

# BULLETIN

AMERICAN COLLEGE OF SURGEONS



August 2003  
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*Chapter leaders  
head to the Hill*

*2003 Chapter Officers and Young Surgeons  
Leadership Conference*

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# From my perspective

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**A**lmost all surgeons, regardless of specialty, agree that the competitive surgeon of the next 10 to 20 years will need to possess a different set of skills than we have needed in the past. Therefore, it is important that organizations like the College identify the characteristics of the twenty-first century surgeon and that we pattern today's programs on the anticipated needs of the near future.

In this column, I identify what I think will be the essential attributes of surgery and surgeons of the future. It is perhaps presumptuous of me to attempt to predict the future, and you may agree or disagree with my theories. In either case, I would appreciate hearing your ideas and receiving your feedback.

## *Early exposure*

As we all know quite well, a major problem facing the future of this profession is the declining interest in surgical training among individuals in medical school. So, first of all, we will have to make the surgical specialties attractive to medical students and introduce them to the joy of a career in surgery during their formative years.

One way in which we already are piquing medical students' interest in surgery is by introducing them to some of the technical aspects of practice while they are still in medical school. For example, medical students at some schools are using simulators to assess their cognitive and technical skills. Such exercises should be more enjoyable for young, technologically adept people than is standing in operating rooms for lengthy periods of time holding retractors.

Students and residents who do identify surgery as an option must be exposed during medical school or the early years of residency to the core curriculum that all surgeons or interventionists will need in the future. Issues such as wound healing, infection, fluids and electrolytes, and blood management are important core areas of understanding, regardless of whether someone has identified neurosurgery or ophthalmology as his or her chosen specialty. Furthermore, training in the basic knowledge of physiology, which all surgeons need to possess, will be key subjects to be covered in the early stages



**“The competitive surgeon of the next 10 to 20 years will need to possess a different set of skills than we have needed in the past.”**

of training as more and more specialists become involved in interventionist care and claim to be “surgeons.”

## *Core competencies*

The American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education have developed a list of core competencies for all physicians, based on the realization that modern medical professionals need to be not only capable of providing scientifically sound services, but also able to perform successfully in other areas as well. Surgeons must be trained in these core competencies and must embrace and maintain these skills throughout their entire professional careers. As noted in several columns in the past, in addition to medical knowledge and patient care the competencies that must be introduced to residents and sustained throughout their professional lifetimes include interpersonal and communications skills, professionalism, practice-based learning and improvement, and systems-based practice. These competencies identify the future.

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To maintain their commitment to lifelong learning, surgeons must be computer literate because much of the continuing medical education (or continued professional development, to use perhaps a better phrase) will be Web-based in the coming years. Additionally, resident education will involve the use of simulators and experiences outside the operating room as the learning process moves away from the traditional approach of “see one, do one, teach one” to “see one, practice many, and do one.”

### **Guidelines and outcomes**

As residents are now working under defined work-hour limitations, it will become important to begin incorporating best processes of care into training and for use throughout one’s full career. Clearly, some of these guidelines have already been developed, but they will need to be further refined, applied, and modified as time goes by. I believe the surgeon of the future will definitely be comfortable using standards of care to define decision making and remain within accepted practice specifications. All will be working as team members.

The surgeon of the future will also need to be aware of accurate outcomes data that demonstrate the short- and long-term effects of operative procedures. As a result, surgeons will need to analyze not only morbidity and mortality, as we do today, but also the long-term functional results of an operative procedure.

Clearly, surgeons will have to document their outcomes and share this information not only with their respective patients, but with payors and the credentialing and privileging bodies of their hospitals as well. The public is expected to become progressively more sophisticated in their selection of providers, and, again, the competitive surgeon will need to be able to readily supply outcomes on specific procedures.

### **Maintenance of certification**

The maintenance of a surgeon’s certification will come under increased scrutiny and will be a more timely and rigorous process. Surgeons must accept this reality and anticipate having periodic cognitive testing in areas of their specialty every few years and of their technological skills with the use of simulators as they progress in their professional careers. Furthermore, it is not inconceivable that

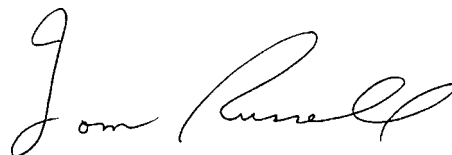
surgeons will be required to undergo periodic physical examinations and other evaluations, such as drug and alcohol screening. Also, it is certainly possible that work-hour restrictions will be imposed upon surgeons in practice, just as they recently have been imposed on surgeons in training.

Again, with patient safety being our paramount concern and goal, the acquisition of new surgical skills for individuals in practice will be much more structured in the future. Going to weekend courses supported by industry and then performing a newly learned procedure on patients the following week will not be acceptable. Surgeons will be required to undergo retraining in centers that are geographically distributed throughout the U.S. and that have restricted affiliations with industry. New skills will need to be acquired not only through a didactic process, but also through hands-on training courses that are properly proctored and monitored once these services are introduced in local hospitals.

### **Other skills**

Surgeons of the future will also need to have more sophisticated leadership, business, and negotiation skills. Having these capabilities will become more necessary as our health care system continues to change and as payment and regulatory constraints intensify.

Some surgeons may believe that all of these activities will ultimately result in a ban on clinical autonomy. That perspective may have some validity, but, hopefully, these changes will lead to more standardized and provable ways of practicing surgery. In turn, our practices will be safer for our patients and driven by education, outcomes analysis, and continued improvements.



*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).

# FYI: *STAT*

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❖ **Rep. Jim Greenwood (R-PA)** was the featured speaker at a breakfast meeting held during the College's Chapter Officers and Young Surgeons Leadership Conference on June 24. Mr. Greenwood—who consistently shares the surgical perspective on issues such as medical liability reform, Medicare payment policies, and trauma system development—emphasized the importance of surgeon involvement in grassroots advocacy, particularly where the medical liability issue is concerned.

❖ Also during the Chapter Officers and Young Surgeons Leadership Conference, Thomas R. Russell, MD, FACS, ACS Executive Director, announced the establishment of **an award recognizing more than 40 years of leadership and service by Art Ellenberger, Executive Director of the New Jersey Chapter** of the College. Chapter President Robert Davies, MD, FACS, was on hand to present Mr. Ellenberger with the inaugural plaque. The award will recognize outstanding leadership in state advocacy for members of the College and their surgical patients. Future recipients will have their names engraved on a large plaque that will hang in a prominent place in the College's Washington Office. For more information, contact [cgallagher@facs.org](mailto:cgallagher@facs.org).

❖ Don't forget to visit <http://www.facs.org/2003clincon/index.html> to **register online and make hotel reservations for the 89th Annual Clinical Congress in Chicago, IL, October 19-23, 2003**. Each year the Clinical Congress brings thousands of surgeons together to learn, teach, and share experiences about the joys and challenges of contemporary surgical practice. Don't miss this exciting educational opportunity. Registration is free for Fellows, Initiates, Associate Fellows, Candidate Group Members, and Medical Student Members.

❖ The **American College of Surgeons Oncology Group (ACOSOG)** recently launched a new Web site at <http://www.acosog.org>. The new site features a new design and an updated structure, making it easier to read and allowing users to find the information they need more quickly.

# Dateline|Washington

*prepared by the Division of Advocacy and Health Policy*

## **Senators block medical liability reform**

In July, Senate Majority Leader Bill Frist, MD, FACS (R-TN), attempted to bring the Patients First Act of 2003 (S. 11) to the floor for debate and a vote. This medical liability reform legislation was introduced by Sen. John Ensign (R-NV) and is almost identical to H.R. 5, the HEALTH Act of 2003, which the House passed in March. Unfortunately, the Senate vote of 49-48 failed to reach the 60-vote threshold needed to bring such a controversial measure up for consideration.

The medical liability reform provisions contained in both the House and the Senate bills are based on the California Medical Injury Compensation Reform Act of 1975. The College and its coalition partners are continuing their efforts to persuade the Senate of the critical need to pass such legislation.

## **Physician supply higher in states with noneconomic damage caps**

States that limit noneconomic damage awards in medical liability lawsuits have about 12 percent more physicians per capita than states without such caps, according to a study released in July by the Agency for Healthcare Research and Quality (AHRQ).

The study examined the growth of physician supply since 1970, before any state had enacted a cap on noneconomic damage awards, and found that the number of physicians has increased more in states with caps. "Our broken medical litigation system is affecting patients' ability to find a doctor," said Tommy G. Thompson, Secretary of the Department of Health and Human Services (HHS). "This study confirms and quantifies the association between reasonable limits in medical lawsuits and the supply of physicians available to treat patients who need them," added Thompson, whose department runs AHRQ.

The study analyzed state experiences over the last 30 years, and adjusted for the impact of multiple factors that are believed to affect physician supply (such as per capita income and physician residency training programs.) The authors, Fred Hellinger, PhD, and William Encinosa, PhD, suggested that "...these findings demonstrate that state laws limiting noneconomic damages in medical malpractice cases increase the number of physicians who practice in the states." The authors find that by 2000, states that had enacted caps had a significantly higher number of physicians per 100,000 county residents (135) compared to states without caps (120). In contrast, in 1970 there was no statistically significant difference between states in their per capita supply of physicians.

## **Trauma bills progress**

On June 23, S. 239, the Trauma Care Systems Planning and Development Reauthorization Act of 2003, passed the Senate by unanimous consent. Senator Frist and Sen. Edward Kennedy (D-MA) introduced the legislation, which the College actively endorsed and supported. If passed in the House, the legislation will reauthorize the trauma program through 2008, improve the collection and analysis of trauma patient data, reduce the amount of matching funds that states must provide to participate in the program, authorize an Institute of Medicine study on the state of trauma care and research, and double the fund-

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## HHS to study Medicare pay for performance

ing available for this program to \$12 million. A House companion bill is expected to be introduced by Rep. Jim Greenwood (R-PA) in the fall.

In other trauma news, the Senate and House Appropriations Committees included \$3.5 million to fund the trauma program in FY 2004. To encourage the House and Senate Appropriations Committees to provide an increase for the funding of the trauma care systems program, legislators in both chambers circulated a sign-on letter to their colleagues expressing support for increased funding. The letter was championed by Sens. Pat Roberts (R-KS) and Jack Reed (D-RI), and by Reps. Greenwood and Luis Gutierrez (D-IL), with 54 senators and 128 representatives cosigning.

HHS Secretary Tommy G. Thompson announced the next step in the Medicare program's effort to improve and reward delivery of high-quality inpatient care. The Centers for Medicare & Medicaid Services (CMS) in conjunction with Premier Inc., a not-for-profit group purchasing collaborative of 1,500 facilities, will voluntarily track hospitals' clinical performance in five areas: acute myocardial infarction, coronary artery bypass grafts (CABG), heart failure, community-acquired pneumonia, and hip and knee replacement.

Measures of greatest interest to surgeons include CABG mortality, appropriate identification and administration of prophylactic antibiotics before surgery, postoperative hemorrhage or hematoma (risk-adjusted, requiring a return to the operating room), and readmission for hip and knee replacement. A complete list of measures will be published on the CMS Web site at <http://www.cms.gov>.

The three-year demonstration project will score 35 individual quality measures, and hospitals that rank in the top 10 percent for a given condition will receive a 2 percent bonus on their Medicare payments. Those that score in the next 10 percent will receive a 1 percent bonus. All hospitals in the upper 50 percent quartile will be publicly recognized by CMS for their quality efforts. Medicare will pay \$21 million in incentives during the three-year term of the project. During the third year, however, hospitals with performance rankings falling in the bottom 20 and 10 percent will receive 1 and 2 percent less in their Medicare revenues, respectively.

Premier's "Perspective Online" database will track the results of participating hospitals and report the progress to the hospitals for quality improvement purposes. CMS will post the results of their progress on their Web site.

## CMS cancels adjustment

CMS has canceled the plan to process an automatic mass adjustment of incorrect payments for services delivered to Medicare beneficiaries in January and February 2003. The possibility of incorrect payments to providers was the result of a delay in the implementation of the 2003 Medicare fee schedule. Physicians will not receive any "demand" letters asking for repayment of any incorrect payments; however, carriers have been instructed to respond to any provider requests for adjustment to payments.



# Health care and competition law and policy:

## *A year-long dialogue*

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

Health care is a large and important component of the nation's economy. Spending in this sector climbed to \$1.4 trillion in 2001, more than 14 percent of the U.S. gross domestic product (GDP) in 2001—an 8.7 percent increase in spending from the previous year. If growth in health care spending continues unchecked, experts predict that it will represent more than 23 percent of the GDP in 2011.<sup>1</sup>

Of course, most health care professionals know all too well that health care costs in the private sector are rising. The results of a national survey indicated that employers' health insurance premiums increased 12.7 percent from 2001 to 2002, even though the general inflation rate was only 1.6 percent. This jump in premiums was the highest since 1990.<sup>2</sup> The survey also showed that employers reacted to those increases by increasing their employees' deductibles and copayments, reducing benefits, or, in some cases, eliminating health insurance coverage completely. The end result, of course, is higher out-of-pocket costs for patients.

Although many factors are likely to have influenced increases in health care spending and costs, market competition plays a role in containing costs and promoting high-quality care. The Department of Justice (DOJ) and Federal Trade Commission (FTC) work to promote that competition by enforcing the antitrust laws. The agencies have considerable experience in the application of competition law and policy to health care. In the past decade, they have

brought dozens of cases annually. Together they drafted health care policy statements in 1993 and substantially revised them in 1996.<sup>3</sup>

**Agencies review issues**

Earlier this year, the FTC and DOJ began public hearings in Washington, DC, to review the implications of competition law and policy for health care financing and delivery. These Health Care and Competition Law and Policy hearings are an extended examination of the state of the health care marketplace and the roles of competition, antitrust enforcement, and consumer protection in satisfying consumer preferences for high-quality, cost-effective care.

