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Although most people look forward to the leisure time associated with retirement, many surgeons are hesitant to give up a thriving career and the recognition it has brought them. In his article, “Easing the transition to retirement: When, where, how?” (p. 12), Robert E. Condon, MD, FACS, offers some helpful advice to surgeons who are ready to put down the scalpel, endoscope, or laparoscope and pick up a fishing pole, painter’s easel, or pair of gardening shears. (Background photo © Keith Brofsky/PhotoDisc.)
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From my perspective

In this column, I generally write about the pressing issues that affect us as we attempt to practice our profession and take care of our surgical patients. Some of the topics that I have addressed include reimbursement and the Medicare fee schedule, the medical professional liability crisis, and the burdens associated with regulatory acts and agencies. The College, independently and as a member of several coalitions of surgical and medical organizations, works persistently to address these issues and to create meaningful change. As frustrating and futile as these efforts may seem at times, they are important in ensuring that we have a seat at the table when policymakers deliberate over these matters, which significantly affect all surgeons and their patients.

Payment, malpractice insurance, regulatory hassles, and other modern-day “challenges” are ongoing, specific problems that affect each of us as we work to deliver the best care for our patients. Hence, the College will continue to address these concerns with devotion and diligence.

Facing the future

While these types of immediate problems demand a great deal of attention, all of us need to be cognizant of the broader issues that will become increasingly relevant as the health care system transforms. Thus, we need to focus not only on the issues that affect us today, but on what is likely to play out in the future.

The next generation of surgical care will very likely emphasize quality care and the reduction of errors through improved patient safety. Hence, as we move into the future, the question we need to be thinking about is this: What types of skills and knowledge will competitive surgeons need to possess in the coming years, and what can surgical organizations like the College do to help prepare them for impending changes?

The shifting emphasis toward quality of care concerns has arisen largely in response to increased scrutiny of errors in medicine and in our hospitals. Fueling this reaction was the Institute of Medicine report, To Err Is Human: Building a Safer Health System, which indicated that tens of thousands of deaths occur each year in hospitals due to medical error.

Outcomes analysis

For many years, we’ve been hearing about plans to analyze outcomes, to use the data drawn from these evaluations to determine which procedures and medical interventions are effective, and to issue report cards for physicians and other providers. There now seems to be increased movement in this area. For example, the federal government, through the Centers for Medicare & Medicaid Services, has endorsed the concept of developing a reporting system to evaluate medical institutions and, eventually, physicians. The government’s first venture into this arena centers on the evaluation of nursing homes and is being promoted through national television.

In the private sector, confederations like the Leapfrog Group have started looking at outcomes and, as a result, are directing their subscribers to high-volume institutions and facilities that meet certain criteria, such as having an intensivist on staff in the ICU. Unfortunately, these types of efforts are based on weak outcomes data and inad-
equate analysis of all the systems that are involved in the delivery of care. To help ensure that outcomes analysis is conducted in a sound way, I believe that the College needs to make a long-term commitment to assessing the effectiveness of surgical procedures and providers.

As outcomes analysis becomes a more integral part of our health care delivery system, surgeons will need to become more involved in the concept of practice-based learning. Moreover, the evaluation of one's own outcomes is going to be a significant component of improving quality. Surgeons will need to work from a qualitative perspective and be able to prove to their patients and other interested parties that they offer beneficial care. Conceptually, moving ahead in this area is simply an extension of continuing one's medical education and ongoing professional development. It's about confronting and responding to problems within one's own practice.

**College's assistance**

The College wants to assist in every possible way as the concept of practice-based learning continues to evolve. As many of you know, we have formed a partnership with the National Surgical Quality Improvement Program (NSQIP), which takes the knowledge attained through the Veterans Administration's quality assessment program and applies it to the private sector. More specifically, NSQIP looks at surgical outcomes in a risk-adjusted way and determines outcomes based on an observed-to-expected ratio.

In addition, we have two databases at the College—the National Cancer Data Base and the National Trauma Data Bank™—which will hopefully generate the information we need to gain further insight into best outcomes and best practices in these two important areas.

Finally, we are expanding our efforts to conduct clinical trials that are aimed at eliminating some of the uncertainty with regard to cancer treatments that are most effective. In 1998, we launched the American College of Surgeons Oncology Group (ACOSOG), which administers clinical trials in cancer care.

Currently, ACOSOG has 13 open trials, and more than 3,000 health care professionals—including surgeons, medical oncologists, pathologists, radiation oncologists, nurses, and others—participate in the program. ACOSOG offers a marvelous opportunity for surgeons of various backgrounds (academic and community-based) to enter patients in trials that will yield evidence with respect to what constitutes best practices in oncology. The College envisions an expansion of activity in this arena to include clinical trials in other areas, such as trauma.

Many of the projects mentioned in this column are clearly long-range in nature. Their ultimate objective will be to produce a better health care system—one that is safer for our patients and that applies the best scientific evidence available to medical decision making. There is no question that the science of medicine and surgery is evolving markedly. We believe that these efforts will allow surgeons not only to keep abreast of, but to be ahead of, the curve regarding such changes.

Thomas R. Russell, MD, FACS
The ACS Health Policy Steering Committee and ACSPA-SurgeonsPAC held a joint meeting in Chicago on January 13 to review the current status of and outlook for legislative issues of concern to surgeons. Details of initiatives coming out of that session and other meetings of the committee will be reported in future issues of the Bulletin and ACS NewsScope.

Can’t think of your ACS ID number when you want to visit the “Members Only” side of the College’s Web site? Your days of frustration are now over. The College has updated the “Members Only” section to allow you to set your own user ID and password to access its many features. To make that change, go to the College’s home page at http://www.facs.org and click on the “Members Only” link at the top of the page. You will still need your ACS ID when you log in for the first time. You can then enter your user ID, password, and security questions. If you forget your password the next time you visit the page, you can recover your password online by answering your previously set up security questions. While you are in the “Members Only” area, please check to be sure that your mailing address, telephone numbers, and e-mail address are current and accurate. Be assured that the College does not provide your e-mail address to outside entities. E-mail addresses are used only for College communications.

A new Quarterly Prevention Summary has been added to the series that is being published by the Committee on Trauma’s Subcommittee on Injury Prevention and Control. “Skiing and Snowboarding Injury” outlines the epidemiology and injury and prevention efforts regarding downhill (Alpine) skiing, snowboarding, and cross-country (Nordic) skiing. A bibliography is included in the summary, which can be found on the College’s Web site at http://www.facs.org/dept/trauma/skiing.html.

Seven general sessions from the 2002 Clinical Congress are now available via a Web cast on the American College of Surgeons Web site. Sponsored by the College’s Division of Education, the program offers practicing surgeons a flexible and convenient way to obtain Category 1 CME credits and is the first step in establishing a comprehensive E-Learning Program. Sessions include: New Technology: What’s Proven, What’s Not; Patient Safety; Damage Control in Trauma and Emergency Surgery: New Applications; Programa Hispanico, Section 1: Surgical Management of Breast Cancer, Section 2: Status of Liver Transplantation in Latin America, Section 3: Bariatric Surgery Update, and Section 4: Management of Pancreatic Cancer; The Ethics of Entrepreneurialism in Surgery; Should Axillary Dissection Be Abandoned?; and Management of Metastatic Disease of the Liver. For further details and to view the program catalog, visit http://www.facs-ed.org/.
The Centers for Medicare & Medicaid Services (CMS) released the 2003 Medicare fee schedule for physician services on December 20, 2002. As a result, the payment update for physician services has been delayed until March 1. The regulation, which was published in the Federal Register on December 31, 2002, includes an across-the-board 4.4 percent reduction in the fee schedule conversion factor, which is caused by the flawed formula used to calculate the annual pay updates. However, the delay in implementation has had other effects that surgeons and their practice managers need to understand. These ill effects are summarized below.

Enrollment period. The enrollment period (that is, the period in which physicians can decide whether to be “participating” or “nonparticipating”) will now run from January 9 through February 28, 2003. The enrollment notice sent by carriers incorrectly states that changes in participation status must be made by December 31, 2002. Carriers will not send another mailing to provide the correct dates.

Surgeons who want to retain their existing participation status need not take any action. However, those who do want to change their status should consult the material they received from their carrier. Any participation decisions made will be irrevocable for 2003 services. (See “Selecting the best Medicare payment option” in the August 2002 Bulletin for details about these options, or view the article on the College’s Web site at http://www.facs.org/dept/hpa/pubs/bullet.html.)

Surgeons who change their participation status should start to prepare claims using that status immediately after submitting their participation agreement or disenrollment request to the carrier. Claims that are misprocessed will be automatically adjusted after July 1, 2003.

Claims processing. The delay in implementing the lower 2003 payment rates applies only to claims paid under the physician fee schedule. Claims for other services, such as drugs, diagnostic clinical laboratory tests, and durable medical equipment, will be paid at 2003 rates effective January 1, 2003.

Claims for physician fee schedule services in January and February will be paid at the higher 2002 rates. The new, lower rates will become effective for services provided on or after March 1, 2003. The higher 2002 rates also will be applied to the deductible for services rendered in January and February, and the 2003 rates will be applied on or after March 1. Copayments, of course, will be 20 percent of Medicare’s allowed amount regardless of when the service is rendered.

Local carriers ask that claims for services provided in January and February be submitted as quickly as possible. Rapid claims submission will allow carriers to process and use 2002 pricing before March 1.

Claims submitted in January and February using new CPT codes will not be processed until after March 1 and will be paid at the 2003 rate. Because surgeons have until April 1 to convert to CPT 2003, they should avoid using new CPT codes until sometime in March.

A direct link to the Medicare program memorandum describing these changes can be found at http://cms.hhs.gov/manuals/pm_trans/AB02181.pdf.
New Congress proposes Medicare fixes

Shortly after the 108th Congress was sworn in on January 7, two bills were introduced to address the impending 4.4 percent cut in Medicare physician payments scheduled to take effect on March 1. House Ways and Means Committee chair Rep. Bill Thomas (R-CA) introduced a joint resolution that would invoke the Congressional Review Act and essentially dismiss the 2003 fee schedule—effectively freezing 2003 payments at 2002 rates. Rep. Ben Cardin (D-MD), a member of the Ways and Means Committee, introduced the “Medicare Payment Restoration and Benefits Improvement Act,” which would revise the physician payment update for three years, beginning with a 2 percent update for 2003. While these actions strongly indicate that members of Congress are aware of the serious effects that the Medicare payment situation is having on physicians, the outlook for passage before the reductions take effect on March 1 is uncertain.

Medical liability insurance crisis continues

It is clear that the rapid increase in the cost of medical liability insurance continues to be a looming crisis for surgeons across the nation. A breaking point was reached recently in West Virginia, where a number of surgeons took leaves of absence from their hospitals.

Congress is expected to begin debating this issue early this year. Last year, the House passed a strong medical liability reform bill, but the Senate rejected a weaker proposal, and a compromise was never reached. President Bush and new Senate Majority Leader Bill Frist, MD, FACS (R-TN), have said liability reform is a major legislative priority for the new Congress. There will also be an effort in many state legislatures to enact reforms similar to those passed in California in 1975.

The College applauded the President’s call to address medical liability insurance reform and increased funding for the Medicare program in the State of the Union address. Thomas R. Russell, MD, FACS, said, “Congress must pass legislation that halts runaway litigation and guarantees that injured patients are fairly compensated.” Noting that “the liability lottery is driving surgeons out of business,” Dr. Russell added that “the liability reform called for by the President in his State of the Union address must work toward stabilizing premiums and keeping surgeons in the operating room where they belong.”

Loan repayment programs announced

The National Center for Minority and Health Disparities recently announced the availability of programs that would provide repayment of educational loan debt for qualified health professionals who agree to conduct either health disparities or clinical research for two years. The objective is to recruit and retain highly qualified health professionals for research careers that focus on minority health or other health disparities issues. The program provides for the repayment of the principal and interest of the educational loans, up to a maximum of $35,000 per year. The online application and additional information regarding both programs may be obtained at www.lrp.nih.gov.
On December 31, 2002, after a two-month delay, the Centers for Medicare & Medicaid Services (CMS) published final regulations concerning the 2003 Medicare fee schedule. The regulations include a reduction in the fee schedule conversion factor, resulting from the inaccurate estimates CMS used to calculate the annual pay update. Due to a delay in the publication of the final rule, these regulations will not take effect until March 1.

All eyes have shifted to the newly elected 108th Congress, which convened last month, to fix the Medicare payment problem. Because CMS disputes its legal authority to correct the estimates, a legislative fix appears to be physicians’ last opportunity to stop the cut before it actually occurs.

The following questions and answers should help clarify the concerns that surgeons may have about the new regulation and its impact on Medicare payments and policies in 2003.

Q. How is the conversion factor calculated?
A. According to a complex formula prescribed by law, CMS must revise the fee schedule conversion factor annually. Each year, the conversion factor is equal to the conversion factor for the previous year multiplied by the update as determined by law. CMS bases the Medicare conversion factor updates on three components: (1) the Medicare Economic Index (MEI), designed to reflect Medicare inflation; (2) an expenditure target performance adjustment based on a comparison of actual and target expenditures, known as the sustainable growth rate; and (3) miscellaneous adjustments, which include shifts to account for budget neutrality.

