be considered only in the presence of significant medical bleeding.

The increasing use of herbal and alternative medicines has led to significant morbidity and mortality as a consequence of unexpected interactions with traditional drugs. Because many patients fail to mention such agents as part of their medication regimen during the preoperative assessment, it is advisable to question all patients directly about their use. Particular attention should be given to Chinese herbal teas, which include organic compounds and toxic contaminants that may produce renal fibrosis or failure, cholestasis, hepatitis, and thrombocytopenia. Specific recommendations for discontinuance of many such agents have been developed.

The authors also discuss anesthesia in morbidly obese patients. Initial management should be based on the assumptions that: (1) a difficult airway is likely; (2) the patient will be predisposed to hiatal hernia, reflux, and aspiration; and (3) rapid arterial desaturation will occur with induction of anesthesia as a consequence of decreased functional residual capacity and high basal oxygen consumption. Often, the safest option is an awake fiberoptic intubation with appropriate topical anesthesia and light sedation. In expert hands, this technique is extremely well tolerated and can usually be performed in less than 10 minutes. Morbidly obese patients often are hypoxemic at rest and have an abnormal alveolar-arterial oxygen gradient caused by ventilation-perfusion mismatching. The combination of general anesthesia and the supine position exacerbates alveolar collapse and airway closure. Mechanical ventilation, weaning, and extubation are usually performed on the 5th postoperative day.
Common coding hotline questions
by the Division of Advocacy and Health Policy

Q. How do we code for an excision of an inguinal benign tumor located in the inguinal canal?
A. Report code 27048, Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular, because the subfascia and muscle are involved.

Q. How do we report an excision of an infected vein?
A. We used code 37799, Unlisted procedure, vascular surgery, but the payor said it does not accept unlisted codes.
There is no CPT code for an excision of an antecubital cephalic vein. If the payor does not accept the unlisted code, request written instructions in writing regarding its policies for reporting the service. If the claim is resubmitted with another code without written guidance from the carrier, it could be considered fraudulent coding.

Q. How do we code for a partial colectomy?
A. If the colectomy is performed for the removal of a lesion, use code 44110, Excision of one or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy. If the procedure is performed for another reason, report code 44140, Colectomy, partial; with anastomosis, with modifier -52 appended.

Q. How do we code when the physician uses fibrin glue to repair an anal fissure?
A. Use code 46706, Repair of anal fistula with fibrin glue. This code is new in CPT for 2003.

Q. How do we report a colonoscopy with excision of colon polyp with cold forceps?
A. Depending upon the technique employed, either of two codes could be reported: 45380, Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple; or code 45385, Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique.

**Socioeconomic tips of the month**

**Common coding hotline questions**

by the Division of Advocacy and Health Policy

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**Around the corner**

May
Q. **What code should we use for parastomal hernia repair?**

A. If there is no revision of the stoma, use the appropriate code in the 49500 series for incisional hernia repair. If a revision is performed, report code 44346, Revision of colostomy; with repair of paracolostomy hernia (separate procedure).

Q. **If the patient’s family members come to the office to talk to the physician regarding the patient’s cancer situation and the patient is not present, may we charge for that visit? The family is not a court-appointed decision maker.**

A. Because the patient’s family lacks legal authority, the visit is not billable to the patient’s insurance. If family members have power of attorney, the service could be reported as if the patient was present. Report the appropriate E&M code, providing documentation, if requested.

Q. **Will Medicare reimburse for a screening if we report the service using an ICD-9-CM V code?**

A. Code based on the reason for the patient’s visit. If the patient presents with no symptoms, it would be appropriate to report the service using the correct ICD-9-CM V code for a screening. Always check carrier bulletins and local medical review policies for reporting and reimbursement instructions. If screening for a particular condition is not a covered service, the payment for the procedure becomes the patient’s responsibility.