“Health care competition law and policy are critical to consumers,” explained Assistant Attorney General Charles A. James. “It is incum-

bent upon government policymakers to understand the implications of the actions they take in these areas, and we look forward to receiving valuable input from relevant medical, insurance, legal, academic, and government groups through these hearings.”<sup>4</sup>

The FTC and DOJ continued these hearings to enhance their understanding in this area and to promote learning among the relevant parties. They have broadly considered the impact of competition law and policy on the cost, quality, and availability of health care, as well as the incentives for innovation in the field. The College was pleased to accept an invitation to testify twice during the sessions, which will conclude next month.

Last September, the agencies held a short workshop on health care issues. That workshop dem-

## Topics at the Health Care and Competition Law and Policy Hearings

<i>February</i>	Overview of Issues Arising at the Intersection of Health Care and Competition Law. Perspectives on Competition Policy and the Health Care Marketplace. A Tale of Two Cities: Boston and Little Rock.
<i>March/April</i>	Defining Product and Geographic Markets for Hospitals. Single Specialty Hospitals. Contracting Practices. Issues in Litigating Hospital Mergers. Hospitals—Horizontal Networks and Vertical Arrangements; Non-profit Status; Joint Ventures and Joint Operating Agreements; Post-Merger Conduct.
<i>April/May</i>	Health Insurance Monopoly Issues—Market Definition; Competitive Effects; Entry and Efficiencies. Health Insurance Monopsony Issues—Market Definition; Competitive Effects. Health Insurance/Providers—Countervailing Market Power. Most Favored Nation Clauses. Physician Hospital Organizations.
<i>May/June</i>	Quality and Consumer Information: Overview; Hospitals; Physicians. Quality and Consumer Protection: Market Entry. Noerr Pennington/State Action. Long-Term Care/Assisted Living Facilities. Financing Design/Consumer Information Issues. Information and Advertising. Dietary Supplements. Mandated Benefits. Pharmaceuticals: Formulary Issues. Prospective Guidance.
<i>September</i>	Physician Product and Geographic Market Definition. Physician IPAs—Patterns and Benefits of Integration; Messenger Model. Physician Unionization/Collective Bargaining. Physician Information Sharing. Quality and Non-price Competition: Providers; Payors. Privacy Issues. Remedies: Civil; Criminal. Medicare and Medicaid. International Perspectives on Health Care and Competition Law and Policy.

Source: Federal Trade Commission, [www.ftc.gov](http://www.ftc.gov).

onstrated the range and complexity of issues arising from the intersection of health care and competition law and policy and revealed a diversity of views on the appropriate role and priorities for the administration in this important area of the economy. The agencies determined that further inquiry would help inform the framing and implementation of competition law and policy as applied to health care. This is only the second time that the DOJ and the FTC have jointly sponsored a series of hearings. Especially in the field of health care, the work of the two agencies is complementary.

"[T]hese hearings exemplify the benefits of having two separate agencies working on competition related issues," commented R. Hewitt Pate, Acting Assistant Attorney General.<sup>5</sup>

"Perhaps these benefits are unintended, as many observers have suggested that nobody would have designed a system with two separate antitrust enforcers having significant overlapping responsibility...some of life's most effective arrangements are less the product of elegant design than of historical accident and years of hard work."

Many experts believe that the overlapping efforts of the FTC and DOJ will complement each other and provide real benefits in terms of promoting competition for the benefit of consumers. The jurisdiction of the agencies, of course, differs. The DOJ is exclusively charged with criminal antitrust enforcement, while the FTC spearheads the consumer protection functions. The former focuses more on law enforcement, while the latter concentrates on policy and empirical research.

"There are substantial consumer benefits and synergies from creating an agency combining administrative expertise and enforcement authority, addressing antitrust, consumer protection, and competition advocacy," explained FTC Chairman Timothy Muris in a speech last November outlining his plans for the hearings.<sup>6</sup> "Since 1975, when

### *Additional resources*

#### **U.S. Department of Justice**

<http://www.usdoj.gov/atr/hc hearing.htm>

#### **U.S. Federal Trade Commission**

<http://www.ftc.gov/ogc/healthcarehearings/index.htm>

#### **ACS Testimony**

Frank G. Opelka, MD, FACS

<http://www.facs.org/ahp/testimony/opelka.html>

LaMar S. McGinnis, Jr., MD, FACS

<http://www.facs.org/ahp/testimony/mcginnis.html>

the commission sharpened its focus on this area, through six presidents and eight chairmen, the commission has maintained a leadership role in implementing competition law and policy in health care," he said.

Over the course of the year, the agencies have had the opportunity to examine a myriad of health care issues. The specific subjects considered include hospital mergers, the significance of not-for-profit status, vertical integration, quality and efficiencies, monopsony power, the adequacy of existing remedies for anticompetitive conduct, and the implications of the FTC's consumer protection mandate with regard to the performance of the health care financing and delivery markets. (See box, p. 9.)

#### **College testifies**

Several sessions dealt specifically with physicians. Frank G. Opelka, MD, FACS, and LaMar S. McGinnis, Jr., MD, FACS, both testified on behalf of the College. In February, Dr. Opelka's remarks examined the state of the health care marketplace and the role of competition, antitrust, and con-

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sumer protection in satisfying consumer preferences for high-quality, cost-effective care. Dr. McGinnis focused on the competitive aspects of physician quality improvement initiatives at the May session.

“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,” remarked Dr. Opelka. His comments addressed a number of marketplace issues, including consolidation of the health insurance industry, all-products clauses, undisclosed fee schedules, unilateral amendments by payors, delayed payments, and insurance antitrust exemptions.

“As a physician, I am forced to accept lower fees with no relationship to the cost of service. I have waded through stacks of paperwork and managed countless administrative burdens. Frankly, as an individual physician, I feel powerless. I alone lack the bargaining power to compel change for the good of care delivered to my patients,” Dr. Opelka concluded.

Dr. McGinnis participated in a panel devoted exclusively to quality measurement, reporting, and improvement, stating, “The College takes its responsibility to share information with patients seriously. To that end, the College has produced information that enables patients to protect themselves from unfair, deceptive, and fraudulent practices.” He explained that the College publishes a range of tools designed to educate consumers about quality and enable them to make informed decisions about their surgical care. He also went on to describe some of the College’s past and current activities to improve the quality of surgical patient care.

“Comprehensive and systemwide efforts to measure, and ultimately improve, health care quality have really just begun,” Dr. McGinnis explained. “As a result, the availability of truly useful comparative information for consumers is very limited. Nonetheless, quality improvement is a founding principle of the College and will continue to remain an essential part of our initiatives in the future.”

Overall, these hearings will assist the agencies by providing timely information from varying perspectives on how competition law and policy affects health care markets and patient welfare. The goal is to promote dialogue, learning, and consensus-building among all interested parties. These communities include patients, physicians, other providers, business, government, and insurers. The College was pleased to be invited to participate and will continue to work with both agencies to protect physicians and patients. 

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# DISASTER AND MASS CASUALTY MANAGEMENT: A COMMENT ON THE ACS POSITION STATEMENT

by Eric R. Frykberg, MD, FACS, Jacksonville, FL

On September 11, 2001, the U.S. was dealt a body blow from which we are still recovering. Beyond the ruthlessness and evil of the attacks on the World Trade Center and the Pentagon, and the tragic loss of innocent lives, was our realization of how naïve and unprepared we were for the consequences of terrorism that much of the rest of the world experiences regularly. We had developed a complacency as to our invulnerability to such attacks, feeling that terrorist activity only affects others in faraway places. We felt no motivation to plan for such attacks or their prevention, as much of the rest of the world does with greater effectiveness.

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In fact, America has been feeling the bite of terrorist murders of our citizens for at least two decades, including, among many incidents, the bombing of the U.S. Marine barracks in Beirut in 1983, the TWA hijacking in Beirut in 1985, the bombing of Pan Am Flight 103 over Lockerbie, Scotland, in 1988, the World Trade Center bombing in 1993, the Oklahoma City bombing in 1995, the Khobar Towers bombing in Saudi Arabia in 1996, the Centennial Olympics bombing in Atlanta in 1996, the two U.S. Embassy bombings in Africa in 1998, and the bombing of the USS *Cole* in Yemen in 2000. In 1990 alone there were over 1,500 isolated instances of terrorist bombings within our own country with

more than 220 casualties and 27 deaths. On sober reflection about our sudden awakening to the need for preparedness after 9/11, it could be asked, “What took us so long?”

Certainly the American medical community recognized its disturbing lack of preparedness and experience in caring for the victims of mass casualty disasters after 9/11, as it did also following the Oklahoma City bombing six years before and the World Trade Center bombing eight years before. It is clear that managing large numbers of acutely injured victims who present all at once involves principles quite different from our everyday management of injured patients. These principles must be learned as a

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new and distinct skill set through an intense educational effort if we are to reach the proper levels of medical preparedness for terrorist events.


This education is especially true for the community of surgeons represented by the American College of Surgeons. Surgeons should be the obvious leaders of disaster planning and management efforts at the local, regional, and national level, as triage and rapid decision making for large numbers of patients are an integral part of what we normally do every day. In particular, trauma centers and systems represent an infrastructure for disaster management and a national disaster system that is already in place, as they already include and have the essential liaisons with the prehospital services, government bodies, law enforcement, search and rescue, health care resources, and public health agencies that are essential to comprehensive disaster management.

Clearly, history tells us that the most common and most likely problems that can be predicted to result from terrorist events, by far, involve severe bodily injury (that is, shootings, fires, bombings, building collapse), which falls entirely within the sphere of what surgeons do and what trauma centers are designed to handle. Even in the quite unlikely, but nonetheless possible, scenario of disasters that do not specifically involve surgical problems (for example, floods, hurricanes, earthquakes, and biologic, chemical, or nuclear events), surgeons and trauma centers will provide a valuable resource of personnel and equipment geared to the handling of mass casualties.

It is important that the apathy of past years, which led to surgeons and surgical organizations taking a backseat in the field of disaster preparedness, be replaced by vigorous efforts to energize, educate, and mobilize surgeons to actively participate in this field that should long ago have become an intrinsic part of surgical training and practice.

The American College of Surgeons has adopted the accompanying position statement (see p. 14), as drafted by the Committee on Trauma, to emphasize and justify the importance of surgical involvement in all disaster efforts and to assert its commitment to achieving

this goal. The statement also makes the point that surgeons must work as part of a large multidisciplinary team if we are to succeed in disaster management. The College, through the Ad Hoc Committee on Disaster and Mass Casualty Management of the Committee on Trauma, has already made great headway in developing liaisons with a number of important organizations involved in disaster planning and management, including the National Disaster Medical System, the Centers for Disease Control and Prevention, the Oklahoma State Injury Prevention Office, the American Public Health Association, the American College of Emergency Physicians, the National Association of EMS Physicians, the U.S. military, and the Department of Homeland Security. Several educational products and programs arising from these relationships have already been developed or are in development and are being made available through the ACS Web site.

We in the surgical community have a lot of catching up to do, but progress is being made. All surgeons are encouraged to become active in their own community disaster planning programs, and we invite all interested surgeons to participate in the College's activities to foster widespread understanding of disaster management. 

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# Statement on disaster and mass casualty management

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*The following statement was developed by the College's Ad Hoc Committee on Disaster and Mass Casualty Management of the Committee on Trauma, and was approved by the Board of Regents at its June 2003 meeting.*

**M**ass casualties following disasters are characterized by such numbers, severity, and diversity of injuries that can overwhelm the ability of local medical resources to deliver comprehensive and definitive medical care to all victims. Surgeons traditionally have played an important role in disaster response. The training and skills of surgeons, and the resources and infrastructure of trauma centers and trauma systems, are especially suited for the logistical demands and rapid decision making required by large casualty burdens following both natural disasters and manmade (biologic, nuclear, incendiary, chemical, and explosive, or "BNICE") disasters.

The American College of Surgeons believes that the surgical community has an obligation to participate actively in the multidisciplinary planning, triage, and medical management of mass casualties following all disasters. Surgeons should provide leadership at the community, regional, and national levels in disasters involving physical trauma to casualties that likely require surgical intervention and management (such as explosions, structural collapses, shootings, fires, or large-scale vehicular crashes).

Disaster management poses challenges that are distinct from normal surgical practice. It requires a paradigm change, from the application of unlimited resources for the greatest good of each individual patient to the allocation of limited resources for the greatest good of the greatest number of casualties. This change is achieved most effectively by planning and training for disasters, through both internal hospital drills and regional exercises involving all community resources. Rescue, decontamination, triage, stabilization, evacuation, and definitive treatment of casualties all require the smooth integration of multidisciplinary local, state, and federal assets. This integration would include (but not be limited to) prehospital services, the media, emergency management and public health agencies, trans-

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portation and communication resources, the military, and health care delivery facilities and personnel. The medical management of mass casualties is only one of many critical functions involved in the overall response to a disaster.

Education and training are especially important in:

- Disaster planning and rehearsal.
- Integration of local, regional, and national resources into a disaster system.
- Hospital Emergency Incident Command Systems (HEICS).
- Communications and security.
- Media relations.
- Protection of health care delivery personnel and facilities.
- Detection and decontamination of biological, chemical, and radiation exposure.
- Triage principles and implementation.
- Logistics of medical evaluation, stabilization, disposition, and treatment of victims.
- Record-keeping and postdisaster debriefing, critique, and reporting.
- Critical incident stress management (CISM).
- Published research and experience in disaster management.

It is incumbent upon all surgeons to attain an appropriate level of education and training in the unique principles and practice of disaster and mass casualty management, and to serve as role models in this field. The American College of Surgeons is committed to providing the leadership and resources necessary to achieve this goal.

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**Motion pictures  
and the College:**

**A history of  
"LEARNING  
BY SEEING"**

by  
**John S. O'Shea, MD, FACS,  
Brick, NJ**

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**I**n an age of robotics and virtual reality surgery, the motion picture may seem like a fairly primitive technology. But little more than three-quarters of a century ago, when the first “Cinematographic Exhibition” was presented at the Clinical Congress of Surgeons of North America, it was a revolutionary technological advance that allowed for expansion of the fundamental educational concept of “learning by seeing,” a principle on which the Clinical Congresses were established. The American College of Surgeons played an early and important role in the production, promotion, cataloging, and distribution of medical motion pictures for use in surgical education in an effort to raise surgical standards.