Q. What is the sustainable growth rate? Why is it so critical?
A. The sustainable growth rate (SGR) is a prospectively determined annual expenditure target that applies to physicians’ services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians’ services. The physician fee schedule update is adjusted for “performance” based on a comparison of allowed expenditures, determined using the SGR, and actual expenditures. If actual expenditures exceed the targeted expenditure amount, the update is reduced. If actual expenditures are less than the target, the update is increased.

Specifically, the SGR is calculated on the basis of the weighted average percentage increase in the fees for physicians’ services, growth in fee-for-ser-
vice Medicare enrollment, growth in the real per capita gross domestic product (GDP), and the change in expenditures for physicians’ services resulting from changes in laws or regulations. For 2003, the preliminary estimate of the SGR is 7.6 percent.

**Q.** Why does the SGR formula need to be revised?

**A.** Over the last several years, the College and other organizations representing physicians have urged CMS to correct the flawed numbers in the SGR formula for two reasons. First, CMS insists that it does not have the authority to substitute actual data for estimates in the formula. The second factor is the statutory requirement for the use of GDP as part of the formula.

As it stands, the formula applies faulty data from projections made about GDP and fee-for-service enrollment growth for 1998 and 1999. Because the SGR is based on cumulative data, these errors unfairly removed $20.4 billion from the allowed spending target. If the baseline were corrected with actual data for those years, higher physician fee schedule conversion factors would have resulted for 2000 and all the subsequent years. Although the law specifically requires CMS to use actual, after-the-fact, data to revise estimates used to set the SGR beginning in 2000, the agency maintains that the statute does not permit it to revise the incorrectly estimated SGRs for 1998 and 1999. Furthermore, as the costs associated with medical practice continue to increase rapidly, particularly for pharmaceuticals and liability insurance, the SGR formula’s reliance on the changes in GDP renders it increasingly less relevant to trends in physician practice expenses.

**Q.** How does the fee schedule account for liability premiums? Does this year’s fee schedule compensate for the dramatic increases in surgeons’ liability premiums?

**A.** The professional liability component accounts, on average, for 3.2 percent of the total payment amount under the fee schedule. This year, recognizing the growing liability crisis and its ramifications on physicians’ practices, CMS increased the MEI update for professional liability insurance by 11.3 percent.

To track the ever-changing liability market each year, CMS solicits physician professional liability premium data from commercial carriers for $1 million/$3 million mature claims-made policies. After collecting information for every state by physician specialty and risk class, CMS aggregates the information by premium date to compute a national total using counts of physicians by state and specialty.

These data include effective premium rates through the second quarter of 2002, which is consistent with the timeliness of other data used in determining the update. Though state insurance commissioners have the most comprehensive data on professional liability costs, the most recent data they could provide were from 2000 and thus would not reflect the evolution of the current crisis.

Because rising costs for individual physicians may not be reflected in changes to the RVUs or geographic adjustments for several years, the professional liability crisis highlights the problem with the adequacy of the conversion factor. Theoretically, when liability premiums increase for most specialties, these increased expenses would be reflected in the annual update to the MEI, which is used to calculate the conversion factor. Alternatively, when premiums spike in a particular specialty, those increases could be reflected in the RVUs every five years when CMS updates the three-year average on premium data. The College continues to urge CMS to more fully address the
problem of rising costs of liability insurance by seeking additional funds from Congress.

**Q.** What is the “productivity adjustment,” and why did CMS revise it?

**A.** A productivity adjustment is applied to the MEI to account for the fact that increased practice costs due to inflation are somewhat offset by increases in physician productivity. Until this year, the productivity adjustment used by CMS reflected an estimated offset that reflected physician labor only. CMS has now revised the productivity adjustment to appropriately reflect other factors that affect productivity, such as capital, office space, medical materials and supplies, and equipment.

As a result, the productivity adjustment applied to the calculated Medicare inflation rate is smaller and produces a higher MEI. Because the MEI is one of the key factors used to calculate the annual conversion factor update, the end product is a less severe conversion factor reduction for 2003. If CMS had not revised the productivity adjustment, the fee schedule conversion factor would have been reduced by at least a full percentage point this year, as opposed to the 4.4 percent cut that was published in the regulations.

**Q.** Did CMS remove the noninvasive vascular diagnostic study codes (CPT codes 93875-93990) from the so-called zero work pool?

**A.** Yes. CMS has removed these codes at the request of vascular surgeons, and they are the ones who predominantly perform the services in this family of codes.

**Q.** Has the definition of ZZZ global periods changed?

**A.** Yes. Previously Medicare paid only the incremental intraservice work and practice expense RVUs associated with the add-on service for a code with a ZZZ global indicator. Beginning in 2003, Medicare has changed the definition of the ZZZ global indicator to include pre- and post-service work and practice expenses associated with the add-on code. This change was caused by the addition in 2003 of the add-on CPT code 33225, Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system), which has the post-service work of monitoring and perhaps programming.

**Q.** For several years, surgeons have argued that CMS should include in the calculation of physician practice expenses the costs of physician-employed clinical staff who provide services in hospitals and other facility settings. Did CMS finally make this change?

**A.** No. CMS continues to exclude the considerable costs that some surgeons incur from employing nonphysician clinical staff who assist in the hospital from practice expense reimbursement. CMS continues to maintain that the services of these staff are paid to physicians through the work RVUs to the extent they serve as physician extenders, to the mid-level practitioners directly, or to the hospital through DRG payments or as part of the Ambulatory Payment Classification system for outpatient services.

**Q.** Does CMS continue to include drug prices in the calculation of expenditures for physicians’ services?

**A.** Yes. CMS continues to inappropriately include drugs furnished incident to a
physician’s service when it calculates the SGR. CMS assumes that physicians are able to control use of, and therefore spending on, drugs. Physician groups have argued, however, that the growth in Medicare spending on drugs is not driven primarily by physicians, but rather by the introduction of expensive new drugs to the Medicare population. Furthermore, the actual prices for new or existing drugs are not set or controlled by physicians.

Q. Why wasn’t the fee schedule published earlier?

A. On November 1, 2002, the statutory deadline for publishing final regulations to implement the 2003 Medicare physician fee schedule, CMS issued a notice of delay, citing concerns about data used to establish payments and the need to further assess the accuracy of the data. Reportedly, the data in question pertained to new relative values that were calculated for certain anesthesia services.

Q. Why doesn’t CMS fix the payment update formula?

A. CMS claims that it would like to fix the errors in the formula administratively but cannot find the statutory authority to do so. Twice, the College briefed CMS on possible sources of administrative authority and repeatedly asked CMS to exercise that power. Nevertheless, the agency agrees that the negative update is inappropriate because the current update system does not reflect actual data from earlier years.

Q. Why doesn’t Congress fix the formula?

A. For the second year in a row, the Senate abandoned physicians when it adjourned in 2002 without addressing House-passed Medicare payment reforms. In an eleventh-hour attempt to avert this cut, the House passed a provision that would have given CMS legal protection from retroactive lawsuits should the Administration make revised determinations in the physician payment formula for previous fiscal years. Concerned that the temporary solutions passed by the House would have helped physicians without assisting other health care providers—such as hospitals, nurses, and home health care providers—Senators from both sides of the aisle actively blocked a fix for doctors.

Q. What role is the College playing in the fight to achieve adequate Medicare payment for surgical services?

A. In addition to direct advocacy from its leadership and staff, the College encouraged Fellows to pressure the House and Senate during the 107th Congress. Thousands of Fellows used the College’s Web-based Legislative Action Center to write lawmakers and encourage immediate action on payment issues. As a result, the majority of legislators are well-educated about the issue and its importance to their physician constituents and their Medicare patients.

The College remains an active member of Medicare payment coalitions that support changing the flawed physician payment update formula. When the newly elected 108th Congress convened in January, the College redoubled its efforts to enact a legislative solution before the cut actually occurs on March 1.

For more information about this issue, contact Jennifer Razor at jrazor@facs.org.
Easing the transition to retirement: When, where, how?

by Robert E. Condon, MD, MSc, FACS, Clyde Hill, WA
Most retirement planning guides are issued by stockbrokers or mutual funds. As a result, they are all about money and nothing else. While money obviously is an important consideration when planning for retirement, it’s not the whole package. There are a number of other factors to weigh in planning your retirement. Because money issues are unique to each individual, I’ll leave advice about this aspect of retirement to you and your financial consultants. I offer only this caveat: the notion that living expenses decrease after retirement just isn’t true; an unchanged lifestyle probably will require just about as much money after retirement as was coming in before.

Some of the other topics to consider during the transition into retirement include when to retire, retirement locale, and health insurance. However, the most important questions to consider are: Who will you be, and what you will do in retirement? This article is intended to offer some guidance on these issues before surgeons walk out of their offices for the last time.

When to retire

The short answer is to retire before you start making uncorrected mistakes in the operating room. We all make mistakes—it’s part of being human. And, nearly always we quickly recognize our mistakes and correct them before there are any adverse consequences. But as we get older, our ability to recognize errors in a timely way diminishes. Greenfield and colleagues are working on the development of a psychomotor test that will help to identify when a surgeon’s capacities are no longer up to par.* But the conclusion of that quest may come far in the future.

In the meantime, remember that even your best friends may be unwilling to tell you when you start slipping. It’s embarrassing and disconcerting to see a great surgical reputation tarnished by a bad end. So, plan to quit while you’re ahead, while still in top form. Don’t wait to be told it’s time to go. Choose a date that’s a lot sooner than you think it needs to be.

Where to live

The choices are staying put, moving, or doing a bit of both. Like money, this is a very personal issue. The decision will be based on individual views about summer and winter weather in various parts of the country, as well as plans for activities in retirement.

In considering this issue, remember that moving is very stressful. On the other hand, a move can also be useful because it usually forces people to get rid of accumulated junk. Moving to a new locale where you are unknown means some time will pass before making new social acquaintances, so loneliness may be a problem. If moving seems necessary, try to develop contacts in the desired community by living there a few years before really retiring.

Health insurance

If you’re over 65, you can’t avoid Medicare. It’s illegal for any insurance company to issue to a retiree any sort of health insurance policy except for one of the congressionally mandated Medicare supplements. These “Medigap” policies may or may not fit an individual’s circumstances, but you have no other choices. The Medigap law was passed because some elderly people were being victimized by unscrupulous insurance carriers that were selling them multiple “cancer” policies, and Congress wanted to stop this abuse. Unfortunately, the result is that no one may buy a non-Medicare-affiliated health insurance policy, such as a high-deductible major medical policy, that is better tailored to the individual’s needs. It’s Medigap or nothing.

Be very careful about entering a so-called Medicare+Choice HMO or PPO plan. If one of these plans drops out of Medicare, or a beneficiary later decides to quit the plan, standard Medicare will be reinstated, but, depending on timing and other circumstances, the choice of Medigap policies may be restricted or coverage may be denied. This area is a real minefield, so be careful what you do.

Once you’re 65 and are covered by Medicare, be prepared for the blizzard of notices that will arrive in the mail. A notice is sent every time any claim, however small, is processed. These notices

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carry a prominently displayed reminder, right at
the top of the page in bold type, about reporting
fraud. Further down the page, in less attention-
getting type, are the numbers indicating how
much was billed, what Medicare “approved,” and
what was actually paid to the providers of the
medical care. Additionally, the insurance carrier
of the Medigap policy may pay only what Medi-
care approved but didn’t pay. Your physicians will
never receive a reasonable and customary fee un-
der Medicare. If you think this situation is inap-
propriate and try to pay the difference yourself,
the physician may not accept the check—that’s il-
legal!

Long-term care insurance is expensive, but it
brings some peace of mind. More than half of
women and one-third of men over 65 years of age
can expect to need long-term care either at home
or in a nursing home. One-fifth of these folks will
need care for at least five years. Nursing home care
can be fiercely expensive, eating up all of one’s
financial resources in a relatively short time. For
individuals who need these services, long-term
care insurance is probably the only way to keep
your savings and your home, and leave anything
for the kids.

Who will you be?

Surgeons work in a meritocracy, a world in which
recognition and reward go to those individuals who
perform in superior fashion. One characteristic of
a meritocracy is that participants identify who they
are by what they do. Think of the common cock-
tail party conversational gambit between strang-
ers: “What do you do?” For those who define them-
Ies only or primarily by their profession, “what
I do” becomes the same as “who I am.”

For surgeons who define themselves only as sur-
geons, and who have not developed any other
major interests, retirement implies the end of sur-
gical existence. It is a kind of death that is very
difficult to accept. After all, who wants to be dead?
So, surgeons who can’t really give up their surgi-
cal role feel uncomfortable not being addressed as
“doctor,” continue to go to the office, and some-
times keep operating beyond when they should.
Such surgeons have no idea how to fill up their
days except to keep doing what they no longer do
as well as they once did.

Hence, an unhappy “retirement” becomes in-
evitable. And then the supposedly “retired” sur-
geon, with nothing else to do, hangs out in the
hospital coffee shop just to “stay in touch.” It’s a
little desperate and pathetic. It’s certainly a sad
way to end a great surgical career.