Q. **May we use a signature stamp in lieu of a signature on submitted claims?**

A. A stamp may be used if the physician is the only individual with access to it. It should be noted that state law regarding the use of signature stamps takes precedent over national policy.
Faculty Research Fellowships awarded by College

Ten American College of Surgeons Faculty Research Fellowships for 2003 were awarded by the ACS Board of Regents in February. These two-year fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty and carry grants of $40,000 per year from July 1, 2003, through June 30, 2005. All of the fellowships are funded by the Scholarship Endowment Fund of the College. The recipients are:

**Allan N. Goldstein, MD**, instructor in surgery, Massachusetts General Hospital, Boston, MA. Research project: A New Model of Intestinal Aganglionosis: Essential Role for BMP Signaling in Enteric Nervous System Development. Dr. Goldstein’s fellowship—the Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons—is named to honor Dr. Martin, founder of the College.

**John A. Olson, Jr., MD, PhD, FACS**, assistant professor, Duke University Medical Center, Durham, NC. Research project: Identification and Characterization of New BRCA1 Interacting Proteins.


**Karl G. Sylvester, MD**, assistant professor, Stanford University Medical Center, Stanford, CA. Research project: Tolerance Induction through Stromal Cell Co-Transplantation for Enhanced Mixed Allogeneic Chimerism.

**Seth J. Karp, MD**, instructor, surgery, Johns Hopkins University, Baltimore, MD. Research project: Molecular Pathways Common to Liver Growth and Development.

**Brajesh K. Lal, MD**, assistant professor, University of Medicine and Dentistry of New Jersey, Newark, NJ. Research project: Hyperglycemia Inhibits Vascular Endothelial Proliferation and Survival by Modulating Insulin Signaling.
Douglas J. Turner, MD, assistant professor, University of Maryland, Baltimore, MD. Research project: Regulation of Intestinal Epithelial Repair by Substance P. Dr. Turner’s fellowship—the C. James Carrico, MD, FACS Faculty Research Fellowship for the Study of Trauma and Critical Care—honors the late Dr. Carrico.

Isaac Samuel, MBBS, FACS, assistant professor, University of Iowa, Iowa City, IA. Research project: Role of CCK Receptor in Acute Pancreatitis Pathogenesis.

Gregory P. Victorino, MD, assistant professor, University of California San Francisco-East Bay, Oakland, CA. Research project: The Effect of Ischemia and Reperfusion on Microvascular Permeability: Involvement of Nitric Oxide, Endothelin-1, and Angiotensin II.

Cynthia Ann Gingalewski, MD, assistant professor, University of Massachusetts, Worcester, MA. Research project: The Role of the Toll-Like Receptor in Necrotizing Enterocolitis.

The Scholarship Endowment Fund of the American College of Surgeons was established in 1965 to provide income to fund scholarship and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are invited. Fellows interested in making gifts to fund these vital programs are encouraged to contact the Development Office at 312/202-5376.

Six American College of Surgeons Resident Research Scholarships for 2003 were awarded by the Board of Regents in February 2003. The scholarships are offered to encourage residents to pursue careers in academic surgery, and carry awards of $30,000 for each of two years, beginning July 1, 2003. The recipients are:

**Allan Tsung, MD**, resident in surgery, University of Pittsburgh School of Medicine, Pittsburgh, PA. Research project: Role of the L-Arginine/Nitric Oxide Pathway in Liver Ischemia/Reperfusion Injury. The scholarship is sponsored by the Scholarship Endowment Fund of the College.