### Watch and learn

American College of Surgeons founder Franklin H. Martin, MD, FACS, believed that surgical education should be “democratized” beyond small elite groups and made accessible to all practicing surgeons, whether they were in urban academic settings or in rural private practices. The widespread acceptance of the journal *Surgery, Gynecology and Obstetrics*, originally published in 1905, convinced Dr. Martin that the profession preferred to receive information directly from practicing surgeons, and he further believed that it was far better to have a practicing surgeon demonstrate his work than to have him tell about it. Fellow Chicago surgeon John B. Murphy, MD, FACS, maintained that “Hearing papers and reading papers is one thing. Seeing men do things is another. We all know that no such benefit can be derived from hearing papers read as can be obtained from seeing the work done right before us.”<sup>1</sup>

The first Clinical Congress of Surgeons of North America met November 7-19, 1910, in Chicago, IL, and consisted of operative or “wet” clinics held from 8:00 am to 5:00 pm each day at various hospitals throughout the city. At the second Clinical Congress, held in Philadelphia, PA, November 7-16, 1911, approximately 1,500 doctors enrolled, and fully as many more attended the clinics without registering.

By the third meeting in New York, NY, in 1912, it had become apparent that the Congress had outgrown its original plans. The “wet clinics” were limited by significant space and time constraints.

The surgical theaters could accommodate only a small number of observers, many of whom had a less-than-optimal view of the operative field. Scheduling of the appropriate “difficult case” to coincide with the dates of the Congress could also be problematic. Many of these logistic problems could be obviated with the use of motion pictures.

### Introduction of film

Rudolph Matas, MD, FACS, of New Orleans, LA, in an address to the Southern Surgical and Gynecological Association in 1912, foretold the importance of “chronophotography” to surgical education by suggesting that “[n]ext to actually doing the thing, or seeing a skilled workman do it, is the seeing of it done in a series of motion pictures.” He proposed the inauguration of cinematographic courses that would illustrate “all the operations of surgery...as contributed by the most noted specialists in the surgical profession.”<sup>2</sup>

Medical motion pictures date to the 1890s and were initially used to illustrate such topics as abnormal gait, patient signs, and short medical and surgical topics. In 1898, Doyen of Paris and Messter of Berlin were among the first surgeons who allowed themselves to be filmed while operating.<sup>3</sup> Films made before 1915 were generally only one to four minutes in length because of the technical limitations of early photographic equipment. Certain technological advances, such as 16 mm film and equipment (1923), the ability to add sound to film with the use of the Vitaphone (1927), and improvements in color filming with the arrival of Kodachrome (1935), made it possible to produce films of high fidelity and realism.<sup>4</sup>

In addition to the urging of Dr. Matas, several factors were important in fostering the involvement of the American College of Surgeons with motion pictures. One was Dr. Martin’s acquaintance in Washington during World War I with Will H. Hays, president of Motion Picture Producers and Distributors, Inc. Another occurred during a European trip in 1925, when Dr. Martin saw several medical motion pictures prepared by some of his Parisian colleagues.

Following this experience, Dr. Martin enlisted the support of Mr. Hays as well as the interest of George Eastman, head of the Eastman-Kodak Company, in the study of the use of medical mo-

tion pictures for the education of surgeons. Mr. Hays, in addressing the Regents at their meeting on Oct. 29, 1926, said, "We have done much work with religious groups.... Now we come to this, perhaps the greatest chance...medicine and surgery.... There is certainly as much value in helping to save lives as there is value in helping to save souls.... We want to come in with you now, to work together with a little contribution by us of facilities and motion picture skill. I am sure...you will

find a surprising amount of good that can be accomplished in your great science." The plan received the unanimous and enthusiastic support of both the Regents and the general fellowship, and a Board on Medical Motion Pictures was appointed, chaired by J. Bentley Squier, MD, FACS, of New York.

In 1927, the American College of Surgeons entered into an agreement with the Eastman-Kodak Company whereby the College would review and

**Figure 1**



Filming a surgical procedure in San Francisco, 1951.

evaluate films with regard to the suitability of their subject matter, satisfaction of medical ethics, and adequacy of demonstration of technique; Eastman-Kodak would then assess the photographic qualities. To accomplish this work, advisory committees were appointed in 19 defined areas of interest to solicit films from leading authorities in each field.

In addition to producing films, the College reviewed and cataloged a large number of exist-

ing films on a variety of special subjects. The first film produced under this agreement, made by Allen B. Kanavel, MD, FACS, in association with Sumner L. Koch, MD, FACS, was entitled *Diagnosis and Treatment of Infections of the Hand* and was shown at the 1927 Clinical Congress in Detroit, MI. The names of the authors were omitted when the film was first presented, as their association with the films was considered unduly commercial. In 1929 films with

**Figure 2**



1949 Congress attendees watching telecast operations at the Stevens Hotel in Chicago.

sound were used, and by 1930 it was acceptable to include the name of the author.<sup>5</sup>

Before the introduction of videotape, filming an operation could be cumbersome, time-consuming, and even hazardous. Providing an ideal vantage point for the photographer and camera required significant alterations to the operating room. (see Figure 1, p. 18) The use of a nonflammable anesthetic agent, such as sodium Pentothal or nitrous oxide, was strongly recommended because the in-

tensity of the lighting required for filming carried with it the possibility of explosion secondary to static electricity. Once the procedure was filmed, it could take as long as 14-16 weeks to finish the original and deliver a copy. Each foot of film involved the making of 40 frames of individual pictures and the typical 15-minute presentation called for the use of 400 or more feet.<sup>6</sup>

Mr. Hays and Mr. Eastman were both aware that the public relations value of making medical mo-

**Figure 3**



A Ciné Clinic in 1953 on the subject of intestinal anastomosis (lecturer unknown).

tion pictures significantly outweighed any small financial gain from the sale of film and filmmaking equipment generated by the program. However, following the stock market crash of 1929, which had a significant effect on Eastman-Kodak, return on investment became an important factor for consideration. Mr. Eastman, who was noted throughout his career for philanthropic efforts, was petitioned by Dr. Martin on several occasions to continue his support, but Mr. Eastman died sud-

denly in 1932, and so too did his company's relationship with the College.

### **Independent filmmaking**

When the partnership with Eastman-Kodak ended, the College assumed the administration of the Motion Picture Program, with Eleanor K. Grimm, Secretary to the College since its beginning, as coordinator. A concerted effort was

**Figure 4**



Crowd viewing a medical motion picture session at the 1958 Clinical Congress, Chicago.

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made to encourage the independent production of films, which were reviewed in the central office in Chicago, and those meeting ACS standards were approved and cataloged for distribution on request.

The first list of approved films was prepared in 1934 and published in the 1935 *Yearbook*. By 1937 the list had expanded to include 250 films, 24 of which were made for a general audience, including one entitled "That Man May Live," documenting advances in medical care through animal research.<sup>7</sup> Throughout the 1930s, the number of motion pictures shown at the Clinical Congress steadily increased, while the number of "wet clinics" correspondingly declined. (The last time "wet clinics" were presented at hospitals was at the 1952 Congress in New York.)

## Outreach

In the early 1940s, in an effort to further "democratize" medical education, the College sent 123 reels of film covering 72 medical and public health subjects to the Division of Cultural Relations, U.S. Department of State, for presentation in countries throughout Latin America. More than 100 mobile film units in sound film trucks owned by commercial firms were used to present these films to an estimated one million people, many in remote areas. This program was expanded in 1942 to include South Africa, Syria, Turkey, Australia, England, Iran, and other countries.

Throughout World War II, the Medical Motion Picture Program continued its important cooperative role with the U.S. Department of State. The films *White Battalions* and *R.N.* were shown to an estimated half-million high school and college students to stimulate recruitment into the U.S. Cadet Nurse Corps. In addition, 20 scientific films and 20 dealing with general health topics were distributed to occupied and liberated countries where medical education had been interrupted by the war.<sup>8</sup> Briefly supported by grants from the Ethicon Suture Division of Johnson & Johnson in the early postwar years, the College expanded its Motion Picture Program under Miss Grimm's direction. A formal Motion Picture Department was established and a Film Library was started.

Television was first used to demonstrate a surgical procedure at the Johns Hopkins Hospital in February of 1947. At the Clinical Congress in New York, held in September of the same year, plans were developed by the Committee on Arrangements along with the Radio Corporation of America and Johnson & Johnson Research Foundation to telecast operations from the New York Hospital. Although favorably received, the size of the early television screens made for difficult viewing and the problem of scheduling cases remained (see Figure 2, p. 19). Televised sessions were discontinued after 1975.

1950 was a decisive year in the history of the Medical Motion Picture Program due in large part to the appointment by the Regents of Hilger Perry Jenkins, MD, FACS, as chairman of the Medical Motion Picture Committee, a position he held until 1966. The son of an architectural designer, Dr. Jenkins was a member of the surgical faculties of both the University of Illinois, Champaign, and the University of Chicago (IL), and brought to his career an innate artistic ability, a highly creative personality, and an intense interest in the use of audiovisual methods of teaching surgery. Dr. Jenkins probably contributed more than any other individual to the College's Motion Picture Program. In addition to his administrative efforts as committee chair, he produced a "Ciné Survey" of surgery of the stomach and duodenum that included at least 20 films, which were shown an estimated 10,000 times.<sup>9</sup>

## Ciné Clinics

Partly in response to complaints by Fellows in New York and Los Angeles, CA, in 1948 and 1949 regarding crowded conditions and the inability to view desired films, an innovation called the "Ciné Clinic" program was included in the Clinical Congress for 1950. This effort was a collaborative one between the College and Davis & Geck, a subsidiary of the American Cyanamid Company. This program consisted of a series of comprehensive talks on specific surgical problems, each illustrated by specially prepared and edited color motion pictures demonstrating major points of the technique employed. The operating surgeon discussed the procedure per-

formed, illustrating his or her lecture with highlights of the details of the operation (see Figure 3, p. 20). This new type of program, while retaining the important features of the surgical clinic, solved major spatial and temporal problems by permitting the demonstration to a large group of surgeons those procedures that were difficult or impossible to schedule electively (see Figure 4, p. 21).

The program was also a financial success for Davis & Geck, who took over the film library in 1972, assuming production and distribution of the Ciné Clinic films.<sup>10</sup> The educational library of the American College of Surgeons is presently managed by Cine-Med, Inc., and, in addition to video programs, offers software and CD-ROM programs in an effort to expand its educational service. The Committee on Video-Based Education (formerly the Committee on Medical Motion Pictures) continues to review all subjects offered in the library.

In a 1931 address to the Fellows of the American College of Surgeons, Mr. Hays stated, "To possess the motion picture and fail to develop its maximum use in science and education, is as unthinkable as to have the printing press and to publish novels only."<sup>11</sup> Early appreciation of the value of this new technology as an educational tool by leaders of the American College of Surgeons as well as the motion picture industry has led to a long and rewarding history of "learning by seeing" that continues to the present. □

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# 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.

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### I. Resuscitation

1. *Cardiac resuscitation*. Terry J. Mengert, MD. The author details the steps that should be taken when resuscitating adult victims of cardiac arrest. He describes the assessment of the airway, breathing, and circulation and application of cardiac pulmonary resuscitation (CPR) until defibrillation becomes possible. Placement of advanced airway and optimization of breathing and ventilation; establishment of circulation access; and cardiac resuscitation based on rhythm findings, including choice of antiarrhythmic agents, are also reviewed. The chapter also covers immediate postresuscitation care and the process of ending a resuscitation attempt.

Nonventricular arrhythmias are one of the topics covered in this new chapter. Community advanced cardiac life support providers are encountering nonventricular arrhythmias (that is, pulseless electrical activity [PEA] and asystole) with increasing frequency. Classically, the prognosis for PEA has been poor, with outpatient survival rates generally reported as 0-7 percent. The sequence of resuscitation steps in the management of PEA is as follows: activation of the emergency medical or code response; primary survey (CPR and rhythm evaluation); and secondary survey (intubation and confirmation of correct ET tube placement, optimal oxygenation and ventilation, establishment of IV access, epinephrine administration, and, finally, problem solving for technical difficulties/cause of cardiac arrest). The two core drugs for PEA management are epinephrine (repeated every three to five minutes for as long as the patient is pulseless) and atropine (up to 3 mg over time if the PEA rhythm on the monitor is inappropriately slow). The best hope for a successful resuscitation is to find and treat the cause of PEA; therein lies the exceptionally challenging aspect of PEA resuscitation management. Subscribers to *ACS Surgery* may view the full text of "Cardiac resuscitation" at [www.acssurgery.com](http://www.acssurgery.com).

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#### **IV. Special perioperative problems**

1. *Pulmonary insufficiency.* Robert H. Bartlett, MD, FACS, and Preston B. Rich, MD. The authors describe the preoperative testing of pulmonary function, preoperative and postoperative measures to prevent pulmonary insufficiency, and intraoperative measures to prevent pulmonary complications. Also in their revised chapter, they describe the clinical presentation of postoperative pulmonary insufficiency, the treatment of postoperative pulmonary insufficiency caused by atelectasis or edema, and progression to pneumonia or acute respiratory distress syndrome.

Some very simple but effective advice that the authors recommend is that physicians tell patients to get in shape before elective operations. If a patient is scheduled for an elective operation, as much time as is necessary should be spent measuring lung function, correcting abnormalities where present, and changing conditions that may predispose them to pulmonary complications. This is particularly true in patients with preexisting cardiopulmonary disease. Patients should be advised to train for a major operation as they would for an athletic event. The respiratory muscles should be exercised and specific breathing maneuvers learned. Subscribers to *ACS Surgery* may view the full text of "Pulmonary insufficiency" at [www.acssurgery.com](http://www.acssurgery.com).

#### **VI. Special perioperative problems**

5. *Morbid obesity.* Harvey J. Sugarman, MD, FACS. This newly revised chapter discusses preoperative and postoperative approaches to reducing the risks associated with morbid obesity in the surgical patient. Cardiac dysfunction, embolism, and respiratory insufficiency are covered; complications of gastric surgery for obesity are described; and the management of diabetes, gallstones, degenerative osteoarthritis, and other obesity-related diseases is presented.