Such individuals need to accept that surgery is
a wonderful career, but it is not their only life.
They need to get a new life, to develop new inter-
ests and activities, to create a new persona that
makes them satisfied, even enthusiastic. If they
can’t succeed in doing so by themselves, they
should seek counseling early in the process of plan-
ing their retirement.

What to do?

There’s a lot of time available in retirement, and
some activity needs to fill that void. Otherwise, too
much time will be spent sleeping, and then, with
no great purpose or involvement in life, the retiree
will become depressed. Also, at this stage of life
it’s “use it or lose it” time; it is very important to
keep your mind as well as your body active.
The availability of time and of much more control over how it is spent provides an opportunity to fulfill ambitions that may have been deferred while engaged in an active surgical practice. For those so inclined, retirement brings a chance to lend their surgical skills and knowledge to a variety of volunteer programs—to share their expertise and their time helping others. The College is in the early stages of organizing a register of such possibilities.†

Many surgeons find that their transition into retirement is eased by a period of a year or two during which they continue to assist their associates in the operating room, and sometimes do some informal consulting of the “curbstone” variety, but not take call or otherwise assume primary responsibility for patient care. Even so, in the end, every surgeon who retires has to accept that his or her role as a surgeon has to come to an end.

Doing things together with one’s life companion is a common romantic goal, and it is possible to do this for some of the time. Activities that have been shared together for years before retirement are easily continued. Travel is the obvious togetherness route, but it’s impossible to be on the road all of the time. And the challenge of golf only lasts so long.

Many retired surgeons find they can start a new career by expanding a hobby into an occupation. It need not produce income, in fact, it may be a bit of an expense. What’s important is that the activity provide real satisfaction and a sense of accomplishment. A new “career” obligates you to get out of bed and to work at it nearly every day. It should be something enjoyable and that brings, at the end of the day, the reward of having done something worthwhile.

More importantly, the new career should be something that gets you out of the house. The major unspoken fear of spouses is that the retiree will be in their space all the time, trying to reorganize things his or her way. Remember that your spouse had an independent life and managed the household or a job without your presence much of the time. Your spouse will ask for your help when needed, but most of the time will get along very well without your assistance. As retirement looms, especially if you are not seen to be developing plans for other activities, your companion will be terrified that you will try to invade his or her domain. This is the short road to a late-life divorce.

In my own case, I continue to do a little teaching and consulting, but I’m now primarily a gardener and a cook, a continuation of lifelong hobbies. In retirement, I’ve finally had the time to do something I had wanted to do for years: take the required course and become certified as a master gardener. I have about a third of an acre in a cutting garden and find great satisfaction in helping things grow. Then, in the evening, I turn my attention to the kitchen. I have a terrific collection of recipes that would be a well-received cookbook if I could find a willing publisher! My wife does what she does best, leading educational tours at a nearby art museum. We both enjoy travel with groups and now have time for the symphony and the theater. We are doing what we enjoy and remind each other daily that “life is good!”

Retirement takes a little planning and some adjustments, but it can be a wonderful, fulfilling time of your life. So get another life before quitting surgical practice. If you do, you’ll find retirement as enjoyable, or even more enjoyable, than your previous surgical career.

CPT changes in 2003:
An overview

by
John T. Preskitt, MD, FACS,
Dallas, TX,
and
Jean A. Harris,
Associate Director,
and
Irene Dworakowski,
Regulatory and Coding Associate,
Division of Advocacy and Health Policy
This article provides an overview of the new and revised Current Procedural Terminology (CPT) codes for 2003 that are of special interest to general surgeons and closely related subspecialties.*

Medicare traditionally has allowed physicians a three-month window, from January 1 to March 31, to switch to the new codes. However, the program will not implement the 2003 fee schedule and new codes until March 1. Most of the work to install new codes can be done before then, but the codes cannot be “turned on” until claims are being prepared for dates of service on or after March 1. Claims using new 2003 CPT codes submitted before March 1 will be held and processed after that date.

Skin procedures

The introductory notes and codes for the excision of benign and malignant skin lesions have been revised to clarify that the code should be selected and reported based on the size of the excision (lesion plus margins). Some organizations, including the College, taught physicians to report the size of the lesion, which is what was formerly stated in CPT. However, other organizations taught physicians to report the size of the defect created, and that language was adopted for CPT 2003. The language in the code descriptors has been changed from “lesion diameter” to “excised diameter,” but codes and the sizes in the code descriptors have not changed. This means that physicians will report a higher level code in many instances. This upward shift will be especially pronounced in the series of codes for the excision of malignant lesions.

The introductory notes have been changed to make the following points:

- The measurement of the lesion plus excised margins should be made before the lesion is removed.
- For irregular lesions, the measurement should be made at the lesion’s widest point and at the most narrow margin required to adequately excise the lesion (for example, when you use an elliptical excision to permit better closure). See the illustration on this page of measuring a lesion using an elliptical excision.

- In the event a frozen section pathology report shows the margins were inadequate and additional excision(s) is performed in the same setting, use only one code, selected based on the total diameter of the excised lesion plus all excised margins (that is, what the excised size would have been if it all been removed initially).
- If the re-excision is performed in a separate operative session but is within the global period of the first excision, report the second excision with a -58 modifier to indicate that more extensive surgery was done within the global period. (Use a -59 modifier to indicate that the surgery was done at a separate operative session if both procedures are done on the same day.)

The CPT manual contains three drawings explaining how to measure the defect. Unfortunately, the wrong text is attached to the drawings in some editions of the book, making it difficult to understand the illustrations. The correct text is shown in the box on the next page. Make pen and ink changes in all copies of CPT in the office.

Code 15756, Free muscle or myocutaneous flap with microvascular anastomosis, has been revised to clarify that the code should be used to report a skin flap procedure rather than a skin-graft procedure. The old descriptor contained the language “with or without skin” which was misinterpreted as describing skin grafts.

*All specific references to CPT terminology and phraseology are: CPT only © 2002 American Medical Association. All rights reserved.
Pediatric procedures

A new modifier -63 reflects the additional work of surgical procedures performed on infants weighing less than four kilograms. The modifier may be used on codes 20000-69999 in the surgery section of CPT except for those procedures that are done only on small infants. Reimbursement for procedures done only on small infants already reflects the increased work associated with the procedure.

Two codes have been added for minimally invasive repair of pectus excavatum (Nuss procedure). Code 21742 is for a procedure that does not include a thoracoscopy and 21743 is for a procedure that does include a thoracoscopy. Finally, an editorial change has been made to code 21740, to clarify that it is the open procedure to repair pectus excavatum or carinatum.

Pacemaker, related procedures

Coding for the insertion and revision of a pacemaker or pacing cardioverter-defibrillator has changed for 2003. Until this year, codes 33216 and 33217 were used to report both insertion and repositioning of pacing electrode(s) 15 days after the initial insertion. Codes 33216 and 33217 are now limited to describing insertion of the device(s). Two new codes were established to report electrode repositioning or replacement any time after the initial insertion. They are code 33215 for repositioning of transvenous electrode(s) implanted in the right atria or right ventricle, and code 33226 for repositioning of cardiac venous system electrode(s) implanted in the left ventricle. Code 33226 includes removal, insertion, and/or replacement of a generator.

Previous coding guidance was that procedures in this section included repositioning and replacement during the first 14 days after insertion or reinsertion of a device. That language has been deleted from the introductory notes. If a reinsertion or repositioning procedure does occur within the postoperative period of the initial insertion, then the appropriate CPT modifier (such as modifier -78) should be appended to the procedure code.

Two new codes and related introductory notes have been added to report insertion of pacing electrodes for left ventricle pacing. The first is standalone code 33224, Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion and/or replacement of generator). The second is add-on code 33225, Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system). Finally, code 33226, Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of generator), has been added.

Vascular surgery

A new code, 34900, Endovascular graft replacement for repair of iliac artery (e.g., aneurysm, pseudoaneurysm, arteriovenous malformation, trauma), makes coding repair of iliac artery aneurysms analogous to aortic aneurysms. Balloon angioplasty within the target treatment zone is included in the code and is not separately reportable. Open femoral or iliac artery exposure, introduction of guidewires and catheters, and extensive repair of an artery is not included in code 34900 and may be separately reported. Procedure 34900 is a unilateral code, so for a bilateral procedure the -50 modifier must be attached. Code

Skin lesions

Check CPT and make the following corrections, if necessary, in the captions of the drawings that appear on the first page of the surgery section.

A. Example: excision, malignant lesion of the back, 1.0 centimeters [sic]. Code 11606.

B. Example: excision, of benign lesion of the neck, 1.0 centimeter by 2.9 centimeters. Code 11423.

C. Example: excision, malignant lesion of the nose, 0.9 centimeters with skin margins of 0.6 centimeters. Code 11642.
75954 was added for the radiological supervision and interpretation of an endovascular iliac artery aneurysm repair. In addition, some conforming changes were made in existing codes. Code 34812 was revised by deleting the word “aortic” to allow use of this code for open exposure of the femoral artery during endovascular iliac aneurysm. Code 34825 was revised to include the placement of an extension prosthesis during iliac aneurysm repair as well as the infrarenal abdominal aortic aneurysm repair.

One new code was added to describe the creation of a conduit to allow the introduction of large carriers and endoprostheses used in repairing infrarenal and iliac artery aneurysms. Code 34833 contains the descriptor Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral. Note that code 34820, Open iliac artery exposure for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral is the same as code 34833, except it does not include “with creation of conduit.” Be sure you select the correct code. Code 34820 should be used if the iliac artery is exposed but a conduit is not sutured in place, while code 34833 should be reported if a conduit is added. Remember that all of the work of code 34820 is included in code 34833, and the two codes should never be reported simultaneously for work on one iliac artery.

Code 34834 is new and should be used to report open brachial artery exposure when required for deployment of infrarenal aortic or iliac endovascular prosthesis. This code is analogous to the existing and much more commonly reported open femoral artery exposure, code 34812.

There is a new add-on code, 35572, Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (including the aortic, venous, coronary, peripheral artery). This code may be used with coronary artery bypass graft (CABG) procedures using venous grafting (codes 33510-33523), venous reconstruction (codes 34502 and 34520), certain open aneurysm repairs (codes 35001-35002, 35011-35022, 35102-35103, and 35121-35152), vessel repairs using a vein graft (codes 35231-35256), bypass graft with vein (codes 35501-35587), open revision of a lower extremity bypass graft (codes 35879-35881), and excision of an infected graft (codes 35901-35907).

Code 37500, Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS), was added and the descriptor for code 37760 was revised to indicate that it is for the open procedure. Code 37501, Unlisted vascular endoscopy procedure, was added as well. The introductory notes indicate that a vascular endoscopy always includes a diagnostic endoscopy.

Category III codes have been established for new technology or for services that are not widely accepted. Eight codes were added to the Category III section of CPT for endovascular thoracic aor-
tic aneurysm (TAA) repair. Five surgical codes were added for TAA repairs (codes 0033T-0037T) and three codes were added for the radiological supervision and interpretation of the procedure (codes 0038T-0040T). To facilitate proper reporting, if a Category III code is available for a procedure, it must be used instead of an unlisted Category I code.

Colon-rectal procedures

A new series of codes was established to describe partial and total laparoscopic colectomy procedures. See the box on page 19 for a complete listing of the new codes. Note that the code to report unlisted intestinal laparoscopic procedures, code 44209, has been deleted and replaced by a new code, 44238. Finally, code 44239, Unlisted laparoscopy procedure, rectum, has been added for 2003. Cross-references have been added to the corresponding open colectomy and open unlisted rectal procedure codes to guide users to the laparoscopic codes.

A new add-on code 44701, which describes intraoperative or on-table colonic lavage performed in conjunction with colectomy procedures, should be reported in addition to the appropriate open colectomy procedure code.

Four new codes for sigmoidoscopy and colonoscopy procedures using directed submucosal injection(s) and balloon dilation of the colon have been introduced this year. Codes 45335, Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance, and 45381, Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance, will allow reporting when a submucosal injection of substances such as India Ink, botulinum toxin, saline, and corticosteroid solutions is administered as part of a sigmoidoscopy or colonoscopy, respectively. The fact that the descriptor says “injection(s)” means that these codes may only be reported once regardless of the number of injections done. Codes 45340, Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures, and 45386, Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures, will be used to report a sigmoidoscopy or a colonoscopy with balloon dilation, respectively. Note that codes 45340 and 45386 are only reported once, regardless of the number of strictures that are dilated. Cross-references have been added to the new codes indicating that they should not be used with transendoscopic stent placement codes 45345 and 45387 because predilations are already included in the stent codes.

Code 46706 has been added to allow reporting of anal fistula repair with fibrin glue.

Peritoneum and omentum procedures

Code 49419, Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (i.e., totally implantable), has been added to describe the insertion of a permanent indwelling, totally implantable catheter without external access ports. To report device removal, use code 49422.

New code 49904, Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects), was added by the plastic surgeons to report extra-abdominal reconstruction of sternal and chest wall defects using an omental flap. Therefore, the add-on code 49905, Omental flap, intra-abdominal, was editorially revised to describe intra-abdominal reconstruction procedures. There is an error in the “Do not report” note that follows code 49905. The note should read: “(Do not report 49905 in conjunction with 44700).”