**Dax A. Guenther, MD** (not pictured), resident in surgery, Massachusetts General Hospital, Boston, MA. Research project: Induction of Tolerance to the Indirect Pathway of Allore cognition by Loading Host Dendritic Cells with Donor MHC Peptides. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

**Chad A. Perlyn, MD**, resident in surgery, Barnes-Jewish Hospital/Washington University, St. Louis, MO. Research project: Roles of Fibroblast Growth Factor Receptor-3 in Normal and Abnormal Skull Development and Growth. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

**Amy S. Colwell, MD**, resident in surgery, Brigham and
Women's Hospital, Boston, MA. Research to be performed at Stanford University. Research project: Microarray Analysis of Fetal Wounds. The scholarship is sponsored by Ethicon, Inc. **Elizabeth Jay Renaud, MD**, resident in surgery, Boston University, Boston, MA. Research to be performed at Massachusetts General Hospital. Research project: The Role of Mullerian Inhibiting Substance and the Mullerian Inhibiting Substance Type II Receptor in Neoplasms of Mullerian Duct Origin. The scholarship is sponsored by the Scholarship Endowment Fund of the College. Further information regarding the scholarships, fellowships, and awards offered by the College for 2004 was published in the January Bulletin and appears on the College’s Web site, www.facs.org/dept/fellowship/acsresident.html.

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**Trauma meetings calendar**

The following continuing medical education courses in trauma are scheduled.

The courses are sponsored by the American College of Surgeons Committee on Trauma and Regional Committees.

- **Trauma and Critical Care 2003—Point/Counterpoint XXII**, June 2-4, 2003, Atlantic City, NJ.
- **Advances in Trauma**, December 12-13, 2003, Kansas City, MO.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at http://www.facs.org/dept/trauma/cme/traumtgs.html or by contacting the Trauma Office at 312/202-5342.

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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, the diplomate is issued a certificate valid for 10 years from the date of expiration of the original certificate. In November 2001, 212 diplomates sat for recertification; 210 diplomates (99%) successfully completed the recertification process.

Currently, there is discussion among the ABMS member boards regarding maintenance of certification that would entail, among other things, ongoing monitoring of physicians by the certifying boards. The ABU is actively discussing the maintenance of certification issue, but the trustees have significant concerns regarding the implementation of the proposal.

**Officers and trustees**

Current officers and trustees are: Martin I. Resnick, MD, FACS, president; Michael E. Mitchell, MD, FACS, vice-president; Paul F. Schellhammer, MD, FACS, president-elect; Joseph A. Smith, Jr., MD, FACS, secretary-treasurer; Peter C. Albertsen, MD, FACS; Peter R. Carroll, MD, FACS; Michael J. Droller, MD; Robert C. Flanigan, MD, FACS; Mani Menon, MD, FACS; Linda M. Shortliffe, MD, FACS; Howard M. Snyder III, MD, FACS; and Robert M. Weiss, MD, FACS.
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Super preferred rates are for best health risks. Economical preferred and standard rates are also available. Policies are only available in the United States and Canada. Not available in all states.
The American College of Surgeons' Division of Education has established four special task forces to address the competencies of Interpersonal and Communication Skills, Systems-based Practice, Practice-based Learning and Improvement, and Professionalism. These competencies have been adopted by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. The task forces will address the spectrum of educational items relating to the aforementioned competencies within the context of both residency training and maintenance of certification. Educational models will be developed to serve the needs of learners across the various surgical specialties.

The Education Task Force on Practice-based Learning and Improvement met at the College’s headquarters in Chicago, IL, January 6-7, 2003. The task force was chaired by Richard J. Finley, MD, FACS, FRCSC. During the meeting, key issues were reviewed in presentations delivered by William C. Nugent, MD, FACS; Robin S. McLeod, MD, FACS, FRCSC; John Parboosingh, MB, FRCSC; and James N. Thompson, MD, FACS.

During the meeting, small groups addressed development and implementation of a national program of practice-based learning and improvement; application of evidence-based surgery to practice-based learning and improvement; use of state-of-the-art technology in models of practice-based learning and improvement; and innovative educational methods to address practice-based learning and improvement. The groups were led by Dr. Nugent, Dr. McLeod, M. Michael Shabot, MD, FACS, and Ajit K. Sachdeva, MD, FACS, FRCSC, respectively. Membership of this task force includes representatives from the various surgical specialties.

The productive discussions resulted in a large number of significant recommendations, which will serve as the foundation for further steps.

