The IOM reports and peer review confidentiality
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ABOUT THE COVER...

Recommendations from the Institute of Medicine (IOM) regarding the reporting of medical errors would diminish confidentiality in the peer review process, according to F. Dean Griffen, MD, FACS. In “IOM reports err regarding peer review confidentiality,” p. 8, Dr. Griffen notes that “the willingness of providers to report and objectively evaluate problems in the delivery of care” is contingent upon the information they share and review staying behind closed doors. Efforts to reduce confidentiality in peer review, therefore, may weaken patient safety, which directly opposes the IOM’s overall goals.
(Cover photo © Ryan McVay/PhotoDisc.)
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From my perspective

In my opinion, it is very important that our Fellows know about the changes that are occurring in the College’s various programs. As a result, I like to use this column to inform you on a regular basis about our progress. Recently I have written about activities related to membership and advocacy issues, and particularly the formation of our political action committee, ACSPA-SurgeonsPAC. This month, I would like to highlight some of the really exciting developments that are taking place in the College’s educational programs.

Continuing medical education

The College’s ability to grant continuing medical education (CME) credits for the meetings of various surgical societies and our local chapters through a joint sponsorship program has been well received. In our realigned CME Unit, we have attempted to streamline our activities from both an administrative and a financial standpoint. The organizations that are taking advantage of this service have uniformly been pleased with this special service, and they have found the new CME Unit to be responsive and efficient. I would encourage other organizations that are experiencing difficulty with the CME process to contact us at the following e-mail address: kgoldsmith@facs.org.

The Accreditation Council for Continuing Medical Education (ACCME) establishes the standards for continuing medical education and evaluates whether organizations that grant CME credits are complying with their mandates. I am pleased to say that we have just been extensively evaluated by the ACCME and have been granted a four-year approval status. This status will allow us to continue to pursue various educational activities that really benefit our Fellows and our affiliated organizations.

It is important to note, and I must emphasize, that in order to receive ACCME approval and CME credits for a program the College is cosponsoring, appropriate paperwork must be completed by both the College and the partner organizations. Such issues as conflicts of interest, goals and objectives of the programs, and educational outcomes must be included in the paperwork that is submitted to the College. It is critically important that we have this documentation in place, so that we will have the information that will be necessary for future evaluations.

Competency

As you are aware, the entire area of physician competency has recently been reviewed and redefined by accrediting and certifying bodies such as the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. Interpersonal and communication skills, systems-based practice, practice-based learning and improvement, and professionalism are now specifically included in the list of competencies required for both surgeons in training and practicing surgeons.

At this time, we are convening work groups to address each of these four important areas. These groups will meet periodically to develop appropriate recommendations and teaching materials to address these competencies. When this work has been completed, new products will be incorporated.
into the spectrum of our educational programs to support surgeons in their efforts to remain not only certified, but competent, throughout their professional careers.

**Electronic education**

Other new products in the Division of Education have already appeared. One of these products is a special Web cast of several sessions from the last October’s Clinical Congress, which makes Category 1 CME credit available online. By participating in this educational activity, a surgeon may conveniently obtain inexpensive CME Category 1 credits. I think you will find the sessions useful, and this program will certainly make credit hours easily obtainable.

Other products from the Clinical Congress consist of a CD-ROM that includes materials from 14 postgraduate courses, the usual audiotapes that have been available in the past, and syllabi from various postgraduate courses.

**Spring Meeting**

Preparations for the Spring Meeting, which will be held April 12-15, 2003, in New York City, are proceeding well. The educational content of this meeting promises to be superb and will offer a wide array of educational opportunities not only for the general surgeon, but for surgeons from other specialties as well. During this meeting, practice-related issues will receive special emphasis. The American Society of General Surgeons has helped in the planning of the opening session of this meeting.