The authors wish to express their appreciation to Robert Zwolak, MD, FACS, and John P. Crow, MD, FACS, for their editorial assistance.

Dr. Preskitt is in private practice in Dallas, TX, and is a member of the College’s Board of Regents.
The U.S. is a wonderful country, especially to those of us whose immigrant experience is not that far in the past. The opportunities, the freedom, the ability to participate, the meritocracy, and the ability to get where one needs to go through hard work, perseverance, and a little bit of luck are beyond compare with any other nation in the world. I point out to my children, and generally anyone else who will listen, what a wonderful opportunity we have to succeed in this country if we will only try.

However, other countries have my admiration as well. Food is better in Paris and, indeed, throughout all of France. It seems very difficult to get a bad meal there. Although the culinary status of the U.S. has improved dramatically with the training of young, enthusiastic American chefs, still one must admit that France and Belgium outdo us in this area. I happen to like England and find, despite the passing of its homogeneity, that country much more civilized than here. For example, the British still queue up without line-crashing, although that is less common than it used to be.

There are some aspects of American culture that are difficult to comprehend, not the least of which is self-hate, which is evidenced periodically by the younger generation or some members of the intellectual elite and liberal left. To these individuals, it seems everything is better everywhere else, although this attitude is less stylish than it was before September 11, 2001.

In the 1980s, we were told that we were headed for economic disaster and that Japan was going to overtake us and become the dominant economic power in the world. I suppose the same group of people will shortly be telling us that China is about to overtake us as well. Periodically, a malaise sweeps through the country, fanned by the aggressive and liberal media.

“Whither goest?:”
A look at Britain’s National Health Service
by Josef E. Fischer, MD, FACS, Boston, MA
One of the most flagrant signs of American self-hate is our love for other medical systems that do not perform as well as ours. The continued infatuation with the Canadian system, despite the wholesale flight of anyone who can afford to come south of the border to receive care, is utterly beyond me. Long waiting lists, inadequate opportunities to treat, continued restrictions on lifesaving technology, the gutting of premier medical programs and institutions, and a florid “brain drain” continue to be a part of the Canadian medical landscape.

Although the infatuation with the Canadian system is less prominent than it used to be, the media, and to some extent those economic gurus who think they know everything about the medical system, continue to trash what once was a pretty good construct in the U.S. My question to them is, What border would they cross to obtain their health care? At the present time, we can’t go south, although perhaps with improvement in Mexico, that may one day be possible.

In my view, the most egregious admiration for a medical system is for England’s National Health Service (NHS). It is true that the NHS has some wonderful qualities. It is totally free, not only for residents and citizens, but for visitors as well, and it is regionalized. People have their own family physician, and so they are not deprived of their support systems when they are most in need of medical care. It is civil and civilized.

Nonetheless, I have always said that if one wants to see where this country is going, then take a look at the NHS. The NHS has been suffering from chronic malnutrition. Only 6.8 to 6.9 percent of the gross domestic product of the U.K. has been allocated to the NHS. This starvation diet has finally wreaked sufficient havoc in the system that its problems—continuous undercapitalization, inability to improve physical facilities, lack of expansion of facilities, and loss of medical personnel at the same time the population is aging and presenting increased needs—have finally come home to roost. The result is not pretty.

History

First, a look back. The NHS, organized in 1948, was a bold step well ahead of its time. At the time, physicians in the U.K. occupied a position in society not quite the same as that held by physicians in the U.S., but not terribly different. They were wooed into joining the NHS with financial and other benefits. And, to an extent, despite the fact that the NHS was chronically underfunded, some investment and the enthusiasm of many of the practitioners held the NHS together reasonably well for about 30 years.

The reason it lasted that long, I believe, is because early recruits to the NHS had been trained as professionals and continued to practice as professionals. It is unlikely that they would change their modus operandi to that of employees. Also, up until the late 1970s, the aging system had not seen the debility of outmoded facilities, lack of investment in technology, and aging infrastructure to the extent that one sees now.

Toward the middle of the 1960s, the almost universal approval of the NHS among Britain’s patient population began to change, and signs of discontent were emerging. Accident floors began to close throughout London. In fact, a patient with a head injury at this time may have traveled for an hour before getting reasonable care at an accident floor. Physicians’ and surgeons’ salaries did not keep pace with inflation. Waiting lists began to lengthen. My guess is that the emergence of these indicators of discontent paralleled the appearance within the workforce of physicians who had never been trained as professionals, but who had been employees throughout their entire experience in the medical profession.

There is a difference between a professional and an employee. A professional gets the job done regardless of hours and circumstances. An employee does his or her job in the time allotted. Some “physician employees,” to be sure, realize they are dealing with human lives and go far beyond the expected effort, but others just do their job. Indeed, given the tax structure in the U.K., a number of the physician employees, when offered time-and-a-half or double-time to work, for example, overtime at accident floors or to keep accident floors open, simply said that as employees they had no obligation to do so, and besides, most of it would be taken by taxes. They would rather be home with their families or at the local pub with their friends.

This particular distinction between professionals and employees has been completely lost on the economists and the self-appointed gurus who control what happens to American medicine. They fail to understand that if you treat people as employ-
ees, even if they may have been trained as professionals, they will no longer act like professionals but like employees, and, indeed, if one looks around the U.S., there are signs of this shift in attitude throughout the health care system.

In the mid-1970s, when the last of those individuals who had entered the NHS as professionals retired, England had a physician workforce consisting largely of individuals who had always been trained as employees and had always worked as employees. The cracks began to widen and the infrastructure began to come apart.

Current status

Fast-forward 25 years. By this time, the chronic underfunding has become so pervasive that the Blair government has promised £1.5 billion investment in infrastructure, technical equipment, and new facilities. There are those who think that after the five decades of chronic underfunding, this is a drop in the bucket and will never restore what was lost. Of greater concern are three themes that seem to be surfacing simultaneously and that appear to signal a real crisis. The third is a symptom of the first two.

1. Lack of physicians. Britain’s economy, after decades of stagnation, is now undergoing a rebirth with the advent of opportunities in technology, finance, and light industry. The traditional smokestack industries, such as coal, iron, and steel, have been driven into the ground by militant unionism, very much as in this country. Automobile manufacturing seems to be undergoing the same steady decline in the U.K. as in the U.S., in which the share of the U.S. market which American-made cars now comprise is less than 60 percent for the first time in history. But now the U.K. has a shortage of medical students and physicians. Where choices abound, people vote with their feet. The Blair government has now requested 10,000 foreign physicians to join the NHS. Mind you, these are not physicians at the ordinary level. These are consultants—the individuals who occupy the highest level in the NHS and who apparently cannot be drawn from endogenous British medical schools. The chronic “brain drain,” the lack of attractiveness of the NHS, and the persistent inability to pay physicians adequately has finally hit home. The parallel with what is happening in the U.S., as I will detail below, is frightening.

2. The waiting lists are now out of control. Waits of a year are common for just about everything in the U.K. Indeed, the government has finally taken steps to make certain that patients get needed operations. Where? Not within the U.K. The capacity, the skill, and the facilities simply do not exist. Forty thousand patients will probably go to the continent for surgery. What a disgrace. A country that holds itself as a second-tier world power cannot take care of its own sick, and has to export them to the European Union. Does anyone really realize what this says about a system that has totally failed?

3. Long waits on accident floors. Long waits in waiting rooms on accident floors now lead to deaths that seem to be avoidable. The Times of London indicates a death that was an accident waiting to happen in a hospital that everyone viewed as a “hell-hole” and that was chronically accused of having—in addition to horrid physical facilities, urine-stained walls, unbelievable stench in the corridors, and filth throughout—the inability to care for its patients. A patient with a relatively minor arm burn lay on a gurney for nine hours and bled out from a Cushing’s ulcer. Apparently the question is whether he had been seen and monitored during the period of time on an accident floor.

The nature of having to send patients to a foreign country, and even worse, having to rely on foreign countries to furnish physicians, leads to an interesting quandary with respect to the NHS. Will interpreters be furnished? The U.K. government now promises a massive infusion of funds in order to be able to rectify the situation. However, many, including a former health minister for a former Labor Party administration (and therefore not a member of the opposition), believe that no amount of money can rescue the system in its current form.

Parallels to U.S.

Does this all sound familiar? Perhaps. I assume that no one who is really monitoring the situation for the federal government, including those self-appointed gurus and economists who seem to control American medicine, is really concerned about a 21 percent drop in medical school applicants from a high of 46,968 in 1996-1997 to 37,092 in 2001, a year (2001) in which 68 places in general surgery programs remained
unfilled, and not only in mediocre training programs, but now in good training programs as well.6

The level of indebtedness of medical students is such that many of them, in my humble opinion, will never be able to repay their debt. The criminalization of medicine and the assumption that a physician is a criminal until proven otherwise has taken its toll in the standing of the medical profession. One cannot hope for physicians who are paid less and unable to educate their children in the schools they themselves attended (which is probably the line in the sand) to urge other people, including their children, to go into medicine. No one wants to get paid less than the neighborhood plumber and at the same time be subject to the barbs and arrows of society.

There is a crisis coming in the U.S., a crisis in access. My guess is that it will be here in less than five years, particularly at a time when the number of elderly is increasing and the needs are increasing as well. The gurus do not believe me, but there are lots of other individuals who are not MDs in medical care who do. Indeed, on the coasts, there are increasing numbers of physicians who refuse to see Medicare patients. It’s a shame that this action will be necessary in order to have some redressing of the situation. My guess is that given the way the government responds to things, there will be more draconian laws, penalties, fines, imprisonment, and so on. These efforts will only make the matter worse.

Unless and until those societal leaders and politicians who have savaged a pretty good system come to their senses and look “across the pond,” as the English say, and see what has happened to a once fine medical system, the same will happen here. No amount of criminalization, harassment, litigation, and downright threat will rectify this situation unless physicians feel better about themselves and their profession. It will be interesting to see which way this country will turn, but I certainly would not want to bet that sensible reforms, increased payment, decreased hassle, tort reform, elimination of unfunded mandates such as the Emergency Medical Treatment and Active Labor Act, and decreased criminalization of medical practice will occur. We will then reap the whirlwind. 

Dr. Fischer is chairman, department of surgery, and Mallinckrodt Professor of Surgery, Beth Israel Deaconess Medical Center, Boston, MA. He is a member of the College’s Board of Regents and Chair, Health Policy Steering Committee.

References
In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

This month, we’re going to take a break from specific Health Insurance Portability and Accountability Act (HIPAA) privacy requirements to offer some clarification about the regulation. We have listed some free resources available from the federal government that may be useful in your compliance efforts.

Does my office have to comply with HIPAA?
The College would like to clarify whether all surgeons’ offices are required to be HIPAA compliant. You must remember that there are multiple parts to the HIPAA rule. All physicians’ offices are required to comply with the standards in the HIPAA privacy rule. Originally the HIPAA statute did not contain any requirement that physicians’ offices bill electronically. However, amendments to the statute did provide that, with certain exceptions, practices begin to bill Medicare electronically by October 16, 2003. The amendments specified that small practices, defined as those with fewer than 10 full-time equivalent employees, are exempt. Practices may continue to bill other insurers on paper. CMS is still developing the method by which small providers can obtain a waiver from the electronic claims provision for Medicare claims. When that information is available, the College will provide additional background for Fellows.

Internet resources
There are two agencies within the U.S. Department of Health and Human Services (HHS) that have oversight of HIPAA compliance activities. The Office of Civil Rights (OCR) is responsible for enforcement of issues that are ruled by the privacy standards. Enforcement of activities that fall within the transactions and code set standards, as well as systems security and identifiers standards (when those are published) are the responsibility of the Centers for Medicare & Medicaid Services (CMS). Both agencies are actively developing Internet Web sites and useful tools to help practices better understand and comply with HIPAA.

The technical assistance Web page of the OCR Web site (http://www.hhs.gov/ocr/hipaa/assist.html) provides links to sample business associate contract provisions and answers to frequently asked questions (FAQs) about privacy standards in easy-to-understand language. The initial series of questions posted in October 2002 have been included in a document, “OCR Guidance Explaining Significant Aspects of the Privacy Rule,” which can be downloaded from the Web site. In addition to explaining the purpose and history of the refinement of the HIPAA regulations, the OCR guidance will offer some real-life scenarios of the practical applications of the rules.

The CMS HIPAA Web page (http://cms.hhs.gov/hipaa/hipaa2/default.asp) provides a database of FAQs to help you understand the HIPAA transaction provisions. The Web site gives an online test to help determine if you are a covered entity under HIPAA and the first of a series of 10 papers about electronic transactions and code set requirements written specifically for health care providers. (The subsequent papers will be posted at the same site as they become available). You can also download copies of the Provider HIPAA Readiness Checklist and the HIPAA Complaint Submission Form.

Although the College will continue to notify Fellows of additional guidance from the federal government on HIPAA issues, your privacy officer may want to check both of the HHS Web sites on a regular basis for new tools to assist with compliance.

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.