For further information on the activities of the Education Task Force on Practice-based Learning and Improvement, please contact Dr. Sachdeva, Director, Division of Education, at 312/ 202-5405 or via e-mail at asachdeva@facs.org.
The Division of Education of
the American College of Surgeons
has made seven General Sessions
from the Clinical Congress available
online at [www.facs-ed.org/](http://www.facs-ed.org/)

## Available courses:

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<tr>
<th>Course Code</th>
<th>Title</th>
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<tr>
<td>GS 08</td>
<td>New Technology: What’s Proven, What’s Not</td>
</tr>
<tr>
<td>GS 10</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>GS 21</td>
<td>Damage Control in Trauma and Emergency Surgery: New Applications</td>
</tr>
</tbody>
</table>
| GS 23       | Programa Hispanico (Offered in English and Spanish):
  - Surgical Management of Breast Cancer
  - Status of Liver Transplantation in Latin America
  - Bariatric Surgery Update
  - Management of Pancreatic Cancer |
| GS 33       | The Ethics of Entrepreneurialism in Surgery |
| GS 34       | Should Axillary Dissection Be Abandoned? |
| GS 40       | Management of Metastatic Disease of the Liver |

— Each session is offered separately.
— Printable written course transcripts.
— Audio of sessions.
— Video of speakers’ presentations.
— Post-test and evaluation.
— Printable CME certificate upon successful completion.

For more information, contact Dawn Pagels at dpagels@facs.org.
In 1989, the ACS Board of Regents committed significant resources to establish the National Trauma Data Bank™ (NTDB) as a central national repository of data on trauma and trauma care. At the present time, the NTDB contains more than 400,000 records from 130 trauma centers in the U.S.

The most recent report from the NTDB—the 2002 Annual Report—is an updated analysis of the largest aggregation of trauma registry data that has ever been assembled. The purpose of this report is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.

Injury is the leading cause of death in the U.S. for people less than 40 years of age. Upon closer examination, we see two early peaks (18–21 and 36–37). As we get older and pass those milestones, one has the sense that we have made it over the hurdle and are less likely to become a trauma statistic. In looking at the 430,577 records of the second annual report of the NTDB, we see the same trimodal distribution of injury that was identified in the first report—a finding that earned its place on the cover of that report (see table, above).

At 80 years of age there is a third peak of trauma. As one would expect, this is primarily due to blunt mechanism, including motor vehicle related injuries and falls. If one takes a closer look at this peak, one can see, for the first time, a female preponderance.

A complete copy of the report may be found at http://www.facs.org/dept/trauma/ntdbannualreport2002.pdf.

If you are interested in submitting your trauma center’s data, contact Melanie Neal, Manager, NTDB, at mneal@facs.org.

Future issues of the Bulletin will provide ongoing coverage of the NTDB and findings from the 2002 Annual Report.
bation may be difficult and dangerous, especially in the presence of significant obstructive sleep apnea. Postoperative pulmonary complications (such as pneumonia, aspiration, atelectasis, and emboli) are common. Subscribers may view the full text of this article at www.acssurgery.com.

Looking ahead
New and revised chapters scheduled to appear as online updates to ACS Surgery: Principles and Practice in the coming months include the following:
- “Surgical incisions,” by Karen Fogelberg, MD, and F. William Blaisdel, MD, FACS.
- “Emergency department evaluation of the patient with multiple injuries,” by Felix Battistella, MD, FACS.
- “Multiple organ dysfunction syndrome,” by John C. Marshall, MD, FACS.

The May issue of the Journal of the American College of Surgeons will feature:

Original Scientific Articles:
- Complications and Costs after High-Risk Surgery
- Watchful Waiting Versus Routine Herniorrhaphy
- Barrett’s Esophagus after Antireflux Surgery
- Surgical Treatment of Esophageal Achalasia

What’s New in Surgery:
- Cardiac Surgery
- General Surgery: Transplantation