We have concentrated our efforts not only on the broad educational content of the meeting, but also on cost-effectiveness. The Spring Meeting really needs to be a gathering that can flourish as a separate, financially sound, self-sustaining entity. Historically, the Spring Meeting has been a costly event for the College. To offset financial losses this year, we are going to charge a modest registration fee, which really is a prudent fiscal move considering the current economic realities. By means of carefully monitoring all expenses, as well as charging the modest registration fee, we believe we can continue to offer the Spring Meeting to our Fellows, both from general surgery and the other specialties, and ensure its viability as a useful, stand-alone educational activity well into the future.

Another attractive aspect of this year’s Spring Meeting will be the social program. There will be ample opportunity in the evenings to enjoy the splendor of New York City and the theaters on and off Broadway—a very nice complement to the educational activities.

The College continues to work diligently to bring surgical education programs closer to surgeons’ practices in a number of ways, including Web casting and other products that are currently available and in various stages of development. Your ideas and suggestions for further activities will be welcomed, appreciated, and seriously considered.

Thomas R. Russell, MD, FACS

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
On December 12, Thomas R. Russell, MD, FACS, ACS Executive Director; R. Scott Jones, MD, FACS; Shukri Khuri, MD, FACS; and LaMar S. McGinnis, Jr., MD, FACS, met with Barbara Paul, MD, director of the Centers for Medicare & Medicaid Services (CMS) Office of Quality Measurement. Dr. Paul and her colleagues are responsible for developing CMS’s program to help patients make better health care “purchasing” decisions. The meeting was held in response to a request from CMS for the surgical perspective on reasonable hospital quality measures and on developing a quality analysis effort.

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 utilizes the same software program and zip code matching technology that the ACS and many other national specialty societies use for Federal advocacy efforts. This system will match 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. Visit the state legislative action center at http://www.facs.org/sslac.

The College secured passage of a resolution during the interim meeting of the American Medical Association’s (AMA’s) House of Delegates in December that calls for the AMA to work with the College in quickly convening a work group of interested specialty societies to look at recent state efforts to regulate office-based surgery. The resolution further charges the work group with developing guidelines and model state legislation for states to utilize when drafting regulations on office-based surgery. Target date for the first meeting of the work group is early February.

At the suggestion of 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 was created and is being maintained by the department of surgery at the University of Washington (Seattle). Topics currently posted include: compensation, contract negotiations, time management, insurance requirements, patient satisfaction, coding and reimbursement, hiring and interviewing staff, and personal finances and tax planning. Members of the College can access the practice management Web site via the “Members Only” section of the American College of Surgeons Web site at http://www.facs.org/members/members.html.
Final regulations to implement the 2003 Medicare physician fee schedule were released on December 20, with plans for publication in the Federal Register on December 31. Although required to issue the following year’s fee schedule no later than November 1 each year, the Centers for Medicare & Medicaid Services (CMS) announced that publication of the 2003 fee schedule would be delayed because of last-minute concerns regarding changes that were planned for relative values assigned to a limited number of services.

Due to the postponement of the regulations, CMS originally said that it intended to delay the effective date of the new fee schedule from January 1 until sometime in February. However, the latest delay means that implementation of the projected 4.4 percent conversion factor reduction will be delayed until March 1, 2003. As a result, services provided by physicians during the first two months of 2003 will still be paid under the higher 2002 payment rates.

More details on the regulations will be published in a future issue of the Bulletin. In the meantime, the entire text of the rule may be viewed on the CMS Web site, at http://www.cms.gov/regulations/.

The U.S. Department of Health and Human Services Office of Civil Rights (OCR) issued its first official guidance document on the Health Insurance Portability and Accountability Act’s Standards for Privacy of Individually Identifiable Health Information, more commonly known as the Privacy Rule, on December 4, 2002. The 123-page document explains the intent of standards and answers frequently asked questions in layman’s terms. The standards that will be of most interest to surgeons include:

- Those for appropriate uses and disclosures of confidential information for patient treatment and payment for those services.
- Situations in which a “Notice of Privacy Practices” must be given to a patient, as well as instances in which incidental uses and disclosures of confidential information are considered appropriate.
- The minimum necessary policies and procedures required to ensure appropriate access to patient information by patients or their personal representatives.

A copy of the document can be found at http://www.hhs.gov/ocr/hipaa/privacy.html.