VI. Special perioperative problems


One such pulmonary complication is atelectasis. As the authors point out, ventilation with 100 percent O₂ before intubation is standard practice, and a fraction of inspired oxygen (FIO₂) higher than 90 percent is commonly used during operation. However, elimination of inert nitrogen in the alveoli leads to absorption atelectasis very rapidly. Accordingly, before extubation it is very helpful to restore normal alveolar nitrogen levels and volume through sustained inspiratory pressure with air.

Some general measures against atelectasis that Drs. Bartlett and Rich describe in their chapter include oxygen and nutritional support. If supplemental oxygen has been instituted as general support, the amount of oxygen should be kept as low as possible to avoid displacing nitrogen from alveoli and causing absorption atelectasis. Nutritional support should be instituted to achieve a positive nitrogen balance so as to maintain respiratory muscle strength and optimize host defenses. To prevent overfeeding, the amount of nutrients given should be based on measured energy expenditure. Overfeeding with carbohydrate causes an excess CO₂ load that may exacerbate pulmonary insufficiency.

In the case of pulmonary edema, the authors state that adequate treatment of increased lung water must include removing excess extravascular fluid (that is, returning the patient to baseline weight). Diuresis is continued until the patient is close to dry weight and is maintained in this condition. The major decrease in total extracellular fluid volume is accompanied by a...
minor decrease in pulmonary extracellular fluid volume, but this change is usually enough to improve pulmonary function greatly. Diuretic drugs remove water, sodium, and potassium at different rates; thus, all of these must be monitored carefully and frequently. Usually, more water is removed than electrolytes; as a result, extreme forced diuresis leads to a hypernatremic, hyperosmotic state. Serum sodium concentrations should be monitored closely: when they are between 145 and 150 mEq/L, diuresis has reached its limit. Subscribers may view the full text of “Pulmonary insufficiency” at www.acssurgery.com.

VI. Special perioperative problems

11. Blood cultures and infection in the patient with the septic response. Donald E. Fry, MD, FACS. Dr. Fry examines the relationship between the presence of organisms and the occurrence of a systemic inflammatory response, including: how to deal with a positive blood culture both in patients with infection and in those without infection; how to deal with a negative blood culture in patients with infection; and what to do in the event of a septic response in the absence of microorganisms. His discussion section covers sepsis as a nonspecific systemic inflammatory response, the natural history of the septic response, and new approaches to management of the septic response.

A positive blood culture in a patient with the septic response identifies the putative cause of the infection. This identification not only permits institution of appropriate systemic antibiotic therapy, but facilitates assessment of potential primary sources of the infection because of the established associations between specific anatomic sites and specific microbial isolates. Although it is not always possible to identify the microorganism or microorganisms responsible for the septic response, organization of the discussion according to the proven or suspected pathogen that may be recovered in a blood culture is a convenient way of addressing treatment options.

Therapy requires aggressive local debridement of necrotic tissue, systemic antibiotic therapy, and systemic supportive therapy for the shock and organ failure characteristic of severe infec-

tions. The recommended antibiotic regimen includes both penicillin, 12 to 24 million units/day, and clindamycin, 900 to 1,200 mg every six hours in adult patients. The addition of clindamycin is believed to reduce toxin production by inhibiting protein synthesis in the rapidly multiplying bacteria. Another reason why clindamycin is useful is that large inocula of group A streptococci are believed not to express penicillin-binding proteins. Subscribers may view the full text of “Blood cultures and infection in the patient with the septic response” at www.acssurgery.com.

VI. Special perioperative problems

3. Endocrine problems. Robert H. Bartlett, MD, FACS, and Preston B. Rich, MD. The authors describe the approach to preventing and managing the common endocrine conditions that occur as complicating factors in the perioperative period.

A major portion of their chapter deals with diabetes. For example, they state that the degree of control of diabetes may be assessed by recording blood glucose measurements at frequent intervals during fasting and at other times during the day and by determining the percentage of total hemoglobin that is combined with carbohydrate (such as glycosylated). Normally, glycosylated hemoglobin (commonly called HbA1c) accounts for 4 percent to 7 percent of total hemoglobin. HbA1c levels increase when hyperglycemia occurs, and the increases are cumulative over time. The value of measuring HbA1c in a preoperative patient known to have diabetes is that it gives the attending physicians some idea of how well hyperglycemic episodes are being controlled by insulin or oral hypoglycemics. Monthly measurements yield a good picture of the adequacy of glucose control over extended periods. HbA1c percentages higher than 10 to 20 percent indicate that the hyperglycemic aspect of diabetes has been poorly controlled. Chronic diabetic complications are reduced when good control of blood glucose is maintained; patients with diabetes are advised to measure their blood glucose levels frequently, which should result in normal HbA1c levels. HbA1c percentages higher than 15 percent suggest that the diabetes is quite brittle and that more frequent monitoring of blood glucose levels and closer con-
control of insulin administration are indicated dur-
ing and after operation. As long as the patient is
carefully monitored, there is no evidence that high
levels of HbA1c are associated with any increased
risk of impaired glucose control or complications
after operation.

The other important laboratory study in pa-
tients with diabetes is measurement of serum crea-
tinine levels (or, perhaps, creatinine clearance) as
an indicator of renal function. Renal insufficiency
is a common complication of diabetes that may
not be recognized during normal preoperative test-
ing.

Additionally, hypoglycemia can be difficult to
detect in critically ill patients. Blood glucose lev-
els in these patients are often elevated for any
of a number of reasons. Accordingly, it has been
common practice to accept blood glucose levels
ranging from 150 to 200 mg/dl in these patients.
This practice, however, was called into question
by a 2001 randomized study of 1,548 ICU pa-
tients in which liberal glucose control (blood
glucose level, 180 to 200 mg/dl) was compared
with tight control (blood glucose level, 80 to 110
mg/dl). ICU survival was significantly better in
the tight control group (95.4%) than in the lib-
eral control group (92%). In addition, the tight
control group had a lower incidence of systemic
infection, had less need of antibiotic therapy,
required fewer transfusions, and were less sub-
ject to hypobilirubinemia. These findings sup-
port the view that tight regulation of glucose and
insulin to maintain normal blood glucose levels
is desirable in critically ill patients. Subscrib-
ers may view the full text of “Endocrine prob-
lems” at www.acssurgery.com.

Looking ahead

New and revised chapters scheduled to appear
as online updates to ACS Surgery: Principles and
Practice in the coming months include the follow-
ing:

- “Ultrasonography: Surgical applications,” by
  Grace S. Rozycki, MD, FACS.
- “Perioperative considerations for anesthe-
sia,” by Steven B. Backman, MDCM, PhD,
  FRCP(C); Richard M. Bondy, MDCM, FRCP(C);
  Alain Deschamps, MD, PhD, FRCP(C); Anne
  Moore, MD, FRCP(C); and Thomas Schricker, MD,
  PhD.
- “Surgical incisions,” by Karen Fogelberg,
  MD, and F. William Blaisdell, MD, FACS.
- “Nosocomial infection,” by E. Patchen
  Dellinger, MD, FACS.
- “Emergency department evaluation of the
  patient with multiple injuries,” by Felix
  Battistella, MD, FACS.
- “Multiple organ dysfunction syndrome,” by
  John C. Marshall, MD, FACS.

Mr. Kelly is editor, What’s New in ACS Surgery: Prin-
ciples and Practice, WebMD Reference, New York, NY.
Late career changes require new practice plan

by the Division of Advocacy and Health Policy

After a successful surgical career, many Fellows plan to enjoy a comfortable retirement with time to travel, enjoy their families, and pursue long-delayed hobbies. In the late 1990s, the prospects of having the financial security to pursue these retirement activities looked rosy because stock market investments were paying off well. But that bubble has burst because of the economic downturn, and now many physicians who had looked forward to not just a financially secure retirement, but even the possibility of early retirement, had to go back and reevaluate those plans.

At the recent ACS Clinical Congress in San Francisco, the Division of Advocacy and Health Policy sponsored complimentary practice management consultations to assist ACS Fellows in a variety of related areas. It was surprising that so many surgeons near retirement were telling the same story. Of course, it was not surprising that the markets of the last two years had devastated portfolios and required investment changes. What was noteworthy were the unexpected challenges facing surgeons who had focused on retirement and who now find they must retrace their steps.

Several surgeons said that they had already begun slowing down their practices, putting continuing medical education priorities on a back burner, and developing exit strategies from their practices. In some cases, group practices had already started to recruit new surgeons in preparation for the senior surgeon’s departure. In other cases, surgeons had ceased cultivating new referring sources or even maintaining their traditional referral network. Some surgeons even asked referring practices to send their patients elsewhere. Contracts with third-party payors were dropped as the surgeon slowed down. By virtue of age and tenure, some surgeons had been relieved of community call responsibilities and even group call responsibilities. The picture painted was of a surgeon who was minimizing his or her practice in a planned and deliberate way...and their community knew it.

Some surgeons now say that they need to refocus on their financial security and continue working to rebuild their portfolios to ensure a secure retirement. So, how do they undo the damage and
rebuilt a practice? Following are some suggestions that may help surgeons who find themselves in this predicament.

1. Get some professional help with your portfolio. If the value of the portfolio dropped significantly, it was probably not well balanced in the first place. Put the assets into safe and prudent investments with some professional guidance. Determine where you are financially and where you need to be. Decide how much money to save over a defined period of time to reach your financial goal. Looking at the formula from a different angle, find out how long you have to continue working if a specific amount of money is invested each month. In either case, determine a timeframe for how long to continue in practice.

2. Keep clinical skills up to expected standards. Some referring sources may assume that a surgeon who has been intent on retiring may have let his or her skills and knowledge decline. Ask yourself the tough questions about your skills. If the state of the art is endoscopy, and you did not bother to attend those courses to learn the procedures, you may need to do some retraining. If you do engage in continuing education, inform referring physicians.

3. Get back in the call schedule. This is probably the toughest thing to do. Call is one element of a surgeon’s practice that almost everyone looks forward to ending, but it is the way many surgeons develop a practice from the very beginning. It may be necessary to go back to what worked from the start.

4. Be available. Often referrals go to the surgeon who can take care of the patient the soonest. Schedule new patient referrals quickly and be available in the office for at least a portion of each workday. Make a priority of getting the new patient into your office within two days.

5. Critically evaluate work habits. Build on the positive ones and strive to eliminate or reduce the negative habits. For example, a surgeon who is habitually behind schedule should evaluate why and make an effort to get back on it.

6. How do the office and the staff appear? In some instances, when people prepare to retire, their offices’ appearance suffers. Do a walk-through of the office and make a list of those things that need to be cleaned, repaired, or replaced. A little paint and some modest attention can turn a dreary office into an inviting space that indicates you are not leaving anytime soon.

7. Surgeons in group practice should be realistic and honest with their colleagues about their plans. More often than not, they can and will help, but they need to know your expectations.

8. Finally, work on your mental and physical fitness. Exercise, eat properly, dress professionally, pay attention to grooming, and have a strong, positive mental outlook. People who are upbeat about their situation find others respond in kind.

This month’s column was prepared by Tom Loughrey, chief executive officer of Economedix, a national practice management consulting and education company with offices in Pittsburgh, PA, and southern California. Mr. Loughrey can be reached at tel. 714/633-2251, or via e-mail at tloughrey@economedix.com.

This column helps answer questions from 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 e-mail HealthPolicyAdvocacy@facs.org.
The American College of Surgeons’ Division of Education has established four special task forces to address the competencies of interpersonal and communication skills, systems-based practice, practice-based learning and improvement, and professionalism. These competencies have been adopted by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. The task forces will address the spectrum of educational items relating to the aforementioned competencies within the context of both residency training and maintenance of certification. Educational models will be developed to serve the needs of learners across the various surgical specialties.

The Education Task Force on Interpersonal and Communication Skills met at the College’s headquarters in Chicago, IL, November 24-25, 2002 (see photo, above right). The task force was chaired by L.D. Britt, MD, MPH, FACS. Small groups addressed interpersonal and communication skills as they relate to interactions between various professionals in the different surgical environments and interpersonal and communication skills as they relate to interactions with patients and their families in the different surgical environments. The groups were led by Kathryn D. Anderson, MD, FACS, and Ira J. Kodner, MD, FACS, respectively.

The Education Task Force on Systems-Based Practice. Front row, left to right: Dr. Healy (Chair); Jeffrey B. Cooper, PhD; Dr. Russell; Matina Horner, PhD; and Mary H. McGrath, MD, MPH, FACS. Back row: Ms. Blair; J. Donald Monan, SJ; Josef E. Fischer, MD, FACS; James P. Bagian, MD; Maurice J. Webb, MD, FACS; Richard J. Gusberg, MD, FACS; David W. Roberson, MD; Dr. Gaba; Dr. Sachdeva; Dr. Steele; Dr. Gordon; Ms. Stewart; Ms. Sherman; and Ms. Morrison.

Not pictured: Julie A. Freischlag, MD, FACS; Thomas M. Krummel, MD, FACS; J. Patrick O’Leary, MD, FACS; and Carlos A. Pellegrini, MD, FACS.
The Education Task Force on Systems-Based Practice met at the College’s headquarters December 8-9, 2002 (see bottom photo, p. 31). The task force was chaired by Gerald B. Healy, MD, FACS. During the meeting, a small group addressed health care systems, optimum resource utilization, patient advocacy, and interprofessional teamwork. A second small group addressed patient safety, simulations and simulators, and new technology. A third small group addressed innovative educational approaches and redesign of surgical conferences, and specifically focused on the morbidity and mortality conference. These groups were led by Glenn D. Steele, Jr., MD, FACS; David M. Gaba, MD; and Leo A. Gordon, MD, FACS, respectively.