For example, morbidly obese patients are at significant risk of coronary artery disease as a result of an increased incidence of systemic hypertension, hypercholesterolemia, and diabetes. Because of this increased risk of cardiac dysfunction, preoperative electrocardiography probably should be performed on all obese patients 30 years of age or older.

Most morbidly obese patients have minimal evidence of cardiac dysfunction as detected by Swan-

Ganz catheterization. Markedly elevated pulmonary artery pressure and pulmonary arterial wedge pressure values will frequently be noted in patients with the respiratory insufficiency of obesity, especially those with obesity hyperventilation syndrome. Intubation and ventilation in these patients often will be followed by a vigorous diuresis, and it is not unusual for a patient to lose 50 pounds or more of retained fluid. In a few obese patients, acute respiratory insufficiency will be caused by a greatly expanded central blood volume and heart failure. Abnormal blood gas values in these individuals will be corrected by vigorous diuresis alone. As with most other abnormalities related to morbid obesity, weight loss will also correct cardiac dysfunction.

Subscribers to *ACS Surgery* may view the full text of "Morbid obesity" at [www.acssurgery.com](http://www.acssurgery.com).

#### **V. Operative management**

34. *Varicose vein surgery.* John J. Bergan, MD, FACS, and Luigi Pascarrelli, MD. In their new chapter, Drs. Bergan and Pascarrelli discuss indications, preoperative evaluation, operative planning and technique, surgical options, complications, alternatives to saphenous vein stripping, and outcome evaluation.

Their review of saphenous vein stripping includes a comparison of the technique to ligation of the vein. Ligation of the saphenous vein at the saphenofemoral junction has been widely practiced in the belief that it would control gravitational reflux while preserving the vein for subsequent arterial bypass. Although it is true that the saphenous vein is largely preserved after proximal ligation, reflux continues and hydrostatic forces are not controlled. Recurrent varicose veins are more frequent after saphenous ligation than after stripping and are more common after saphenous ligation and sclerotherapy than after saphenous stripping and sclerotherapy. A prospective randomized trial comparing proximal saphenous vein ligation and stab avulsion of varices with stripping of the thigh portion of the saphenous vein and stab avulsion of varices showed the latter approach to be superior. Routine saphenous

*continued on page 52*

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# In compliance...

## ...with HIPAA rules

by the Division of Advocacy and Health Policy

Recently, the Centers for Medicare & Medicaid Services (CMS), which has oversight of compliance with the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set (TCS) standards, expressed concern about the readiness of physicians' practices to comply with the October 16 deadline to transmit and receive health care claims electronically. Because all but small providers\* must begin submitting their claims to Medicare and other insurers electronically by the deadline, this issue is no small matter.

Testing of the transmission of electronic transactions between payors and physicians offices using HIPAA standards was originally to begin by April 16. However, the final rule for the standards was not published until February 20. The final rule changed some of the data elements in the electronic claims software and many payors waited until the rule was issued to begin finalizing their computer programs, instruction manuals, and agreements with trading partners (that is, physicians, billing services, clearinghouses). Consequently, the initiation of the testing phase was delayed. In the view of industry experts, it will be impossible for all payors to complete testing the final version of TCS standards by October 16 due to the sheer number of providers that must complete the testing process.

### **TCS standards explained**

TCS standards address more than claim submissions. Practices are required to use the standards for electronic submission of Medicare claims using the approved procedure (HCPCS/CPT) and diagnosis (ICD-9-CM) code sets and to receive payment and remittance advice. Practices have the option of implementing the standards for eligibil-

\*The small provider, defined as "a physician...with fewer than 10 full time equivalent employees," is not required to conduct claims transactions electronically and will be able to continue to submit paper claims. CMS has not yet issued a regulation that confirms its assertion that small providers will not have to apply for a waiver to continue paper claim submission.

### **Around the corner**

#### **September**

- ACS-sponsored basic and advanced coding workshops for surgeons in St. Louis, MO, September 18-19, 2003. Visit the ACS coding workshop Web page at <http://www.facs.org/dept/hpa/workshops/cdworkshop.html> to register.

#### **October**

- 2004 ICD-9-CM code changes effective October 1. The 90-day implementation period during which Medicare will allow claims to be submitted with the 2003 and the 2003 ICD-9-CM code versions begins.
  - Quarterly update to 2003 Medicare fee schedule effective October 1.
  - Quarterly update to 2003 Correct Coding Edits effective October 1.
  - ACS-sponsored basic (SC 10) and advanced (SC 13) coding and practice management (PC 28) courses for surgeons during ACS Clinical Congress in San Francisco, CA. To register for these courses, go to <http://www.facs.org/clincon2003/index.html>.

ity inquiry and response, referral certification and authorization inquiry and response, coordination of benefits, and claim status inquiry and response. Likewise, practices may choose to receive payment for services via electronic transfer, but that function is not part of HIPAA and would be arranged directly with payors.

The foremost problem for physicians' practices is that if all of the elements of the claim process cannot be transmitted to payors, they cannot pay physicians for their services. The disruption to cash flow that would result from this scenario could be potentially devastating to practices.

Throughout April and May of this year, organizations representing insurers, hospitals, physi-

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icians, and clearinghouses petitioned the Secretary of Health and Human Services to establish a short transition period during which insurers may accept nonstandard electronic transactions from trading partners that are still testing the final standards. As of this writing, the HHS Secretary has not directly responded to the petitions. CMS issued additional guidance on July 24, 2003. Any CMS actions for noncompliance on or after October 16, 2003, will be complaint-driven and will take into account whether providers have made a “good faith” effort to become compliant. The full text of the guidance can be found at <http://www.cms.gov/hipaa/hipaa2/guidance-final.pdf>.

### **What practices should do**

What steps must your practice take to make sure it is participating in the testing process with the appropriate groups? Health plans, clearinghouses, and software vendors most likely will take the lead in testing electronic data interchange (EDI) systems for compliance with the HIPAA transaction and code set standards. A practice’s informed participation in the process is essential. It would be a good idea to assign a point person to coordinate testing. To better understand the steps involved, refer to the CMS’ HIPAA information series, available in both English and Spanish, which can be downloaded at <http://www.cms.gov/hipaa/hipaa2/education/infoserie>. In particular, you and your staff should review the following papers: “What electronic transactions and code sets are standardized under HIPAA?”; “Is your software vendor or billing service ready for HIPAA?”; “What to expect from your health plans”; “What you need to know about testing”; “Trading Partner Agreements”; and “Final steps for compliance with electronic transactions and code sets.” Additionally, the CMS Southern Consortium’s Achieving Compliance Together (ACT) Team offers helpful video presentations—*HIPAA Basics* and *Provider Steps to “Getting Paid under HIPAA”*—available via the Internet. To register to access the presentations, go to [http://www.eventstreams.com/cms/tm\\_001/database/register.asp](http://www.eventstreams.com/cms/tm_001/database/register.asp). Furthermore, some Medicare carriers are scheduling HIPAA provider readiness education, which would be announced in Part B newsletters or on carrier Web sites.

Additionally, be sure to contact software providers to verify that they have provided the final version of the transaction standards. Also, contact each health plan with which your practice conducts electronic transactions to determine whether it is necessary to complete and submit EDI trading partner or enrollment agreements and 837P Professional Registration forms to that plan to gain access to their information systems. It is possible that more than one payor has contracted with a Web-based service, such as WebMD Envoy, HealthFusion, or MedUnite, to conduct their electronic transactions, in which case your practice will conduct transactions testing with that organization.

### **Three-stage process**

The testing process consists of three phases. *Internal testing*, which will be conducted with software vendors or billing services, will ensure that your computer system or billing software generates the correct information in the correct formats for HIPAA compliance.

The purpose of *compliance testing*, to be conducted with health plans, clearinghouses, and other business associates, is to identify whether your computer systems are speaking the same language. This process will verify that your system is creating, supplying, and receiving information in the correct electronic grammar, using the current code set dictionaries, and that the dollars reported by and remitted to your practice add up.

Once your practice has completed the internal and compliance processes, it will be ready to participate in *trading partner, or business-to-business, testing*. This final phase is designed to verify that the integrity of the data exchanged with a trading partner is maintained. It will involve the creation of electronic transaction files that may be unique to each trading partner. (Although there is a core data set required by all payors, health plans other than Medicare may require fewer or additional data elements.) Trading partner testing will allow all parties to identify and, if necessary, correct any data inconsistencies that could result in the nonpayment of a claim. Once a practice completes this phase, electronic claims and reimbursement for ser-

*continued on page 37*

## Chapter leaders head to the Hill

by Diane S. Schneidman, Senior Editor

Chapter officers, executives, and young surgeon representatives sharpened their leadership skills, learned about health policy issues, and voiced their concerns on Capitol Hill during the 2003 Chapter Officers and Young Surgeons Leadership Conference. Another highlight of the meeting, which took place June 22-24 in Washington, DC, was the establishment of a new award for dedication to chapter advocacy. Approximately 160 chapter officers and young surgeon representatives attended the meeting, which was coordinated by the College's Division of Member Services and the Washington Office of the Division of Advocacy and Health Policy.

### **The new leader**

A workshop for young surgeons centered on the role and attributes of today's leaders. According to Bruce L. Gewertz, MD, FACS, professor and chair, department of surgery, University of Chicago (IL), many of the most successful people have a higher emotional quotient (EQ) than intelligence quotient (IQ). The elements of EQ include: self-awareness (knowledge of personal strengths and weaknesses); self-regulation (emotional control, trustworthiness, adaptability, initiative); social awareness (empathy, service orientation, organizational insight); and relationship management (communication, conflict

management, and teamwork).

People with high EQs use their insight to make good decisions, remain optimistic despite setbacks, and manage their behavior, Dr. Gewertz said. These traits make them the type of people who others want to follow. For example, he said, surgeons with high EQs bring an operating room together to create better outcomes and inspire their patients' trust.

Today's leaders must have skills that can be measured qualitatively and that are similar to the characteristics of people with high EQs, according to Wiley W. Souba, MD, MBA, FACS, director of the Center for Leadership and Development, Penn State University, Hershey, PA. More specifically, Dr. Souba said surgeon leaders should possess the following traits: a hunger for learning and growth; an ability to build trust and teamwork; a willingness to act as mentors; and the ability to take time to be reflective, creating a culture in which people can find meaning and identity.

Leaders have a clear vision for their organizations or institutions. They provide "a clear, compelling direction aligned with a focused, understandable strategy that everyone is aligned with, committed to, and contributes to," Dr. Souba said. To achieve their vision, they must empower, coach, inspire, liberate, develop, and challenge the people they work with. "If you're

not challenged, you can't learn; if you can't learn, you can't change; if you can't change, you can't grow," he added.

ACS Regent L.D. Britt, MD, MPH, FACS, identified the challenges facing the surgical community and areas in which surgeons can play a leadership role.

According to Dr. Britt, the "barbarians at the gate" include: (1) efforts to turn medicine into big business; (2) "purchased" academic institutions and primary care practices; (3) the decline in applicants to medical schools; (4) weak integration of women into general surgery; (5) resident work hour restrictions; (6) workforce shortages; (7) fragmentation; (8) slow adoption of information technology; and (9) a perceived failure to address medical errors and quality of care issues.

The College is working to resolve these matters, Dr. Britt said. Some of the efforts under way include the College's: clinical trials programs; efforts to contribute to the fund of evidence-based medicine; work groups that are studying communications, ethics, and collaboration; and expanded advocacy programs, including the formation of a political action committee (PAC) through the establishment of the American College of Surgeons Professional Association (ACSPA).

"The advocate for us is the American College of Surgeons," Dr. Britt said. "When people ask



Left to right: Dr. Opelka; Dr. Miller; Josef Fischer, MD, FACS, Chair, Health Policy Steering Committee; Richard Sabo, MD, FACS, ACS President; and Dr. Ginsburg.

you, 'Who's helping me?,' I want you to say the College is helping me."

Thomas R. Russell, MD, FACS, Executive Director of the College, addressed the participants in the young surgeons' workshop, noting that "one of the real challenges for the ACS is to develop the leadership abilities of young surgeons." He defined leadership as guiding other people in an effort to fulfill a vision for the future.

Dr. Russell noted that the College is working to be a leader among the medical and surgical societies that are striving to resolve the current problems in our health care delivery system. These matters are "too big for one individual or one organization to tackle," Dr. Russell said. Hence, the College must continue to work with other groups "to create an environment for change." Some of the College's collaborative efforts include working to correct flaws in re-

imbursement and to resolve the medical professional liability crisis.

#### ***Chapter executives' session***

The session for chapter executives and administrators, which took place concurrently with the young surgeons' seminar, focused on improving nondues revenues. Henry Schaffer, Esq., Jenner & Block, Chicago, IL, answered legal questions posed by participants. Additionally, Eileen Murray, CFRE, CAE, director for foundation, American Health Information Management Association, Chicago, IL, offered insights into new activities and programs that chapters may use to increase nondues income.

#### ***Keynote address***

Paul B. Ginsburg, PhD, delivered the keynote address, focusing his remarks on health policy issues. A primary concern con-

tinues to be cost, said Dr. Ginsburg, president of the Center for Studying Health System Reform, Washington, DC.

Short-term drivers of increasing costs include the retreat from tightly managed care, hospital consolidation, labor shortages, new drugs and advertising, and, possibly, the economic boom of the 1990s, Dr. Ginsburg said. Long-term drivers of rising health care costs include clinical innovation and heightened social expectations. "Cost containment will be painful and will take a long time," he said.

Some efforts to contain costs within the private sector include the development of tiered insurance plans and increased cost sharing for individuals who have employer-based coverage. The ability of patients to access health insurance, however, is dismal, according to Dr. Ginsburg. He noted that premium increases are exceeding income growth, resulting in

more uninsured people. "Conditions today resemble in many ways the early 1990s," Dr. Ginsburg said, with rising costs and eroding coverage. Hence, the time is ripe for reform.

### **Medicare reform**

Members of the ACS Health Policy Steering Committee spoke about the College's Medicare-related activities. Frank J. Opelka, MD, FACS, said that surgeons are currently traversing "stormy seas." Some major concerns at this time include changes in the conversion factor that is used to set Medicare payment to physicians, malpractice expenses, prescription drug benefits, and access.