In cooperation with medical and surgical specialty societies, the American Medical Association (AMA) is conducting an e-mail survey of physicians to determine whether Medicare access problems are increasing for patients because of past and projected payment reductions. The collected data will be used by the specialty societies in their ongoing advocacy efforts to reform the Medicare physician payment system that is producing steep, across-the-board declines in reimbursement.
Surgeons need not be members of the AMA in order to participate in the survey, and the organization has indicated that nonmembers will not receive membership solicitations as a result of participating. Surgeons who would like to participate must register online before receiving a copy of the questionnaire by e-mail so that the AMA can verify that they are, in fact, either an MD or a DO.

Because issues of patient access differ across specialty lines, it is important that the data reflect the practices and experiences of all specialties. To participate in this effort, surgeons should register via the AMA’s Web site, at http://www.ama-assn.org/go/memberconnect/registration.

College announces 2003 Capitol Hill Visit Program

The chapter visit program offers surgeons a chance to meet personally with members of Congress and their staffs to discuss the College’s legislative agenda. Legislators need to know how proposed legislation and regulation will ultimately affect surgeons and their patients in their home states and districts. In some cases, members of Congress have also come to rely on chapter representatives for advice and insights about the implications of proposed changes when new legislative issues arise. This past year, chapter visit participants helped illustrate the local impact of such issues as professional liability, physician reimbursement, patient safety, and funding for trauma care systems planning and development.

In 2002, a total of 19 College chapters traveled to Washington, DC, to meet with members of their congressional delegations. Since the inception of the Capitol Hill Visit Program in 1988, about three dozen chapters have made the trip to Washington to participate in the College’s grassroots congressional education effort.

As the 108th Congress convenes in January 2003, Senators and Representatives will face a number of issues central to the concerns of the surgical professions. Chapters that are interested in participating in this program should contact Christian Shalgian in the College’s Washington Office at cshalgian@facs.org.
IOM reports err regarding peer review confidentiality

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

“The granting and continuation of surgical privileges should be based upon the surgeon’s record of demonstrated performance as evaluated by an established peer review mechanism and medical audit.”

—Statements on Principles, American College of Surgeons, 1994

Current federal and state laws provide confidentiality for peer review. Because of an increasing frequency of judicial opinions denying privilege, this confidentiality has become tenuous. There is now a new and equally threatening attack on confidentiality that has been launched by a group of scientists in related fields who have concluded that a current presumed increase in medical errors is in part related to a failed peer review mechanism.

In 2000, these experts at the Institute of Medicine (IOM) published their conclusions regarding the problem of errors as well as their recommendations for solving the problem in a report titled To Err Is Human: Building a Safer Health System. This report was followed by a second report, Crossing the Quality Chasm: A New Health System for the 21st Century.
These reports espouse disclosure of serious errors and are of considerable concern because most health care organizations and providers consider both patient safety and professional liability to be favorably affected by peer review confidentiality. Although the authors have introduced many exciting possibilities for improving our health care delivery systems, they have erred in a very human way regarding their assessment of confidentiality in peer review. To be forewarned and knowledgeable will help health care providers and other concerned parties defend against initiatives that propose to advance the destructive force of disclosure.

Most observers consider peer review confidentiality essential to enhance the willingness of providers to report and objectively evaluate problems in the delivery of care. Agreeing with this premise, the federal government included confidentiality provisions for peer review in the Health Care Quality Improvement Act (HCQIA) in 1986 (42 USC § 11101). The act states that a qualified peer review body and any member of a qualified peer review body “shall not be liable in damages under any law of the United States or of any State” with respect to peer review actions that are solely for the furtherance of quality health care. Virtually every state has enacted additional statutory provisions in support of the confidentiality provided by HCQIA.