The productive discussions during the meetings of both task forces yielded a large number of major recommendations, which will serve as the foundation for the next steps.

For further information on the competencies task forces, please contact Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, at 312/202-5405 or via e-mail at asachdeva@facs.org.

2003 ANZ Travelling Fellow selected

Christopher R. Forrest, MD, FRCSC, FACS, medical director of the Craniofacial Program of the Hospital for Sick Children, Toronto, ON, has been selected as the 2003 Travelling Fellow of the Australia and New Zealand (ANZ) Chapter of the American College of Surgeons.

As the Travelling Fellow, Dr. Forrest will participate in the annual Scientific Congress of the Royal Australasian College of Surgeons in Brisbane, Australia, May 5-9, 2003. He will attend the ANZ Chapter meeting during that congress, and will then travel to several surgical centres in Australia and New Zealand.


2003 International Guest Scholars selected

Eight International Guest Scholarships for 2003 were awarded by the Board of Regents during the 88th annual Clinical Congress in San Francisco, CA.

The scholarship program enables talented young academic surgeons from countries other than the U.S. or Canada to attend and participate in the activities of the Clinical Congress, then to tour surgical institutions of their choice in North America. The program is administered by the College’s International Relations Committee.

The 2003 International Guest Scholars are: Emmanuel A. Ameh, MBBS, Zaria, Nigeria; Felipe A. Catan, MD, Santiago, Chile; S.V. Suryanarayana Deo, MBBS, New Delhi, India; Arnulfo F. Fernandez, MD, Havana, Cuba; Yur-Ren Kuo, MD, Kaohsiung, Taiwan; Marie Carmela M. Lapitan, MD, FPCS, Manila, Philippines; Maria A. Matamoros, MD, San Jose, Costa Rica; and Hans Rahr, MD, Odense, Denmark (Abdol Islami Scholar).

The requirements for applicants for the 2004 International Guest Scholarships appeared in the January Bulletin. They can also be viewed on the College’s Web site at www.facs.org.
CREATE YOUR OWN ID/PASSWORD
for “Members Only” area of ACS Web site

Can’t think of your ACS ID number when you want to visit the “Members Only” side of the College’s Web site? Your days of frustration are now over.

The College has updated the Members Only section to allow you to set your own user ID and password to access its many features. To make that change, go to the College’s home page at http://www.facs.org and click on the “Members Only” link at the top of the page.

You will still need your ACS ID when you log in for the first time. You can then enter your user ID, password, and security questions. If you forget your password the next time you visit the page, you can recover your password online by answering your previously set up security questions.

While you are in the “Members Only” area, please check to be sure that your mailing address, telephone numbers, and e-mail address are both current and accurate. Be assured that the College does not provide your e-mail address to outside entities. E-mail addresses are used only for College communications.
The College succeeded in passing all three of the resolutions it sponsored during the 2002 Interim Meeting of the American Medical Association House of Delegates (AMA HOD), which took place December 7-11 in New Orleans, LA. As directed by a previous action of the HOD, this meeting focused on issues related to legislative and regulatory advocacy. The result was a streamlined and more efficient agenda for the HOD.

Office-based surgery
Probably the most controversial proposal from the College called for the AMA and the ACS to convene a workgroup of interested specialty societies and state medical societies, which would use a consensus approach to develop uniform requirements for office-based surgery. The end result of this workgroup’s activity would be model legislation that physicians could propose at the state level.

Liability and reimbursement
The second College-sponsored resolution addressed medical liability reform and reimbursement—two issues that are weighing heavily on delegates from all regions of the country. The resolution, which was unanimously affirmed by the HOD, calls on the Centers for Medicare & Medicaid Services (CMS) to adjust the Medicare fee schedule methodology to ensure that actual liability costs and increases in those costs are reflected in physician payments. The resolution also asks CMS to use more current data to assess the impact of professional liability premiums on the resource costs involved in providing physician services.

Quality
Finally, the College took a leadership role in encouraging the house of medicine to become more heavily involved in the development of evidence-based quality measures. The College’s last resolution calls on the AMA to “advocate for wider support and funding for adequate collection of clinical data needed for the development of quality standards.” In addition, it urges the AMA-coordinated Physician Consortium for Performance Improvement “to move ahead in a proactive and highly visible manner to address quality and safety concerns.”

Other issues
In other matters, the AMA HOD adopted a number of other resolutions on issues of interest to surgeons, including support for: continued graduate medical education funding by Medicaid; an immediate update by CMS of the ambulatory surgery center list of covered procedures; strong prompt payment laws to avoid preemption by the Employee Retirement Income Security Act; and efforts at the state level to prohibit smoking in public places and businesses.

Surgical caucus
The surgical caucus of the AMA met during the HOD and focused on improved collaboration in advocacy. LaMar S. McGinnis, Jr., MD, FACS, ACS Delegation Chair, highlighted the cooperative efforts that the College is undertaking with other surgical specialty societies and the AMA. In addition, he showcased the new Surgery State Legislative Action Center (SSLAC)—an Internet advocacy tool that the College and 11 other surgical specialty societies are now using for state-level advocacy (www.facs.org/sslac). As a result of Dr. McGinnis’s presentation, College staff have been approached by three additional surgical specialty societies that want to support the SSLAC.

In addition to Dr. McGinnis’s leadership, the College also benefitted during the HOD meeting from the input and expertise of its other delegation members: Drs. Charles Logan, Richard Reiling, Tom Whalen, and Amlu Rothhammer (all Fellows of the College). Chad Rubin, MD, FACS, also continued his effective service as the College’s
representative to the AMA Young Physicians Section. For further information about AMA HOD activities, please contact Jon Sutton, State Affairs Associate, in the College’s Chicago Office, tel. 312/202-5358, fax 312/202-5031, or e-mail jsutton@facs.org.

Clowes research award given

The George H.A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award for 2003 was granted to Bhuvanesh Singh, MD, FACS, assistant attending, Memorial Sloan-Kettering Cancer Center, New York, NY, and assistant professor of surgery, Weill Medical College, Cornell University, Ithaca, NY, for his research project entitled “Functional characterization of the novel oncogene SCRO (squamous cell carcinoma related oncogene).”

The purpose of the Clowes Award is to provide support for promising young surgical investigators. The award is sponsored by The Clowes Fund, Inc., of Indianapolis, IN, in the amount of $40,000 for each of five years, beginning July 1, 2003.

Information regarding the Clowes Award and the other scholarships, fellowships, and awards offered by the College appear on the ACS Web site, www.facs.org.

Coding workshops

The American College of Surgeons will sponsor a series of basic and advanced CPT and ICD-9-CM coding workshops during 2003. Foundations in CPT and ICD-9-CM Coding and Mastering Surgical and Office-Based Coding will be offered back-to-back in five locations. These one-day workshops are designed for all surgeons and their staffs and will be presented by representatives of KarenZupko and Associates.

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The American College of Surgeons designates each coding workshop for up to a maximum of seven hours in Category 1 credit towards the Physician’s Recognition Award of the American Medical Association. Visit the ACS Web site for more information about the workshops, locations, and online registration at http://www.facs.org/dept/hpa/workshops/cdwkshop.html. ACS coding workshops will also be offered as postgraduate courses during the College’s 2003 Spring Meeting and Clinical Congress, so watch your mail for them in the coming weeks and months.
Practice management course to be featured at Spring Meeting

A didactic postgraduate course entitled Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons will be featured at this year’s annual Spring Meeting in New York, NY.

ACS Regent Charles D. Mabry, MD, FACS, Pine Bluff, AR, and Frank G. Opelka, MD, FACS, Boston, MA, will serve as co-chairs and instructors.

The sessions will take place Monday, April 14, 8:00-11:30 am (Session I), and 12:30-4:30 pm (Session II). The fee for the postgraduate course is $450.

The program will address improvements in management and efficiencies of surgical practice operations. It will involve discussion of business practices and overall components of operations. The instructors will provide insights to solve real-life practice management problems.

Scheduled topics include:

- Organizing Your Office for Optimal Efficiency.
- Financial Reports and Insurance Claim Processing.
- Corporate Compliance.
- Benchmarking.

Breakout sessions for small surgical practices will consider managing personnel, fees/insurance/collections, compliance and HIPAA issues, and practical computer systems. Breakout sessions for large surgical practices will consider financial management for large/academic practices, fee/insurance/collections, activity-based costing, and other issues for large practices.


Additional course opportunities

Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons will also be offered in 2003 as follows: March 15—Phoenix, AR, May 31—Atlanta, GA, August 23—St. Louis, MO.

Further information regarding these courses may be obtained from Irene Dworakowski, ACS Washington Office, 1640 Wisconsin Ave., Washington, DC 2007, tel. 202/672-1507, e-mail idworakowski@facs.org.
In an effort to meet the growing and ever-changing needs of our Fellows and a diverse surgical community, the Division of Education is offering seven online general sessions from the Clinical Congress. These sessions are offered in the form of a Web cast at [www.facs-ed.org](http://www.facs-ed.org).

Each session is offered separately and contains written transcripts, audiovisual displays, a post-test, an evaluation, and, upon successful completion of each session, an online printable CME certificate.

**Available courses:**

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Announcing...

CME online

Web casts of general sessions from the Clinical Congress

NOW ONLINE
Randolph Fellowship in Pediatric Surgery established

The Children's National Medical Center, Washington, DC, recently established the Dr. Judson G. Randolph Fellowship in Pediatric Surgery, honoring the founder of its nationally renowned pediatric surgery training program.

In November of last year, the Joseph E. Robert, J r., Center for Surgical Care at the center welcomed Judson G. Randolph, MD, FACS, current surgical staff, and alumni for a reception and grand rounds lecture delivered by LaSalle D. Leffall, J r., MD, FACS, professor of surgery at Howard University College of Medicine, Washington, DC. Joined by many of the 30 pediatric surgeons he trained during his 28-year career at Children's, Dr. Randolph named Christopher P. Coppola, MD, FACS, the first recipient of this endowed fellowship, which aims to provide superior education to emerging leaders in pediatric surgery.

“The endowment of this fellowship ensures that Dr. Randolph's legacy will continue here at Children's for generations to come,” said Kurt Newman, MD, FACS, associate chief of surgery, who trained under Dr. Randolph from 1984 to 1986. “Dr. Coppola and future Randolph fellows will benefit from his outstanding leadership and commitment to children's health care,” he said.

Children's National Medical Center raised more than $1 million to establish the hospital's first Pediatric Surgery Fellowship Endowment. All funds will be directed toward enhancing the hospital's already well-established surgical training program.

In 1963, Dr. Randolph began his career at Children's as the first pediatric surgeon dedicated solely to the care of children in Washington, DC. The following year he established the Pediatric Surgery Fellowship Training Program and went on to mentor over 30 pediatric surgeons, many of whom became chairs and training directors at other children's hospitals. “It has always been my belief that a good pupil will always outshine his teacher,” Dr. Randolph said. “The success of this training program relies on Children's ability to offer superior educational opportunities to the country's finest young surgeons.”
Dr. Coppola, the 2002 recipient of the fellowship, began his surgical training at Children’s in 2001 after completing a general surgery residency at Yale University School of Medicine, New Haven, CT. He received his MD degree from Johns Hopkins University School of Medicine, Baltimore, MD, and his undergraduate degree from Brown University, Providence, RI. A native of Washington, DC, Dr. Coppola is a Major in the U.S. Air Force and has lent his medical expertise to volunteer projects in the U.S. and abroad.

Dr. Randolph’s commitment to health care and education was reflected in the selection of Dr. Leffall as the featured lecturer. Dr. Leffall has served as a member of Howard University College of Medicine’s faculty for over 40 years and has taught over 4,500 medical students and trained nearly 250 general surgery residents. He is a Past-President of the College and was recently named the chairman of the President’s Cancer Panel by President George W. Bush. Dr. Leffall’s lecture, “Ethics in Surgical Practice,” addressed “end of life” discussions, clinical trials, and alternative therapeutic measures.

Trauma meetings calendar

The following continuing medical education courses in trauma are scheduled.

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

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

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

**Tort reform**

The growing medical malpractice crises across our nation are the result of a tort system that encourages and rewards behaviors that are detrimental to the delivery of quality health care to patients. Characterized by inconsistency, unpredictability, and exorbitant costs, the medical malpractice subfield of the law of torts has shown itself to be ill-suited as a legal remedy either for compensating individuals who have sustained injury at the hands of medical providers or for deterring further similar harm to others. Tort law is a legal tool that is mismatched to these tasks.

Tort is like a carpenter’s hammer in the hand of an optician. Its use can do little to correct a loose lens by tightening a hinge screw on a pair of glasses. Regardless of the modifications made to the hammer, clearer vision will not result unless the hammer is placed aside and more appropriate tools are employed. Stubborn insistence on using the hammer, even after innumerable modifications, will only result in further visual distortion. That the evolving hammer of tort has been with us for over a century is no excuse for perpetuating the application of a system that is failing and threatens to bring down a large sector of our service economy as it flounders.