Dr. Opelka, who also serves on the College's Coding and Reimbursement Committee, noted that a major flaw within the Medicare payment formula is the use of the sustainable growth rate in setting the conversion factor. He explained how the College has worked with other groups and independently to demonstrate to policymakers problems in the methodology.

Robert H. Miller, MD, FACS, gave a historical overview of the Medicare program. Dr. Miller noted that Medicare was established in 1965 to guarantee coverage for individuals who are age 65 and over, have disabilities, or are afflicted with end-stage renal disease. The program was modeled on the Blue Cross/Blue Shield policies of the 1960s but has become far more complex over time. "There aren't very many people who understand all of Medicare," Dr. Miller said, but, in a nutshell, the program has three parts:

Part A pays for inpatient treatment, Part B for physicians' services, and Part C covers Medicare+ Choice plans.

Medicare already suffers from economic woes, he said, and the situation is only likely to worsen. When the program first started, there were six workers contributing to Medicare per beneficiary. In 2010, when the first wave of Baby Boomers becomes eligible for benefits, it will be about 2.5 workers per beneficiary, Dr. Miller said.

### **Liability crisis**

Christian Shalgian, Manager of Congressional Affairs for the College, noted that 18 states are struggling with a malpractice insurance crisis, while another 25 are on the verge of a similar situation. According to Mr. Shalgian, the best solution to this problem is passage of national legislation modeled on California's Medical Injury Compensation Reform Act (MICRA), which, among other provisions, limits noneconomic damage awards to \$250,000.

In March, the House passed H.R. 5, the Help Efficient Accessible Low Cost Timely Health Care Act, which was introduced by Rep. Jim Greenwood (R-PA) and is similar to MICRA. Subsequent to the meeting, comparable legislation was blocked in the Senate. "The Senate is really our greatest challenge with regard to this issue," Mr. Shalgian said during the meeting.

Nonetheless, increasing the likelihood that professional liability reform could be enacted is the fact that "President Bush has taken this issue and has really championed it," Mr.



Dr. Meredith



Dr. Warshaw



Dr. Jones

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Shalgian said. In addition, the media have focused a great deal of attention on the topic.

Also speaking on medical liability was Larry Smarr, president of the Physician Insurers Association of America. Mr. Smarr discussed and dispelled several myths about the malpractice crisis. Some of the falsehoods he highlighted are as follows:

- There is no liability crisis; the current problems are simply part of the insurance cycle. Actually, claims are rising too rapidly.

- Insurers lost money in the stock market. In fact, more than 80 percent of insurer investments are in bonds, not stocks.

- The average paid claim is \$30,000. Really, the average is 10 times that amount.

- The average annual malpractice insurance premium is \$9,000. Actually, physicians' premiums range from \$11,000 to \$201,376.

- There are no frivolous lawsuits, and physicians win 70 percent of the lawsuits. Mr. Smarr said the reality is that malpractice provides a "lottery system" for the trial lawyers.

- It's a state issue. Unfortunately, many state laws have been nullified on constitutional grounds.

- MICRA doesn't really work. Actually, states that have similar laws have avoided a crisis situation.

### **Problems and solutions**

According to Rex Cowdry, MD, MPH, associate director of the National Economic Council, Washington, DC, health care spending now accounts for 14

percent of the gross domestic product. That level is higher than in any other country. Further, health care costs are rising faster than the economy.

Two drivers of increasing health care costs are advancements in technology and the malpractice climate, Dr. Cowdry said, characterizing the liability situation as "a tragedy from a cost perspective and a tragedy from a justice perspective." Malpractice concerns also are deterring efforts to improve quality because some health care practitioners are concerned that more fervent outcome analysis will lead to finger-pointing and lawsuits. As a result, "our profession has been a bit obstructionist" in this area, Dr. Cowdry said.

In addition to improving quality and cutting costs, a reformed health system must expand access to care for the 40 million Americans who are uninsured, he said. Most of these individuals are employed but cannot afford coverage or forgo that expense because they are young and healthy. Dr. Cowdry said that options for making health insurance more attainable are: insurance plans based on income, fixed premiums, or plans that have a standard premium for basic coverage with copayments for other treatments.

### **Trauma funding**

An overview of the College's Committee on Trauma (COT) and of the relevance of trauma systems was presented by J. Wayne Meredith, MD, FACS, Chair of the COT. In particular, Dr. Meredith encouraged meet-

ing participants to advocate for Congress to again fund the Trauma Care Systems Planning & Development Act. This legislation authorizes the Secretary of Health and Human Services to award grants to states to assist them in planning, implementing, and monitoring state-wide trauma care systems.

"Vast areas of the country" are without Level III, IV, or V trauma centers, Dr. Meredith said. This situation poses a public health crisis given that "having a trauma system is more effective in saving lives than having a seat belt law," and trauma results in "more years of life lost than other cause," he said.

Dr. Meredith noted that since 9/11, concerns about treating the victims of terrorist attacks has increased. However, much of the emphasis is being placed on bioterrorism, when, realistically, people are more likely to experience physical injury, he said.

### **ACS SurgeonsPAC**

Last year, the College's Board of Regents approved and formed the ACSPA, which has 501(c)6 tax status, allowing the College to augment its advocacy capabilities. The first activity for the ACSPA was the formation of a PAC that would promote surgeons' interests in Congress. The PAC is chaired by Andrew L. Warshaw, MD, FACS, who provided an update on the ACS SurgeonsPAC's activities.

Since the PAC was formed on October 3, 2002, its governing body has developed a set of legislative priorities for the College, including: liability re-



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form, payment, trauma systems development and funding, patient safety, work hours, and graduate medical education, Dr. Warshaw said. Additionally, the ACS SurgeonsPAC made contributions to 10 campaigns during the 2002 election cycle. "All 10 won, and all 10, I hope, have some measure of gratitude to the College," he said.

Dr. Warshaw noted that surgeons can promote their political agenda by meeting with their elected officials, using the College's Legislative Action Center, becoming better informed about the issues, and supporting the PAC. "We can't do this without your help, and it has to be financial help," he said.

### **Meeting members' needs**

Some of the College's division directors spoke about how the organization is working to meet surgeons' ongoing needs. Ajit K. Sachdeva, MD, FACS, FRCS, Director of the Division of Education, spoke about enhancements to the Clinical Congress and the Spring Meeting programs, such as the addition of new skills courses. Dr. Sachdeva also noted that the Surgical Education and Self-Assessment Program has been updated and that task forces are addressing surgeons' communication skills, practice-based learning, professionalism, and systems-based practice.

Paul E. Collicott, MD, FACS, Director of the Division of Member Services, noted that the College recently added a membership category for medical students. Additionally, he



Dr. Davies (left) and Mr. Ellenberger.

said, the College is "trying to do everything we can to encourage women to become surgeons and Fellows," particularly in light of the fact that only 4 percent of ACS members are women.

R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, spoke about the College's Office for Evidence-Based Surgery, which focuses on improving quality of care problems through surgical research and clinical trials programs. "We must never forget that the reason that we're here is to care for and heal sick people," Dr.

Jones said. He explained that by arriving at best practices and applying the best evidence about treatments that work, surgeons will be better able to fulfill that mission. Additionally, "we will reduce the cost of health care. I can almost guarantee it," he said.

### **State advocacy**

"Congress sometimes doesn't get around to these complex issues," so the states often are responsible for passing legislation aimed at improving the health care system, according to Chris Gallagher, Manager of State Affairs, ACS Washington Office.

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Mr. Gallagher noted that the College offers a number of venues that allow surgeons to participate in state-level advocacy efforts, including: (1) the Surgeons' State Legislative Advocacy Center; and (2) the State Advocacy Representative Program, which is a network of Chapter members who agree to contact legislators as issues arise.

Chapters also can operate at several levels to become effective state-level advocates, Mr. Gallagher said. He suggested that each chapter establish a legislative committee, educate patients, create or enhance their Web site, make an "annual pilgrimage" to the statehouse and Capitol Hill, and contribute to the SurgeonsPAC.

### **Art Ellenberger honored**

One chapter executive who has ensured that the surgeons in his state have a voice in Washington, DC, and at the statehouse is Arthur Ellenberger, Executive Director of the New Jersey Chapter of the ACS. In recognition of his dedication, the College presented the first Arthur Ellenberger Award for Excellence in State Advocacy during the meeting.

Robert Davies, MD, FACS, president of the New Jersey Chapter, presented the inaugural award to Mr. Ellenberger, noting that each chapter needs "someone with close ties to the legislature and knowledgeable about how the process works. I am happy to say we have such a person in New Jersey," Dr.

Davies said, referring to Mr. Ellenberger.

The award will be presented periodically to recognize an individual's commitment to state advocacy. Recipients' names will be engraved on a plaque to be displayed in the College's Washington Office.

### **Conquering the Hill**

The meeting concluded with opportunities for chapter leaders to attend a reception on Capitol Hill, engage in legislative briefings, have breakfast with Representative Greenwood, and visit the offices of their Senators and Representatives. Several surgeons who participated in these activities describe their experience in the following article.

## **Surgeons reflect on Capitol Hill experience**

**Editor's note:** Four surgeons who participated in the Capitol Hill visits that took place during the Chapter Officers and Young Surgeons Leadership Conference shared their thoughts about the experience via e-mail. These surgeons are: James L. Johnson II, MD, FACS, a general surgeon in Cody, WY; Debra Koivunen, MD, associate professor of surgery and interim division chief of general surgery, University of Missouri; Mark Nehler, MD, FACS, assistant professor of surgery and surgical residency program director at the University of Colorado, Denver; and Karen

Rieger, MD, an Associate Fellow and thoracic surgeon in Indianapolis, IN.

### **Dr. Johnson**

I had the good fortune to be asked to serve the Montana/Wyoming Chapter as a Young Surgeon Representative at the Chapter Leadership Conference in Washington, DC. What a great learning experience it was on a personal as well as a professional level. I was able to find out what is going on politically with our profession and had a firsthand opportunity to try and effect change by discussing is-

suues with the lawmakers on Capitol Hill.

The College's legislative affairs team arranged for each of us to meet with a Senator and a member of Congress. I was thoroughly invigorated by the experience. Instead of standing by the scrub sink and griping about how bad my premiums are and how little Medicare is reimbursing me, I went to the source of power and made my voice known. My legislators both seemed to be well-versed in each of the areas. Honestly, I was a little surprised at how well they understood the issues.

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I now appreciate how hard the ACS is actively working on our behalf to help stabilize our profession. It really is apparent that the College appreciates the importance of a strong and consistent voice on Capitol Hill.

It has become clear to me that the only way to change the system is if we all do our part. As a group, we must make our concerns known to our legislators because we have a unique and thorough understanding of the problems. We can no longer afford to sit back and let others fight our battles. That attitude is what got us to where we are now.

Each one of us has very little time to spare and a million reasons why we can't get involved, but if we want our profession to survive, it is time to make our concerns and desires known.

#### **Dr. Koivunen**

During our Capitol Hill visits, I met with legislative aides (LAs) to Sen. Kit Bond (R-MO) and Rep. Kenny Hulshof (R-MO). We discussed medical liability reform, Medicare payment issues, resident work-hour regulations, and trauma center funding.

Both aides struck me as being very intelligent and well-versed in most of the topics we covered. They appeared interested in what we had to say, and if they were unfamiliar with a particular issue, they indicated a plan to further research the topic. I felt that my visit was a welcomed event, as opposed to just being another "entry" on the day's calendar, and I had the impression that they found it helpful/educa-



Dr. Johnson



Dr. Koivunen

tional to meet with a surgeon and hear my views and concerns.

I found it extremely educational to attend the preparatory conference the day before and the briefing on the morning of the visits. These sessions crystallized in my mind the issues at hand and also gave me a greater appreciation of the hard work being done by the ACS SurgeonsPAC on our behalf.

Visiting Capitol Hill was in itself an educational event, even if our state Senator and Representative were not physically there. I don't think many of us truly understood before that day just how important the aides and other personnel working for the legislators are in the whole Washington, DC, process.

I would certainly recommend this visit to other surgeons. The more the House and Senate members see us, the more likely they are to figure the

needs of our patients into the "big equation" as they work on legislation. They particularly need to know that we are not supporting key issues out of greed, but out of concern for the future of medical care in this country and the accessibility to it for our patients.

#### **Dr. Nehler**

Throughout the conference, the other surgeons from Colorado and I were very impressed with...the large role the American College of Surgeons has played in representing the political leadership of our profession—sponsoring legislative campaigns, protecting surgeons' interests in Medicare reform, and widely supporting tort reform. (As a junior member of the organization, I previously was unaware of this level of involvement.)

On the final day of the conference, Tom Rehring, MD, FACS, and I met with advisors to a U.S. Senator and Repre-



Dr. Nehler



Dr. Rieger

representative from Colorado. Each meeting was 20 to 30 minutes in length. We were able to present our views on tort reform, Medicare, and trauma systems. We exchanged cards, and Dr. Rehring and I left feeling that a potential relationship was initiated between these government offices and our chapter.

Reflecting on this experience, I realize that I was relatively naive previously regarding professional leadership and its relationship to government. These sorts of activities—lobbying in the legislature to effect positive government change—are, in essence, a large part of what it means to be in a free society. Most other industries/professions consider this type of involvement to be a critical responsibility for their representative organizations. Much has been written about physicians organizing unions and the like. However, the American College of Sur-

geons already functions in this capacity and many more for our profession.

***Dr. Rieger***

I met with the LAs to Sen. Evan Bayh (D-IN) and Rep. Julia Carson (D-IN). During the meetings, we discussed liability reform, Medicare reimbursement, and trauma systems. Indiana has several neighboring states that are near crisis with regard to liability issues. Our liability insurance premiums are increasing, too. We also discussed the financial difficulties that are occurring at our county hospital, which serves the majority of Indianapolis's indigent population and is a Level I trauma center.

Senator Bayh's LA was polite but did not seem receptive to our concerns. She ended our meeting saying that Senator Bayh would look at both sides and vote fairly. Representative Carson's assistant was much

more receptive to our visit and questions. Questions and responses were exchanged back and forth, and I felt he was interested in our concerns.