Recent studies cited in public ads by attorneys suggest that the number of injuries among hospitalized patients is alarming. These findings coincided with remarkable increases in the tort burdens imposed on health care providers. Further evidence that tort law is the wrong tool for the job exists in the thousands of tort reform legislative initiatives that have been proposed nationwide over the past quarter-century. The net effect of these efforts is a fragmented system that is increasingly dysfunctional and displays characteristics of a negatively reinforcing process that is driven further from effective restructuring with each new wave of state tort reform efforts. Quality management theorists recognize this as tinkering and the predictable result is increasing dysfunction. Systems analysts recognize this as a failed paradigm that does not take into consideration secondary effects and externalities.

Persons who are familiar with medical malpractice cases understand that such cases are frequently won or lost due to the persuasiveness of the respective attorneys and not because of the actual merits of the case. This situation benefits neither the public nor the health care system. More often than not, it does not even benefit the plaintiff. The search for truth in these cases is often lost in a flurry of zealous advocacy. Truth, as generally understood, is neither the goal nor the driving motivation in the litigation process. The avuncular pursuit of inordinate shares of the monies intended for the compensation of patients who have sustained genuine maloccurrences has escalated to the point where we are experiencing a profound decline in the ability of physicians and hospitals to deliver quality health care to our citizens. This result has been underwritten by what amounts to legalized extortion of unreasonable and burgeoning liability premiums from health care providers to fuel a failed tort system.

Like a dangerously high fever, which is a symptom of an underlying illness, unreasonable and skyrocketing liability premiums have surpassed the point of peril for many physician practices and hospital services. As a result, many states have entered an era wherein the tort system is causing far more harm than benefits. The net effect is to increasingly deny citizens access to quality health care. While exorbitant insurance premiums are not the root cause of the problem, some form of immediate symptom relief is needed in many jurisdictions. Out-of-control premium assessments portend a meltdown in health care delivery across wide areas of our nation.

In the larger view, if we are to preserve and enhance what is good about the health care professions in service to our nation, it will be necessary to look beyond treating the symptoms of a system that has run amok. The current tort system, as it applies to medicine, serves as a money magnet that attracts people from diverse groups who parlay positions of regulatory, legal, and medical advantage into financial gain and outright cash rewards. Placing blame on individuals or groups misses the more fundamental truth that it is the tort system itself that is at fault. Individuals and groups operating within and gaming the system are simply availing themselves of golden opportunities provided by a flawed system at the expense of the common good. A tragedy is playing out that will increasingly place the public’s health in jeopardy.

The problems that we are encountering were both predictable and predicted by physicians and physician groups decades ago. While most jurisdictions largely ignored these warnings, a few states managed to forestall the onslaught of the tort juggernaut through legislative initiatives designed to discourage abuse of tort. The majority of states failed to successfully address even the symptoms, let alone the root causes, of the problems. Most fundamentally, as a nation we will not be able to reverse the vortex of adversarial legalism...
that holds our health care system hostage until we come to grips with the fact that the tort system itself, as it applies to medicine, is the problem. There must be a willingness to recognize that there are more just, less costly, and nonadversarial ways of compensating individuals and families who have sustained maloccurrences in the health care field. Additionally, there are more just, less costly, and more effective means of preventing harms that occur in the health care arena. Ultimately, it is the public who stands to gain the most through symptom relief and system supplantation.

Dan F. Kopen, MD, FACS

There is little question that medical liability costs and the lack of meaningful tort reform are very important issues to practicing physicians and surgeons in this country. As past-president of the Westchester County, NY, Medical Society, I have participated in numerous meetings with legislators and public demonstrations about these issues. Nothing has been accomplished in New York State, because the Democratic speaker of the state assembly has vowed that there will be tort reform only “over my dead body.”

The impetus for tort reform must come from the general public. They need to know that there is a crisis in health care that will immediately affect them—a lack of physicians and surgeons willing to give them care because of the abuses and costs of the current tort system.

As you know, the people of Pennsylvania are now being subjected to the loss of physicians’ services in offices, clinics, hospitals, and emergency departments. Doctors who cannot obtain or cannot afford liability insurance are no longer offering care. It is the crisis of no available health care—not the concerted efforts of the Pennsylvania Medical Society and chapters of the ACS—that will change the situation.

As a member of the house of delegates of the Medical Society of the State of New York, I am submitting a resolution recommending a week of mandatory medical education for New York physicians; during that week their only professional obligations will be learning about the latest medical advances and about how to avoid malpractice liability claims. During that week, the people of New York—except for those with truly emergent medical conditions—will have to learn to do without medical care, or to see their legislators for changes that will result in the ability of physicians to practice medicine without the threat of groundless suit or of exorbitant insurance premiums.

It is time that our crisis becomes everyone’s crisis. Then, and only then, will we see meaningful tort reform.

Peter S. Liebert, MD, FACS

Optimal patient care

I agree fully with Dr. Russell’s comments in the Bulletin (October 2002) regarding professionalism and was glad to see him close his remarks with emphasis on “optimal patient care.” We need to stress in all our communications with the public and politicians that the American College of Surgeons was founded primarily to improve the quality of surgical care and that is our continued concern. It’s a message we need to repeat over and over. The American Medical Association has never recovered its prestige because in the debate over Medicare their stance became too closely identified with doctors’ economic interests. It must be clear that our actions are sincerely driven as advocates for quality surgical care—not our own pocketbooks.

Stuart A. George, MD, FACS

Medical education/mentors

I am now and have been for the past four years assisting in the gross anatomy lab at UCLA School of Medicine. Prior to my retirement in 2000, I had been at Kaiser Permanente in Panorama City, CA, for 40 years, chief for 17 years, and, in those years, residents from the surgical service at UCLA rotated through our department (and still do) at both the junior and senior levels.

It is clear to me that we all have an obligation to participate in teaching medical students and residents. Were it not for volunteer surgeons, most programs would suffer greatly. Someone did it for us; we should give back.

I truly think that every medical school would greatly appreciate and benefit from having surgeons participate in teaching history and physical examination sessions for students, now almost exclusively populated by internists and family practitioners. This is another point early in the careers of medical students when they can be influenced to consider the surgical specialties. How to accomplish this will vary from one community to the other. I don’t know if the College would consider approving the medical school administrations nationwide about this, to jointly recruit surgeons for this purpose.

Of course, many of us have been asked to participate in science fairs in high schools, but how many of us have done so?

Richard A. Braun, MD, FACS

Resident hours

I read with great interest your article on house staff hours (November 2002). As an intern and resident at Bellevue Hospital before and after my time in service, I heartily concur with your conclusions.

As an intern, I had to have the history and physical on the chart along with a CBC and urine by 8:00
am. This is to say nothing about the routine daily urines on diabetics. I worked on average over 90 hours a week, but much of that time I was able to rest adequately.

At no time was I confused or hallucinating as so many New York house staff complained to the legislature. The New York laws are all wet, and have been influenced by the house staffs that testified before the state legislature. Those people felt that, after medical school, they deserved a life of ease.

An example of the ability to carry on after stress is the Egyptian heart doctor who worked in London and decided to return to Cairo to donate his services to the land of his birth. He performed three procedures, starting at 7:00 am and finishing at 3:00 am the next day. The first patient died, but the other two did very well. For all I know, it may have been the cardiac surgeon, Sir Magdi Yacoub, FRS, FRCS(Eng, Ed, Glas), FACS(Hon), who was honored in the November 2002 issue of the Bulletin. Obviously, this particular surgeon was not and did not appear to be harmed by his long hours.

John S. Hooley, MD, FACS

They fit not only in your pocket, but into your busy schedule as well. You can take the 2002 Syllabi Select courses wherever you have access to a computer...at home, at work, or even on the road.

Syllabi Select is a CD-ROM containing 14 postgraduate course syllabi from the 2002 Clinical Congress. These syllabi—selected and packaged for your convenience—can be purchased by calling 312/202-5474 or through the College’s Web site at http://secure.telusys.net/commerce/current.html

The 2002 Syllabi Select CD-ROM is priced at $75. There is an additional $12 shipping and handling charge for international orders.

John S. Hooley, MD, FACS
Highlights of the ACSPA Board of Directors and the ACS Board of Regents meeting

October 5, 6, and 11, 2002

by Paul E. Collicott, MD, FACS, Director, Division of Member Services

American College of Surgeons Professional Association (ACSPA)

The ACSPA Board of Directors approved the appointments of a Vice-Chair and two additional members to the political action committee (PAC) Board. They are Jean Hausheer, MD, FACS (Vice-Chair); L.D. Britt, MD, FACS; and Paul Weiss, MD, FACS. There are now 19 members of the PAC Board. The PAC Board’s composition reflects a broad range of surgical specialties, and no additional appointments are anticipated in the near future.

A few of the items on the agenda for the PAC Board’s first meeting included:
• Approval of necessary organizational resolutions.
• Adoption of committee bylaws.
• Consensus on a legislator scoring system.
• Approval of a donor recognition system.

American College of Surgeons (ACS)

Ad Hoc Committee to Review the Structure, Composition, and Terms of the Board of Regents

W. Gerald Austen, MD, FACS, presented the committee’s recommendations to the Board of Regents. The Board approved the following recommendations:
• Regents may continue to serve three three-year terms.
• Individuals who are no longer in active surgical practice should not be nominated for an initial term on the Board of Regents. If a Regent retires from active clinical practice while serving on the Board, he/she should not be nominated for reelection when the current term expires.
• A public member will not be added to the Board of Regents at this time.
• An international Fellow will be invited to attend one year of Board meetings as a guest.
• The size of the Board of Regents will be increased from 18 to 21, to allow for adequate specialty representation, with the President serving as the twenty-second Regent.
**Erie Street properties**

The Board of Regents approved the retention of the Nickerson Mansion and the John B. Murphy Memorial Auditorium. The Board also approved the recommendation that the Murphy Auditorium be used as the American College of Surgeons Center for Patient Safety.

**Communications**

The following projects are just a few of Communications’ recent as well as ongoing projects:

- A press release citing the College’s position on compensation for organ donations was developed and distributed.
- A press kit highlighting new developments in surgery that were to be presented at the Clinical Congress was prepared and distributed to reporters around the world.
- The revised and updated versions of the patient information brochures are now available in print and online on the College’s Web site. The review process for the last three of the existing 13 brochures that have not yet been updated has been initiated.
- The ACS Smart Site™ program was launched in August for interested chapters of the College. An online presentation has been provided for chapters that would like to evaluate its viability as an alternative to their current systems.
- Current articles featured or to be published in the Bulletin include charitable immunity protection for volunteer surgeons, surgeons and Washington, DC, a historical perspective of SESAP, the origins of regulated resident work hours, and using data as a weapon to reduce gun-related violence, among many other subjects.

Regarding organ donations, the work of the Rapid Response Group was initiated on June 20 in response to an AMA House of Delegates action concerning the question of compensation for organ donations. The College does not agree with payment of any kind for organs to be used for purposes of transplantation. The group agreed that valid studies of this question are in order, but that a major part of those studies should be a real attempt to find valid solutions to the problem of organ donations without making the issue one of compensation. The American Society of Transplant Surgeons has referenced the College’s position in communications with federal lawmakers who are studying the issue.

**Development Program**

The Board of Regents was updated on the activities of the program. It was reported that as of September 5, 2002, the Committee on Development received 1,357 contributions totaling $515,661. These figures exceed those of the same period in 2001.

**Journal of the American College of Surgeons (JACS)**

The Board of Regents was apprised of JACS’s activities. Owen H. Wangensteen Surgical Forum participants received a letter inviting them to submit a full manuscript from their accepted abstracts. Several young investigators called personally to thank JACS for the upcoming supplement and for the chance to provide a manuscript.

The Elsevier Web site for JACS will migrate to a new platform and provide a more customized site. Among other features, the new Web site will be able to display multimedia content including operative videos with sound and will also be able to provide important new capabilities to alert Fellows to forthcoming articles on selected topics, as articles appear.

Elsevier is hoping to be able to provide online subscriptions to MDConsult for medical students. Details of this project are not yet complete.

As of September 9, 2002, a total of 17,949 CME-1 credits were provided to ACS Fellows.

**Information Services**

The Board of Regents approved several strategic projects. They are:

- Fellowship portal: A Web page that allows viewers to see a wide variety of topics and allows viewers to select the topics they want to see.
• CD-ROM and Web-based CME programs.
• Expansion of patient education materials by providing a searchable Web site with extensive and up-to-date medical information.
• Development of online communities in which our members can interact with each other about areas of common interest.
• Provide basic computer training for our members.

Conventions and Meetings
It was reported that during the last few years, overcrowding has been experienced in some of the general sessions. The sessions were monitored and as a result a few were moved to larger rooms. This step was taken to eliminate any safety issues and to allay any dissatisfied attendees.

Joint Commission on Accreditation of Healthcare Organizations (J CAHO)
Two of the College’s commissioners to J CAHO, Irwin N. Frank, MD, FACS, and Robert E. Hermann, MD, FACS, will complete their service in 2002. Drs. Frank and Hermann will be replaced by David L. Nahrwold, MD, FACS, and Kurt D. Newman, MD, FACS. The College’s third commissioner, Robert B. Smith III, MD, FACS, will serve through 2004. These appointments were made by the Executive Committee of the Board of Regents.