What I found different between my experience and my expectations of the Capitol Hill meetings was that most policymakers seem to agree that there are problems with the health care system, but it seems as though the way our government is trying to solve these matters is inefficient. I was also surprised at how difficult it is for our elected officials to get beyond their party concerns and make compromises to get things done.

Nonetheless, I think the Capitol Hill visits were useful in conveying surgeons' views to policymakers. Physicians are respected people in the community, and it's important and necessary for the policymakers to see that we care and to know that we are watching what they're doing in Washington. Hearing personal stories about what's really going on in hospitals and practices is important for policymakers, especially for those who represent states that are in crisis or near crisis.

The visits also opened my eyes to how important it is for citizens to follow what's really going on in our country and to make our voices heard. It's easy to live our lives, working hard but being totally uninformed about what really affects us. Physicians should be more politically active, and it's a shame that the activism had to come at a point when there is truly a crisis.

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In memoriam

# William Polk Longmire, Jr., MD, FACS, 1913-2003, remembered

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

Fifty-seven years ago, W.P. Longmire, Jr., became a Fellow of the American College of Surgeons (ACS) following the example of his father, a surgical practitioner in the small Oklahoma town of Sapulpa. Fifty years later, one of his daughters, Sarah Jane Longmire-Cook, also entered the Fellowship to which her father had made such magnificent contributions. An appreciative account of three generations of Longmire surgeons in the ACS was written by Bill's longtime colleague, Sherman M. Mellinkoff, MD, FACS, the distinguished gastroenterologist and dean of the medical school at the University of California in Los Angeles (UCLA).<sup>1</sup>

In March 1998, the *Bulletin* featured on its cover a series of pictures highlighting an historical article by Dr. Longmire covering the "middle period" of College history from 1937 to 1973.<sup>2</sup> As a third-year medical student at Johns Hopkins in 1937, he had attended his first Clinical Congress in Chicago, IL, where his father was inducted as a Fellow of the American College of Surgeons. Thirty-six years later, Bill completed his formal service to the College after a year as President, following three terms as a member of the Board of Re-



Dr. Longmire

gents (1962-1971) with a final two years as Chairman of that Board.

The 1998 *Bulletin* article in its text and pictures provides an invaluable view of the College during the middle third of its 90-year history. Notable among the farseeing Longmire contributions was his initiation of a special relationship with surgeons under 45 years of age, stipulating that "their

counsel should be sought" and that they should be represented significantly at all levels of College administration. This groundbreaking notion has vivified College activities over more than three decades since he perceptively established this large cadre of "young surgeons" as active participants in ACS decision making.

The Surgical Research Committee of the College takes its origin from his chairmanship of the Conjoint Council on Surgical Research, which focused the investigative efforts of a number of surgical organizations. His work in reorganizing the structure and function of multiple College committees resulted in guidelines known familiarly as "the Longmire Rules." And to those Fellows who were privileged to work as Regents under his deft, decisive management of that important Board, he will be remembered as one who brought to administration the same superb skills that marked his many achievements in operative surgery.

In addition to his great technical skills in the operating room, Dr. Longmire conceptualized and brought to wide use a number of eponymic surgical procedures.<sup>3</sup> These were opera-

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tions that evolved and improved as he instructed his resident surgeons and senior surgical colleagues worldwide, especially in Germany and Japan. Mellinkoff has warmly recorded many details of his pedagogic legacy based on several decades of close association at UCLA.

Space limitations preclude a listing of his many contributions in research, clinical surgery, and administration, except to note his role as one of five founders of the medical school at UCLA. He was a vital contributor to the International Federation of Surgical Colleges, held high office in many major surgical societies, and received Honorary Fellowship in the Royal Colleges of Edinburgh, England, and Ireland. During a military tour of duty, he established a distinguished record with academic colleagues in the German surgical profession and was the first honorary foreign member of the Japanese Surgical Society in 1985.

Bill died quietly on May 9, 2003, after a two-decade struggle with a carcinoid tumor, burdened as well by the dementing illness of his lovely consort, Jane. His graceful equanimity was inspiring, marked by

continuing significant achievement in spite of these sore trials.

It is difficult to express adequately the value of our friendship and collegial relationship that began as freshmen in medical school, continued during a summer of work in pathology before our sophomore year, and was cemented by a post-intern year of joint research in the venerable Hunterian laboratory at Johns Hopkins. In 1946, after my naval service, his recommendation to Alfred Blalock, MD, FACS, played a significant part in my securing a position on the Hopkins surgical faculty, and his suggestion to an ACS search committee that I might serve as Director of the College led to my assuming that post in 1969 during his Chairmanship of the Board of Regents and beyond. These specific instances of personal indebtedness serve to indicate both his generosity of spirit and his concern for the progress of such organizations as the American College of Surgeons, Johns Hopkins, and UCLA to which he made such immense contributions.

Rather than risk a sentimentally biased evaluation of his stature and achievements, I re-

fer the reader to Mellinkoff's book and to Longmire's biography of Alfred Blalock.<sup>4</sup> In this latter, personal account, drawn from Longmire's diary entries over 23 years of close, affectionate relation with Blalock as "the Professor," one can grasp the persona of the diarist himself. Biographers reveal important clues to their own characteristics, and the Blalock biography is a splendid testament not only to Bill Longmire's mentor, but to the unassuming, noble surgeon whose star shone in the surgical firmament as a brilliant blessing to patients and colleagues alike.

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## IN COMPLIANCE, from page 27

vices should be accurately transmitted.

CMS suggests that providers view testing as an ongoing part of their regular information system management process. Throughout this final phase of the transaction standard implementation, remember that the purpose of the standards is to improve the efficiency and effectiveness of the health care system.

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This column responds to questions from the Fellows and their staffs and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site. If you would like to see specific topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or by e-mail at [HealthPolicyAdvocacy@facs.org](mailto:HealthPolicyAdvocacy@facs.org).

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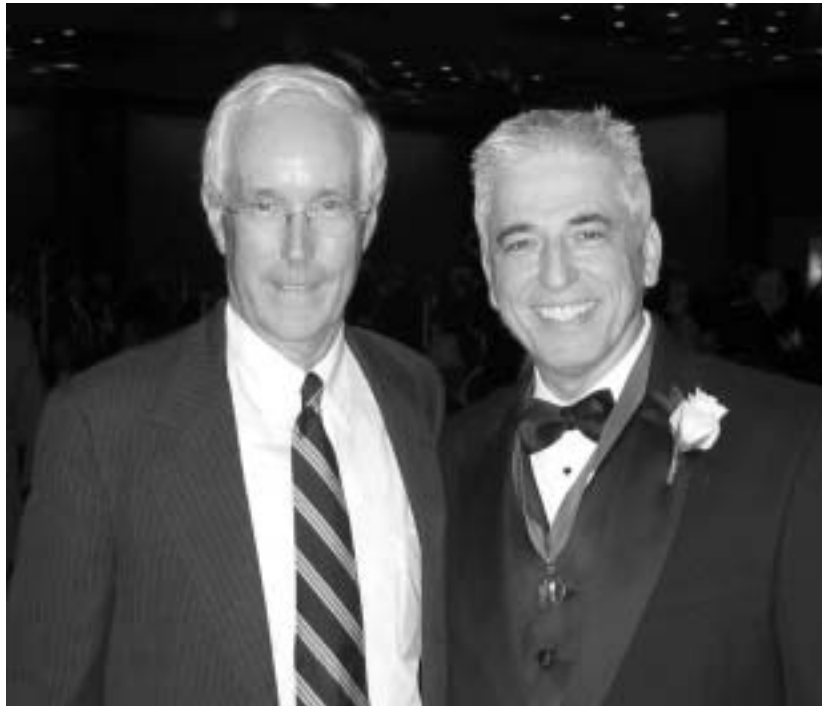
# ACS Fellow installed as president of the AMA

Donald J. Palmisano, MD, JD, FACS, was installed as the 158th president of the American Medical Association (AMA) during the annual meeting of the organization's House of Delegates in June. In his inaugural address, Dr. Palmisano, who has been a Fellow of the College since 1972 and was an active member of the Regents' Patient Safety and Professional Liability Committee for 10 years, vowed to preserve patient access to care by advancing professional liability reform.

"Our medical liability system has a fatal illness. It costs our patients access to care and sometimes costs them their lives," Dr. Palmisano said. "A crisis rages in 18 states—home to 140 million people—half our nation's population. Our patients are at risk. The time to fight is now."

Although resolving the current medical malpractice crisis will be a complex and difficult task, it is worth the effort, he said. "We cannot expect change—we cannot effect change—if we do not work for change. And in this work, we can never give up. If we desert this battle, we will lose the most experienced of the practitioners among us and cripple the next generation of physicians," Dr. Palmisano said.

Dr. Palmisano has witnessed how dedication to the cause can bring about change, hav-



Dr. Palmisano (right) at his inauguration with Thomas R. Russell, MD, FACS, ACS Executive Director.

ing been credited with playing a key role in the passage of the Louisiana Medical Malpractice Act of 1975, which implemented a number of reforms, including a cap on damage awards. Other physicians who want to counter the negative effects of the liability situation should do their homework, have courage, and not give up, he said.

A clinical professor of surgery and clinical professor of medical jurisprudence at Tulane University School of Medicine, New Orleans, LA, Dr. Palmisano also runs a private practice with five other surgeons and is president of Intrepid Resources®, a medical risk management company.

Dr. Palmisano received his medical degree in 1963 from

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Tulane, and upon graduation, he was honored with the Psychiatry and Neurology Award, as well as the Senior Thesis Award. He completed his surgical residency at Tulane and Charity Hospital in New Orleans and served as chief of surgery for the Air Force's 821st Medical Group. While

servicing in that position, Dr. Palmisano was awarded the Air Force Commendation Medal for his efforts following the crash of a B-52 strategic bomber. He went on to obtain a juris doctorate in 1982 from Loyola University School of Law, also in New Orleans.

First elected to the AMA

Board of Trustees in 1996, Dr. Palmisano has been a member of the executive committee since 1999 and served as AMA secretary-treasurer in 2001. He also served as president of the Louisiana State Medical Society from 1984 to 1985 and was elected to that organization's "Hall of Fame" in 2000.

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## New postgraduate courses to be offered at Clinical Congress

The American College of Surgeons' Division of Education invites you to attend four new hands-on postgraduate (PG) courses at this year's Clinical Congress in Chicago, IL: Bedside Procedures Workshop; Advanced Stereotactic Breast Biopsy; Bariatric Surgery Primer; and Mastering Surgical Coding.

- The Bedside Procedures Workshop is outlined in the box on the next page.

- Advanced Stereotactic Breast Biopsy (SC 05) is a four-hour course intended for surgeons who are already using stereotactic breast biopsy and are preparing for the recertification process. This didactic and interactive course will stress practical solutions to targeting dilemmas, in-depth mammographic lesion analysis, mammographic/pathologic correlation, and image-guided intervention: the rationale for ster-

eotactic versus ultrasound-guided biopsy. The course is chaired by Darius S. Francescatti, MD, FACS, of Chicago, IL, and will be offered on Sunday, October 19, 1:00-5:30 pm.

- The Bariatric Surgery Primer (SC 16) is an intense, two-day course that will provide a broad overview of bariatric surgery and will feature didactic presentations, panels, and live interactive closed-circuit television sessions presented by world-renowned surgeons. It will be chaired by Henry Buchwald, MD, PhD, FACS, of Minneapolis, MN.

Upon completion of the course, participants should be able to describe the epidemiology, etiology, and incidence of morbid obesity; outline the physiologic basis for bariatric surgery; identify appropriate candidates for bariatric surgery; and discuss the various

bariatric surgical procedures. The pre-, intra-, and postoperative care associated with each procedure will be described, along with the possible postoperative complications and their appropriate management and prevention strategies. In addition, principles underlying a multidisciplinary approach to bariatric surgery and the consequences of post-bariatric weight loss will be discussed. A special evening presentation by an international expert and dinner are included as part of the course. The course will be offered on Tuesday, October 21, and Wednesday, October 22.

- Mastering Surgical Coding (SC 13), usually offered at the ACS Spring Meeting, is new to the Clinical Congress this year. The six-hour course will provide an in-depth discussion of advanced concepts in ICD-9-CM diagnosis coding,



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## Bedside Procedures Workshop to debut

A new skills-oriented postgraduate course, the Bedside Procedures Workshop, will debut at this year's Clinical Congress in Chicago, IL.

Bedside procedures are becoming a vital part of health care delivery. The knowledge and clinical techniques associated with performing bedside procedures are an important component of the surgeon's skill set. Other medical specialists are competing with surgeons to perform these procedures, and surgeons must be adequately trained and prepared to take an early lead in performing them in order to maintain a competitive edge in the field.

The seven-hour didactic and interactive course is designed to teach surgeons how to perform three bedside procedures: percutaneous dilational tracheostomy, percutaneous endoscopic gastrostomy, and percutaneous vena cava filter placement. Participants will hear lectures in the morning and rotate through a series of workshop stations in the afternoon.

The morning lecturers will describe the three procedures, discuss concepts in documentation and coding for professional billing of bedside procedures, and show how team building and quality control can improve performance and patient outcome. The workshop portion of the course will provide hands-on training so that participants will gain proficiency in each procedure.

George C. Velmahos, MD, PhD, FACS, Los Angeles, CA, will chair of the course and,

along with expert faculty, will lead instruction and share direct experience in various components of the clinical techniques and administrative issues with bedside procedures. The following faculty will be teaching the course: Walter L. Biffl, MD, FACS, Providence, RI; Ernest F. J. Block, MD, FACS, Orlando, FL; Edward E. Cornwell III, MD, FACS, Baltimore, MD; Samir M. Fakhry, MD, FACS, Falls Church, VA; David G. Jacobs, MD, FACS, Charlotte, NC; Fred A. Luchette, MD, FACS, Maywood, IL; Frederick A. Moore, MD, FACS, Houston, TX; John T. Owings, MD, FACS, Sacramento, CA; Frederick B. Rogers, MD, FACS, Burlington, VT; Marc J. Shapiro, MD, FACS, St. Louis, MO; and Ronald F. Sing, DO, FACS, Charlotte, NC.

Bedside procedures have been shown to be safe, convenient, teachable, and cost-effective. Reimbursement rates are significant, and the discussion of coding, documentation, and billing will highlight the importance of basic business knowledge, completeness and accuracy in coding, and professional staffing to increase the chances of proper payment and decrease the chances of an audit.

This course will be offered on Tuesday, October 21, 8:00 am-5:30 pm. For further information about registration and course content, please refer to the Program Planner, or the ACS Web site at [www.facs.org](http://www.facs.org), or contact Katherine Stack, Academic Administrator, at [kstack@facs.org](mailto:kstack@facs.org) or tel. 312/202-5433.

*Current Procedural Terminology (CPT) surgical coding and modifier use, reporting staged operations, consultations, and variables that influence the correct reporting of physician services, including the National Correct Coding Initiative and the impact of carrier medical review policies. Hands-on coding of surgical case studies will be included. John T. Preskitt, MD, FACS, of Dallas, TX, will serve as Chair of the course, which will be offered on Tuesday, October 21, 8:30 am-5:00 pm.*

In addition to these hands-on skills courses, six new didactic postgraduate courses are being offered: The American College of Surgeons' Oncology Group Clinical Trials; Safety for Office-Based Procedures; Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons; Evidence-Based Surgery; Career Development; and Business Aspects of Health System Management: The Surgeon's Role in Health System Leadership.

For further information about registration and course content, please refer to your Program Planner, or the ACS Web site at [www.facs.org](http://www.facs.org), or contact Katherine Stack, Academic Administrator, at [kstack@facs.org](mailto:kstack@facs.org) or tel. 312/202-5433.

# Profiles in Leadership

## Paul H. Jordan, Jr., MD, FACS

Fellow of the American College of Surgeons since 1955. Retired general surgeon. Served on the International Relations Committee and Committee on Medical Motion Pictures of the ACS.



*"We need a spokesperson for surgery. The ACS has long served this function well and is best prepared to continue in the future.*

*If the ACS is to extend its activities on our behalf, it requires our collective financial support. A financial gift to the College provides support to an organization that best understands our needs.*

*The College has had enormous influence on medical research, education, and patient care. These have been the major benefits I have received from the ACS. I have no reason to doubt that these benefits will extend for generations to come."*

Dr. Jordan supports the College financially through active membership in the Fellows Leadership Society.

For information about joining the Fellows Leadership Society, please contact the College's Development Office via telephone at 312/202-5376, via e-mail at [fholzrichter@facs.org](mailto:fholzrichter@facs.org), or by visiting the ACS Web site at [www.facs.org](http://www.facs.org).



*We invite you to consider joining Dr. Paul Jordan in the Fellows Leadership Society of the American College of Surgeons.*



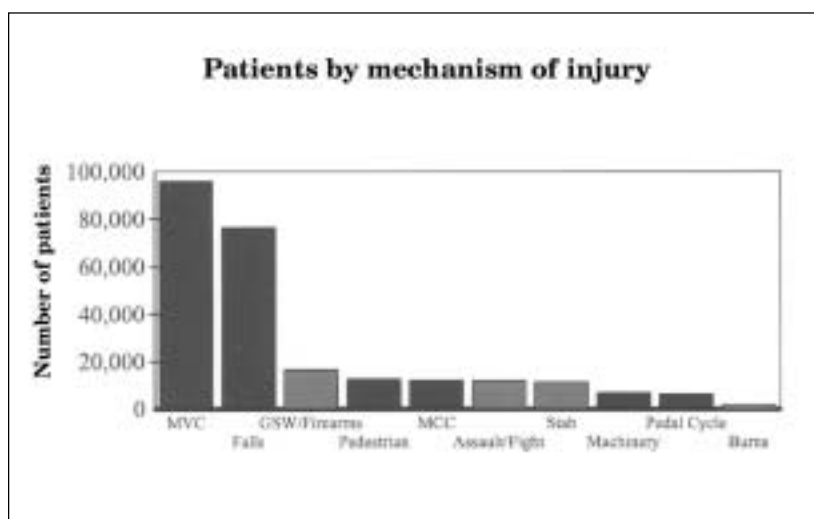
## NTDB™ data points

# The blunt majority?

by Richard J. Fantus, MD, FACS, Chicago, IL, and John Fildes, MD, FACS, Las Vegas, NV

Contrary to popular belief that trauma is primarily the result of the local knife and gun club's activities, the majority of patients taken care of in trauma centers across the country are victims of blunt injury. This fact is borne out in the second annual report of the National Trauma Data Bank™ (NTDB™). As depicted in the graph at right, the overwhelming leader in the blunt injury category is motor vehicle-related injury followed closely by falls. When the two categories are combined, they account for almost 70 percent of the records. Gunshot wounds are a distant third, representing less than 7 percent of trauma cases. The two penetrating injury categories combined account for only one out of every 10 trauma cases reported to the NTDB.

When reviewing these mechanisms of injury and the distribution of trauma records contained in the NTDB, it becomes obvious that trauma is a major public health issue. Trauma knows no boundary and affects people from all walks of life, socioeconomic classes, lifestyles, occupations, and geographic regions. This truth underscores the importance of trauma centers and trauma systems around the country. Trauma centers play a vital role in public health,



Number of patients in each category of injury mechanism. Dark grey bars represent blunt mechanisms of injury. Light grey bars represent violent mechanisms of injury. Last bar on right represents burns.

one that needs to be strongly supported, especially at a time when funding, reimbursement, specialty availability, and liability-related issues are all having a negative impact on their viability. In light of recent world events, this is a time when our country needs strong trauma centers and comprehensive trauma systems to ensure the well-being of our patients.

Throughout the year we will be highlighting these data

through brief reports that will be found monthly in the *Bulletin*. For a complete copy of the National Trauma Data Bank *Annual Report 2002*, visit us on the Web at <http://www.facs.org/dept/trauma/ntdbannualreport2002.pdf>.

If you are interested in submitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at [mneal@facs.org](mailto:mneal@facs.org).



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**GS 02:** A Town Meeting:  
Changes in Surgical Practice—  
Getting Ahead of the Game

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## **Clinical Congress 2002**

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**GS 08:** New Technology:  
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**\*GS 10:** Patient Safety

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**GS 21:** Damage Control in Trauma  
and Emergency Surgery:  
New Applications

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**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

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**GS 33:** The Ethics of  
Entrepreneurialism  
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**GS 34:** Should Axillary Dissection  
Be Abandoned?

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**GS 40:** Management of Metastatic  
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# Report of the 2003 Travelling Fellow

by Christopher R. Forrest, MD, FACS, FRCSC, Toronto, ON

“Travel is the best form of education,” as my mother always used to say. The truth of these words was borne out as I had the great privilege of visiting Australia as the Travelling Fellow of the Australia/New Zealand Chapter of the American College of Surgeons for 2003. In short, this was a wonderful opportunity that allowed me to expand my academic and personal horizons and gave me the chance to visit and interact with other academics to educate and be educated.

Around the time of my scheduled departure on April 29, 2003, Toronto was in the grip of a Severe Acute Respiratory Syndrome (SARS) epidemic that had virtually shut down the regional health care system with the exception of life-threatening and urgent conditions. The impact of this epidemic cannot be overstated, and as such, I had grave concerns as to whether my Travelling Fellowship would get off the ground. After several frantic e-mails and careful perusing of both the Australian and Canadian official government Web sites, I felt that it was appropriate to proceed with the Travelling Fellowship given that neither myself nor my family had any risk factors for SARS nor had any of the acknowledged symptoms.

My knowledge of Australia had been gained secondhand through a stream of clinical fellows who had visited the division of plastic surgery at The Hospi-



Dr. Forrest

tal for Sick Children in Toronto, ON. This education was supplemented by reading standard texts, such as *The Fatal Shore*, by Robert Hughes, and *In a Sun-Burned Country*, by Bill Bryson. My three-year-old son Conor's fascination with the Wiggles and Steve Irwin, the crocodile hunter, rounded out the preparations that were necessary for the trip. However, I must acknowledge the amazing organization skills and fortitude of my wife, Sandra, who planned the trip superbly with the help of some correspondence from the 2002 Traveling Fellow, Douglas S. Tyler, MD, FACS.

## **Brisbane**

After a brief period en route in Hawaii, we arrived in Sydney on May 3 and had a wonderful two

days to acclimatize before attending the Annual Scientific Congress in Brisbane on May 5. This meeting is unique for surgeons and covers such esoteric subjects as military surgery, rural surgery, and surgical history. One of the highlights of the meeting was meeting Prof. Harold Ellis, whose book, *History of Surgery*, provided some of the inspiration for my keynote address, The Future of Heroes in American Surgery, which was presented at the American College of Surgeons Symposium on May 7.

At the Annual Scientific Congress Meeting, I was taken under the gracious wing of Professor Stephen Deane and his wife Anne, who ensured that I was fully accommodated. During the congress, my participation included presenting the American College of Surgeons Lecture entitled Craniofacial Reconstruction, as well as presenting my basic science research studying The Role of Cytoprotection in the Prevention of Radiation-Induced Craniofacial Bone Growth Inhibition as the basic science lecture in the panel on complex craniofacial cases. I also participated in panels entitled Meet the Masters and Facial Trauma, and gave a final lecture entitled Aesthetic Craniofacial Surgery.

The Scientific Convener for the Plastic Surgery Section, Richard Lewandoski, MD, was a wonderful host who ensured my participation in the meeting.

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I was fortunate to attend the specialty dinner at the Custom House in Brisbane, where I had the opportunity to become reacquainted with Peter Callan, MD, FACS; David Ross, MD, FACS; and Tristan De Chalain, MD, FACS, all former Fellows who had spent time in Toronto in the past undertaking postgraduate work in plastic surgery.

My final duty in Brisbane was to attend the Annual General Meeting of the ANZ Chapter of the American College of Surgeons and lecture on the Effect of SARS on Toronto.

During my time in Brisbane I was fortunate to be reacquainted with Prof. Thomas Reeve and to meet Richard Sabo, MD, FACS, current President of the American College of Surgeons.

We departed Brisbane on May 9 for a few days of rest and relaxation in Palm Cove, just north of Cairns. We traveled to the Daintree Rainforest after the initial trepidation of becoming rapidly acquainted with driving on the opposite side of the road. The astonishing beauty of Australia was highlighted by the immense size of the country and the fact that there are only 20 million or so people who live there. Driving along the coastal roads on the Captain Cook Highway, we were amazed to see isolated beautiful beaches with nobody on them.

### **Adelaide**

We arrived in Adelaide on May 13 and spent the next day touring Kangaroo Island under the watchful eye of our guide, Ron Swan. It proved to be a wonderful day trip in which we saw all forms of Australian life, includ-

ing Australian sea lions, New Zealand fur seals, kangaroos, wallabies, koalas, echidnas, and parrots, as well as the picturesque Remarkable Rocks and Admirals Arch. I also had the opportunity to become intimately acquainted with a four-foot black tiger snake whose personal space was violated during my attempt to capture his image. Fortunately, we both parted ways intact.

One of the highlights of the trip was visiting with Prof. David David at the Australian Craniofacial Unit in Adelaide. Professor David conducted a stellar two-day program that gave me full access to the amazing infrastructure and organization of the Australia Craniofacial Unit. I was most indebted to Prof. Neil Maclean for his kindness and patience in allowing me to follow on his coattails.

During my visit I gave tutorials on Management of Non-Syndromic Unicoronal Synostosis in Infancy, The Role of Cytoprotection in the Management of Radiation-Induced Craniofacial Bone Growth Inhibition, The Management of Orbital Floor Fractures in Children, and Application of Bone Paste in Craniofacial Reconstruction in a three-hour symposium on Aspects of Craniofacial Surgery.

I was rewarded the following day by meeting members of the research team working in the Australian Craniofacial Unit during a morning symposium covering research aspects of craniofacial and cleft-related problems. I attended a wonderful dinner organized by Eugene Tan, MD, at the Melting Pot res-

taurant in Adelaide, before leaving for Melbourne the next morning. I am most grateful to Tania Petroccia at the Australian Craniofacial Unit for helping coordinate my visit to Adelaide and providing information to keep my wife Sandra and son Conor occupied during my busy stay there.

### **Melbourne**

I arrived in Melbourne on May 17, where I was warmly greeted by John G. Meara, MD, director of the Plastic Surgery and Maxillofacial Program at the Royal Children's Hospital. John and I found out we had a lot in common, ranging from recent appointments as chiefs of our respective divisions to having spouses who were dermatologists. I was grateful to Damien Bates, MD; Simon Bernard, MD; and Chris Poon, MD, who tried to give me a crash course on Australian wine at lunch. I presented a lecture entitled Pediatric Facial Fractures to the house staff and had a wonderful two-day opportunity to interact with both John and Professor Tony Holmes. We had a great session showing complex cases on our respective Macintosh laptop computers, trying to outdo one another.

On May 19, I met Professor Adrian Polglasse at the Cabrini Monash University Hospital and presented a lecture entitled Working with SARS at The Hospital for Sick Children in Toronto. The reception to this lecture was interesting—a combination of intense interest about the latest epidemic mingled with some hesitancy to get close enough to shake my

hand. Coming from an entirely socialized medical system in Canada, I was very interested to observe firsthand the private medical system in Australia.

I was also grateful for the opportunity to visit the St. John of God Hospital in Geelong with my good friend, Dr. Peter Callan.

### Sydney

The final leg of the tour took us back to the spectacular city of Sydney, and with the kind and generous hospitality of Mike Poole and Mark Giannottis, I spent a very stimulating few hours touring around the Prince of Wales Hospital. I was very excited to meet Prof. Bill Walsh, a human dynamo in research, and establish a linkage that I hope will lead to productive collaborations in the future. The meeting at the Prince of Wales Hospital was concluded by my two lectures to the Surgical Reg-

isters entitled Management of Secondary Cleft Nasal Deformity and Craniofacial Reconstruction, followed by a dinner with the faculty.

### Reflections

We returned home to Toronto on May 23, fully anticipating that the SARS situation was over, but were most disappointed to see a second outbreak of this virulent and nasty disease.