Division of Education
Bariatric surgery course. The Board of Regents approved a proposal to establish a bariatric surgery course and to create an electronic primer. Obesity and morbid obesity have reached epidemic proportions in the U.S. and in many parts of the western world. Surgery is the treatment of choice for morbid obesity and may soon become so for obesity. The ACS, in association with the American Society for Bariatric Surgery and the Society of American Gastrointestinal Endoscopic Surgeons (SAGES), will present the course at the Spring Meeting and Clinical Congress and also offer freestanding courses at major cities throughout the year. These skills-oriented courses will be complemented by an electronic primer (CD-ROM) that will be distributed by the ACS. In addition, an interactive Web site will be established to share timely information between past participants of the course and other interested parties.

Resident work hours. The Board of Regents received a report on division activities. Among them, it was reported that the Subcommittee on Resident Education plans to work closely with the new Ad Hoc Committee on the Environment of Residency Education to address the impact of reduced resident work hours as well as other critical issues.

New technologies and surgical procedures. In another area, the Committee on Emerging Surgical Technology and Education will address two sets of activities. The first set involves the development, implementation, and rigorous evaluation of programs to train surgeons in new technologies. The second set involves the evaluation and adoption of new surgical
procedures. Patient safety will remain the overarching goal in this process.

Licensing/credentialing. A special certificate will be awarded to individuals who attend the Ethics Colloquium. This may be of value to surgeons during the processes of local credentialing and license renewal.

Medical student program. The program for medical students has been completely redesigned. An open invitation was sent to all medical schools in the U.S. and Canada, inviting each school to send interested students from any level to attend the Clinical Congress. One-hundred-eighty-one students registered—170 from the U.S., 10 from Canada, and one from Germany; 83 of them were fourth-year students, 54 were third-year students, 37 were second-year students, and seven were first-year students. Special activities conducted from Sunday through Wednesday included:

- Lectures combined with receptions to promote interaction between speakers and students.
- More interactive and informal events to allow students additional time to network with surgeons and other students.
- Topics of special interest to first- and second-year students such as planning summer research projects.

SESAP. Sales of Surgical Education and Self Assessment Program (SESAP) 11 continue to remain robust. The development of SESAP 12 continues to progress well. The opportunity to create surgery case simulations continues to be pursued.

SAGES. Dialogue is continuing with the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) to collaborate in the implementation of the Fundamentals of Laparoscopic Surgery course.

Division of Member Services

Member benefits. It was reported to the Board of Regents that the American College of Surgeons Insurance Trust (ACSIT) finalized a contract with The Doctors Company. The sponsored product will be available soon. Fellows will benefit by having a quality insurance product at a competitive rate. There will be a separate risk pool for Fellows in each state, which will affect premiums in each state. The ACSIT also established an affinity partnership with Liberty Mutual Group for auto, home, and personal liability policies. In addition, the ACSIT offers an International Travel Medical Insurance Plan.

ACS toll-free number. The American College of Surgeons now has a toll-free number. The number (800/621-4111) has been assigned to the central switchboard.

Practice management Web site. Through its Committee on Young Surgeons, the College has established a link to a practice management Web site for surgical residents and young surgeons. The Web site, created and maintained by the department of surgery at the University of Washington, features topics that include: compensation, contract negotiations, time management, insurance requirements, patient satisfaction, coding and reimbursement, hiring and interviewing staff, and personal finances and tax planning. Additional topics will be posted in the future.

New Fellows. The Board of Regents approved the induction of 1,512 Initiates into Fellowship: 1,360 from the U.S. and its possessions; 30 from Canada; and 122 from 43 international countries.

Chapters. There continues to be an increasing interest in chapter mergers either with local surgical organizations, other chapters within a state, or chapters of other states. The division is actively assisting those chapters that wish to pursue this activity.

Multi-country chapters. Some international countries have too few Fellows to qualify for a Governor and, therefore, a chapter. ACS educational programs can only be introduced into international countries through a recognized surgical society in that country or an established ACS chapter in that country. The Board of Regents approved a request to allow countries to petition the Executive Committee of the Board of Governors in applying for a multi-country chapter for the purpose of introducing ACS educational programs.
Board of Governors’ Committees’ Structure

The Board of Regents approved the proposed changes to the structure of the Governors’ committees. Four of the eight committees were consolidated and renamed, reducing the total number of committees to six. In addition, each committee will have a mission statement and terms of reference.

Governors’ Committees’ Programs

The Board of Regents approved proposed programs submitted by three of the Governors’ committees. They are:

- “Agents of Bioterrorism” and “Newer Transmissible Pathogens in the Surgical Care of Patients,” submitted by the Committee on Blood-Borne Infection and Environmental Risk.
- “Volunteerism by American Surgeons,” submitted by the Committee on Socioeconomic Issues.
- “Safety for Office-Based Surgery,” submitted by the former Committee on Ambulatory Surgical Care, now the Committee on Surgical Practice in Hospitals and Ambulatory Settings.

Scholarships

The Society of Thoracic Surgeons has partnered with the American College of Surgeons to award an annual Health Policy Scholarship. This scholarship will be offered initially in 2003. The scholarship is to subsidize attendance and participation in the Harvard course, Understanding the New World of Healthcare: A Healthcare Policy Program for Physicians, Trustees, and Healthcare Leaders. The scholar is required to serve one year as a pro temp member of the health policy steering committees of both organizations.

Statement on correct site surgery

The Board of Regents approved an ACS Statement on Ensuring Correct Patient, Correct Site, and Correct Procedure Surgery. The statement was published in the December 2002 issue of the Bulletin (p. 26).

Division of Research and Optimal Patient Care

Cancer. The Commission on Cancer (CoC) released its Web-based National Cancer Data Base (NCDB) Benchmark Reports application in mid-March 2002 and updated the application with more recent data toward the end of July. This easy-to-use application is available for public use and consists of reports that include patient demographics, tumor characteristics, treatment, and survival outcomes data for 14 major cancer sites.

Trauma. The Board of Regents reviewed a report on the activities of the Committee on Trauma. Some of its key activities are:

- Regional Committees are collecting additional legislative information and working with state legislative efforts to compile a profile of state legislation activity regarding trauma, to be used to work with the Washington office in developing trauma systems.
- The CD-ROM project, Trauma Patient Management Problems, continues to do well and the committee continues to explore other ways in which video and CD-ROM technology can be used for ongoing continuing education.
- Trauma Registry—Version 3.11 has been released for beta testing and is doing well.
- ATLS®—The new version of the course book has been completed.
- The Education Committee is working on a curriculum for a surgical skills course.
- The Trauma Systems Consultation Committee has accomplished two complete site visits and both were well received.
- The Optimal Care Resource Document is being revised. The targeted publication date is 2004.
- National Trauma Data Bank™—Federal agencies have looked to this as an example of a compiled national database and this program is referred to directly in the proposed Title XII legislation for reappropriation of trauma systems development funding. Health Resources and Services Administration has supported this during FY 2002-2003 with another $200,000 grant.
Accepted abstracts* will be presented at:

- American College of Surgeons Clinical Congress
- October 19-23, 2003
- Chicago, Illinois

**Who**
- Young surgical investigators (principal investigator is first named author).
- Up to eight (8) co-authors allowed.

**What**
- 250 maximum word abstract that presents a concise summary of research done and in progress, but not presented or published previously. Title must be brief; body of abstract must include Introduction, Methods, Results, Conclusions. One-page table may be submitted separately (see Author Instructions on Web site) if absolutely necessary; table does not count toward the 250 maximum word count.

**When**
- Abstracts accepted from December 1, 2002, through March 1, 2003.

**Where**
- Online submissions ONLY: http://www.facs.org/sfabsabstracts/
- Final Decision: May 2003 (principal author will be contacted).
- Format: Follow Author Instructions, Online Submission.
- Questions: kkoenig@facs.org or: 312.202.5336.

Chapter news

by Rhonda Peebles, Chapter Services Manager, Division of Member Services

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

Chapters combine to create new Keystone Chapter

In mid-November 2002, the final procedures and paperwork were completed to create the new Keystone Chapter of the College. This new domestic chapter consists of the former Central Pennsylvania Chapter and the former Eastern Pennsylvania Chapter. The Keystone Chapter will comprise more than 1,000 Fellows. With regard to governance and representation, the Keystone Chapter will be divided into eight geographic regions, each having at least one councilor; regions with one or more teaching hospital(s) will be represented by additional councilors. Finally, there will be two at-large council positions.

According to its mission statement, the new Keystone Chapter will “…provide a regional voice for surgeons in all specialties, be an advocate for its members and the patients they serve, provide educational opportunities for its members, and encourage the highest standards of ethical surgical practice.”

The new officers of the Keystone Chapter include: Richard A. Close, MD, FACS, President; Aaron David Bleznak, MD, FACS, President-Elect; Collin Lewis Myers, MD, FACS, Secretary/Treasurer; and Immediate Past- Presidents Robert Sinnott, DO, FACS, and Narayan Deshmukh, MD, FACS. Charlene Wandzilak will serve as the chapter’s Executive Director (see photo, right).

Regents approve multi-country chapters

At its October 5-6 meeting, the Board of Regents approved the formation of multi-country chapters. Currently, there are 27 international chapters that are organized by country, and there are three international chapters in Mexico (Federal District, Nor-Occidental, and Northeast). The Regents’ action will permit the formation of chapters in countries where small numbers of Fellows reside. Procedures to form multi-country chapters will be similar to those for single-country chapters, which must represent at least 15 Fellows before a Governor may be elected. After the Governor is elected, the Governor petitions the Board of Regents to form a new chapter. For additional information on forming new chapters, contact the author.

Update on chapter Web sites

In early January 2003, two additional chapters went online—the Southern California Chapter and the New Jersey Chapter—bringing the total number of chapter Web sites to 38. All of the chapters’ Web sites are accessible at: http://www.facs.org/about/chapters/chapmenu.html.

In addition, a new SmartSite™ program was made available last fall to the chapters through one of the College’s Internet service providers. The new SmartSite program substantially simplifies the development and maintenance of Web sites.
As of January 2003, five chapters had switched to new SmartSites: Florida, Colorado, Connecticut, Metropolitan Chicago, and Virginia. In addition, the Indiana Chapter anticipates transitioning its Web site to the SmartSite very soon. For more information or assistance with the SmartSite program, visit http://www.facs.org/chapters/webprog/proglist.html.

**Chapter anniversaries**

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**Chapters continue to support College funds**

Last year, 25 chapters contributed a total of $35,500 to the College’s Endowment Funds. The chapters’ donations to the various funds support the College’s pledge to surgical research and education. Chapters may contribute to several different funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Fund. The chapters that contributed during 2002 are as follows:

- Life Members of the Fellows Leadership Society*: Arizona, Southern California, Louisiana, Maryland, Nebraska, Brooklyn-Long Island (NY), Ohio, South Carolina, and North Texas.

**Leadership conference for officers and young surgeons**

The 2003 Leadership Conference for Chapter Officers and Young Surgeons will take place June 22-24 in Washington, DC, at the Washington Court Hotel. A special education program is planned, which will examine four topics: professional liability, uninsured and underinsured patients, trauma, and physician reimbursement. In addition, all chapter officers, young surgeons, and administrators will have an opportunity to attend a congressional reception and to meet with their members of Congress on Capitol Hill. A preliminary schedule includes:

- Sunday, June 22: Afternoon: Special session for young surgeons; Special session for chapter administrators and executive directors. Evening: Welcoming reception for participants, spouses, and guests.
- Monday, June 22: All-day plenary and special education program sessions. Evening: Congressional reception.
- Tuesday, June 22: Morning: Breakfast and briefings; visits with members of Congress. Afternoon: Debriefings, lunch, and adjourn.

**Surgical specialty societies launch state action center**

The College has joined in a collaborative effort with 11 other specialty societies to launch a new Surgery State Legislative Action Center (SSLAC). The SSLAC is an electronic advocacy tool that uses the same software program and zip code match-

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*The Fellows Leadership Society (FLS) is the distinguished donor organization of the College. Chapters that contribute at least $1,000 annually are members. Chapters that have contributed $25,000 are FLS Life Members.
ing technology that the ACS and many other national specialty societies use for federal advocacy efforts. This system matches surgeons with their elected state representatives—allowing them to reach out to members of their state legislatures on an ad hoc basis or through a coordinated grassroots campaign. Check out the new state action center at www.facs.org/sslac and look for alerts from the College and other surgical specialty societies. For more information about the SSLAC, or if your chapter would like to post an alert on the action center, contact Christopher Gallagher, Manager of State Affairs, at cgallagher@facs.org.

Next month in JACS

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

Commission on Cancer Oncology Lecture:
Esophageal Cancer: What Price Swallowing?

Original Scientific Articles:
• Gender and Coronary Bypass Graft Surgery
• Cost Analysis of Intraoperative Cholangiography
• Decision Analysis of Gastric Bypass versus Diet

What’s New in Surgery:
Plastic and Maxillofacial Surgery