I am most grateful to the Royal Australian College of Surgeons and the American College of Surgeons for providing me with the opportunity to broaden my academic horizons and experience firsthand a culture that I thought I knew about by working with the Fellows from Australia and New Zealand who had traveled to Toronto. This was a wonderful opportunity to form new relationships and refresh old ones, and I believe that I was

successful in my aim of developing new collaborations in clinical and scientific endeavors.

As indicated, my mandate when I first applied for this fellowship was to educate and be educated, but I feel somewhat embarrassed to say that I gained much more than I gave.

The Travelling Fellowship of the Australia and New Zealand Chapter of the American College of Surgeons is truly a unique and special opportunity that I was most fortunate to experience.

It is said that the world is a very small place, but my world has been expanded in immeasurable ways by the relationships, experiences, and collaborations that were fostered by my trip to Australia.

*Dr. Forrest is medical director, Craniofacial Program, The Hospital for Sick Children, Toronto, ON.*

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

## **Ethics/morals**

In the letters section of the June 2003 *Bulletin*, Dr. James Neely had trouble describing the distinction between ethics and morals. Ethics are what keep us from misbehaving at work and morals keep us from misbehaving after work.

**Michael Van Ronzelen,  
MD, FACS**

## **Commitment to the profession**

I read Dr. Russell's column in the June *Bulletin* with interest. I was reminded of a late night call in the early 1960s to see one of my patients in the ER. I was then a junior faculty member at the University of Pennsylvania. The man needed an emergency procedure, and lacking a transporter, I wheeled him three blocks through the long dark corridors of the hospital to the OR suite. I saw this patient regularly until I left the university in 1972. The thing he remembered about me, and for which he was most grateful, was the ride I gave him to the OR. He remarked about this almost every time I saw him.

I am among the many who are dismayed by what you see as young physicians' protective attitude toward their privacy and personal time. This has contributed to the change in the public's regard for those who practice our profession. It has led to the use of unlisted telephone numbers and handing off of surgical patients at night, on weekends, or for vacations, to partners who know little about the patient and may not have even met the patient. I addressed some of these issues in an article published in the October 1996 *Bulletin* (p. 21-31).

I can't argue against the working-hour restrictions if, in fact, data show that long hours reduce patient safety. However, there is something wrong with our commitment to our profession when our privacy and free time become more important than the care we give our patients.

The period of training is long, but not forever. However, habits acquired during training may be hard to break. Maybe there is something wrong with our role models. None of the men who trained me ever had an unlisted phone number, and, on call or not, if one of their patients needed them, they were there. What I learned from them was incorporated into my own conduct throughout my professional life.

Kenneth Ludmerer, in his excellent book, *Time to Heal* (Oxford University Press, 1999), describes what he calls the *hidden curriculum* of undergraduate medical education that he places in the early decades of the last century. The following are a few quotes from this section:

Equally important were a physician's attitudes, values, character, and professional identity. One was the cultivation of a physician's bedside manner. To listen to patients, to be attentive, to inspire confidence, to provide comfort—these qualities of good physicianship required demonstration and reinforcement. So did other important attributes, such as thoroughness, reliability, empathy, and devotion.... A good bedside manner was prompted by example, not preaching. No platitudinous lecture on the importance of valuing patients as people could undo the damage if students witnessed their instructor treating patients curtly or abusively, or showing more interest in the laboratory results than in the patients' problems and

worries...the hidden curriculum was the primary determinant of whether students learned to view patients as people or as abstract disease entities.

These values may be too old-fashioned for our modern times. However, they still resonate with our patients and some of us might get more satisfaction from our work if they became habits. They have the added benefit of getting the patient to like you, and as any malpractice defense attorney will tell you, this is one of the best measures one can take to prevent unjustified law suits and, in some cases, even justified ones.

**Harry W. Schoenberg,  
MD, FACS**

I read with interest Drs. Trunkey and Mabry's discussion in the March *Bulletin* regarding the commitment of today's surgeons to our venerable profession. And I found the letters in response to their comments even more fascinating and was compelled to respond in writing myself.

I have been practicing general and vascular surgery for 23 years in San Francisco, CA. I serve as chief of surgery at my main hospital, I cover three ERs, and I work 12 to 14 hours most days. I am a woman, and at 55 years of age, I am one of the youngest surgeons in the city. There have been no new surgeons coming to our wonderful city because the reimbursement is so low, relative to the cost of living, that to get started here is impossible. The hospitals started paying us to cover the ORs because there are very few of us; we work incredibly hard, and it is only fair, ethical, and just to pay anyone for the work the surgeons do. Every surgeon I know right now is suffering from major burnout from overwork, long hours, and bur-



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densome paperwork, but we continue to work under these ridiculous conditions (which I'm sure no union would ever put up with!) because we do care about our patients, we do care about the practice of surgery, and we are committed to our calling as surgeons.

I have to agree with most of your letter writers, that for any surgeon to question our commitment and ethics for wanting to be fairly compensated for our hard work is way off base. We are intensely committed, work hard, and have sacrificed much in terms of our time, families, and own personal health to care for our pa-

tients. There is nothing wrong with being compensated for our work.

Finally, I cannot let the comments of Dr. James Neely (Letters, June *Bulletin*) go unchallenged. He actually states that "the ubiquitous presence of women" in medicine today is what is negatively affecting commitment, as women miss twice as much time on the job as men. Although some women doctors do work part-time, this is certainly not from a lack of commitment to medicine. The actual number of part-time women doctors is small and the number of part-time

women surgeons is even smaller. The women I know in surgery are incredibly hard working and dedicated surgeons. I will even go out on the proverbial limb and say we are more committed because we had to be to get here, and we often do have increased pressures with family responsibilities.

But we really shouldn't be wasting our energy accusing each other of unethical behavior or lack of commitment, while our health care system is slowly falling apart from overmanagement, mismanagement of valuable resources, and greed.

**Susan A. Bailey, MD, FACS**

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## Tours of College headquarters available during Congress

It is now over six years since the American College of Surgeons moved its headquarters to its current location at 633 N. Saint Clair St. The very modern blue-green stone and silver glass building is located about two blocks east of the old 55 E. Erie St. headquarters, which was sold and subsequently razed for a new high-rise condominium. The College completed negotiations for the new building in March 1996 and staff completed the move by January 1997.

College staff will direct tours of the ACS headquarters building during the upcoming Clinical Congress in Chicago. The tours will last for approximately 45 minutes each, and

will be conducted at 1:00 pm and 2:30 pm, Monday, October 19, through Thursday, October 23. Preregistration is required for the headquarters tours; sign-up sheets will be available at the Hilton Chicago ACS Registration Desk, Social Program Counter; and at the McCormick Place Convention Hall, Member Services area. If you are interested in participating in one of these tours, please complete the tour registration form and indicate a preferred date and time for the tour of your choice.

All tours will commence in the ground floor lobby of the headquarters building. Transportation to the College headquarters from McCormick Place will be

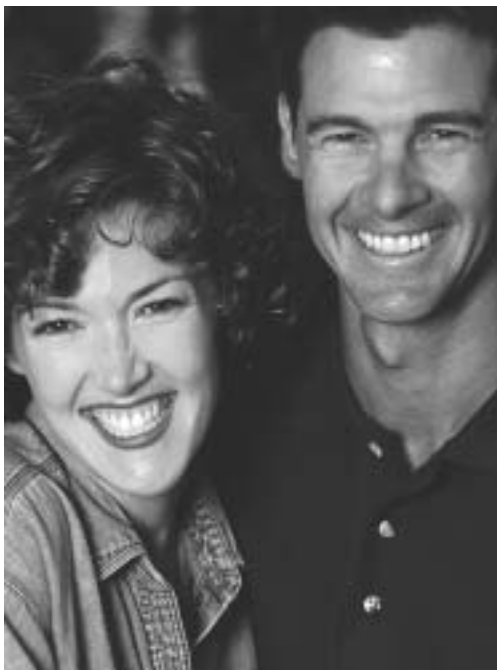
provided by the Orange Bus Line (Route 5). The bus will unload at the Wyndham Hotel, which adjoins the College, and access to the College can be gained through its main entrance on Saint Clair Street.

At press time, the possibility of tours of the College's historic Murphy Memorial Auditorium, which will be undergoing renovation, was not yet known. However, more information about this possibility will be available at the Hilton Help Desk and McCormick Place Convention Hall, Member Services area.

For further information, contact Susan Rishworth at 312/202-5270 or e-mail [srishworth@facs.org](mailto:srishworth@facs.org).

# Smile.

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# Chapter news

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by Rhonda Peebles, Division of Member Services

To report your chapter's news or to share photos of your chapter's events, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at [rpeebles@facs.org](mailto:rpeebles@facs.org).

## Chapters observe fiftieth anniversaries

The **Kentucky Chapter** held its fiftieth annual meeting April 17-18 in Lexington. During the event, Thomas R. Russell, MD, FACS, the College's Executive Director, presented the fiftieth anniversary commemorative charter to the chapter.

Additionally, a number of residents participated in a papers competition, and the winners were: First prize: Charles Levy, MD\*; second prize: Andrew Bernard, MD\*; and third prize: Melanie Scott, MD.

Meanwhile, the **Mississippi Chapter** conducted its fiftieth annual meeting May 2-3. The education program was dedicated to James D. Hardy, MD, FACS, who passed away February 19. The fiftieth annual meeting also served as an opportunity to initiate a new lectureship to honor Richard J. Field, Jr., MD, FACS, who served as a Regent of the College 1984-1993. R. Scott Jones, MD, FACS, Immediate Past-President of the College, presented the fiftieth anniversary commemorative charter to the chapter's president, Gerhardt Mundinger, MD, FACS (see photo, right).

Lastly, the **Michigan Chapter** held its fiftieth annual meeting May 16-17. The main event each year is the residents' competition, and this year, 41 residents presented. During the annual dinner, Richard Sabo, MD, FACS, the College's President, presented the fiftieth anniversary commemorative charter to Farouck Obeid, MD, FACS, the Immediate Past-President of the chapter. Also, chapter members elected new officers, including: Cheryl Ann Wesen, MD, FACS, President; Donald J. Scholten, MD, FACS, President-Elect; Mark W. Puls, MD, FACS, Secretary;



Mississippi Chapter: Dr. Jones (left) and Dr. Mundinger.

and Daniel Joseph Reddy, MD, FACS, Treasurer (see photos, left column, p. 51).

## Ohio Chapter conducts annual meeting

The Ohio Chapter conducted its annual meeting May 8-10. The three-day education program launched a new named lectureship for the Ohio Chapter—the Frederick M. Douglas Foundation Memorial Lecture—which was presented by Julius H. Jacobson II, MD, FACS. Additionally, Julie Freischlag, MD, FACS, Secretary of the Board of Governors, delivered the Ohio Oration. Along with a variety of surgical presentations, a number of residents participated in research-paper competitions in oncology, trauma, and basic and clinical sciences. The winners included:

Oncology: Saleem Zafar, MD; Trauma: Konstantin Umanskiy, MD\*; Basic Science first place: Russell Juno, MD\*; Basic Science second place: Teng Lee, MD\*; Basic Science third place: Jefferson Lyons, MD\*; Clinical Science first place: Matthew Recht, MD; Clinical Science second place: Eren Berber, MD; and Clinical Science third place: Hani Baradi, MD.\*

\*Denotes Associate Fellow or participant in the Candidate Group.



Michigan Chapter: Left to right: Dr. Russell; Dr. Obeid; Frank R. Lewis, MD, FACS, Past-President; Dr. Wesen; and Dr. Reddy.



Rhode Island Chapter: Last year, Dr. Russell presented the fiftieth anniversary commemorative charter to the chapter. Pictured, left to right: Peter Gill, MD, FACS, Immediate Past-President; Michael P. Vegeridis, MD, FACS, President; and Dr. Russell.



Michigan Chapter: This custom-designed architectural tile was commissioned by the chapter to commemorate its fiftieth anniversary. The tile was produced by Pewabic Pottery, which has been located in Detroit for 100 years. The title is a striking blue color, to depict the Great Lakes. In addition to the College's seal, which is white, the tile also includes the names of Frederick A. Collier, MD, FACS, and Alexander J. Walt, MD, FACS, two general surgeons from Michigan who have served as Presidents of the College.

During the annual business meeting, the Ohio Chapter agreed to establish its own statewide political action committee and elected the following officers: E. Christopher Ellison, MD, FACS, President; Michael E. Stark, MD, FACS, President-Elect; Gary Brian Williams, MD, FACS, Secretary; and Linda Marie Barney, MD, FACS, Treasurer. Richard B. Reiling, MD, FACS, was honored for serving the Ohio Chapter as Editor for 25 years.

## Chapter anniversaries

Month	Chapter	Years
July	Southwest Missouri	51
	New Jersey	52
	Eastern Pennsylvania	51
	West Virginia	53
	Georgia	53
August	Hawaii	52
	Illinois	53
	Brooklyn-Long Island, NY	53
	Northwest Pennsylvania	52
	Rhode Island	51

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## KEEPING CURRENT, from page 25

vein stripping reduces the rate of varicosity recurrence and the need for reoperation for recurrent saphenofemoral incompetence. Subscribers to *ACS Surgery* may view the full text of “Varicose vein surgery” at [www.acssurgery.com](http://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:

- Pulsatile abdominal mass, by Timothy A. Schaub, MD, and Gilbert R. Upchurch, Jr., MD, FACS.
- Pulseless extremity and atheroembolism, by Vicken N. Pamoukian, MD, and Cynthia K. Shortell, MD, FACS.
- Diabetic foot, by Cameron M. Akbari, MD, FACS, and Frank W. Lo Gerfo, MD, FACS.
- Fundamentals of endovascular surgery, by Jon Matsumura, MD, FACS, and Joseph Vijungco, MD.
- Antibiotics, by Nicolas V. Christou, MD, PhD, FACS.

## Next month in JACS

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

### Collective Review

- Robotic Fundoplication

### Original Scientific Articles

- Cardiac Surgery in Nonagenarians and Centenarians
- 115 Patients with Hepatic Hemangioma

### Palliative Care

- Time to Integrate Trauma and Palliative Care?

### Symposium

- Stem Cells in Clinical Practice

### What's New in Surgery

- General Surgery: Endocrine
- Urology