Challenges

In spite of this well intended and carefully drafted legislation, the judiciary is challenging peer review confidentiality. The courts’ interpretations of HCQIA and supportive state legislation are increasingly denying privilege and allowing the disclosure of peer review materials. A recent Kentucky case (Nazareth Literary and Benevolent Inst. v. Stephenson, 503 SW 2d 177) provides a good paradigm. The judge denied the defendant’s plea for confidentiality of peer review documents, and in his summation wrote that “although this might be regarded as an initially appealing argument, on reflection, one might well debate wherein the public interest lies. Claims of privilege are carefully scrutinized, and impediments to the discovery of truth are afforded validity in relatively few instances in the common law.” Simply stated, judges have great latitude to interpret the law according to the pleasure of the court and with total disregard for legislative intent.

This judicial attack on confidentiality is threatening enough, but now a new and equally bothersome challenge has been launched. The IOM report is on the brink of forever changing the way we conduct peer review and, as a consequence, is placing both health care providers and patients at great risk for loss of confidentiality. The problem that the report addresses is well defined by two large studies, one conducted in Colorado and Utah and the other in New York, which show that adverse events occur in 2.9 and 3.7 percent of hospitalizations, respectively. These percentages have been questioned by various medical groups, but their degree of accuracy is irrelevant; any error is one too many. According to these data, medical error is the eighth most common cause of death in the U.S. Citing that “the frequency and significance of errors in health care create an imperative to improve our understanding of the problem and devise workable solutions,” the report makes numerous recommendations. Categories include: (1) building leadership and knowledge for patient safety; (2) designing error-reporting systems; (3) setting performance standards and expectations for patient safety; (4) creating safety systems in health care organizations; and (5) vis-à-vis confidentiality, establishing a new system for peer review.

In introductory statements, the committee clarifies its intentions: “The combined goal of the recommendations is for the external environment to create sufficient pressure to make errors costly to health care organizations and providers, so they are compelled to take action to improve safety.”

This statement clearly indicates a vision for a system that achieves the goal of patient safety through the intimidation and punishment of health care providers. Accordingly, in terms of peer review, the committee recommends mandatory reporting and public disclosure of adverse events that involve death or serious harm. Confidentiality is reserved for a second system of voluntary reporting to focus on less serious errors and near misses. According to the report, this voluntary system is already in place, and the committee does not suggest new statutory regulations.

Organized medicine, including the American College of Surgeons, aggressively lobbied the IOM...
regarding its stand on disclosure of adverse events and related peer review materials. These groups enumerated potential problems that could result from disclosure, including: (1) loss of confidentiality for patients; (2) less effective peer review due to the loss of confidentiality for involved health care providers; (3) increased liability by providing a list of already presumably validated errors for plaintiff attorneys; (4) creation of incentives to hide errors; (5) inappropriate damage to the patients’ perceptions of their health care delivery system; and (6) inaccurate and unfair comparisons for institutions and providers who, because of rural settings or tertiary care environments, are called upon to treat more difficult patient populations.

The IOM then published what the Quality of Health Care in America Committee has characterized as its final report: Crossing the Quality Chasm: A New Health System for the 21st Century. In this second report, although the disclosure recommendations remain the same in spite of the revelations from organized medicine, the rhetoric is tempered: “One important route to restoring trust is through a commitment to transparency by all health care systems.... The transition to openness is a difficult one for our often beleaguered health care organizations, but it is a journey worth making.”

Congressional activity
The recommendations for mandatory reporting and disclosure are of considerable importance because the IOM is an arm of the National Academy of Sciences, a private not-for-profit society. The academy is mandated to advise the federal government on scientific and technical matters upon the authority of a charter granted by Congress in 1863. Accordingly, the Senate’s Health, Education, Labor and Pensions Committee (HELP) met three times during the 106th Congress and once again in the 107th Congress to review the IOM reports. The committee concluded that congressional action is absolutely indicated. In response, a Senate bill called the Patient Safety Improvement Act was drafted for consideration by the 106th Congress, but it was never acted upon. The bill was minimally modified for the 107th Congress and resubmitted in the Senate as S. 2590 and in the House as H.R. 4889.

These bills have suffered the same fate as their predecessors. After all, the 107th Congress became necessarily preoccupied with terrorism and other related matters. This understandable preoccupation and a lack of consensus regarding the issue of confidentiality and disclosure of peer review materials among key members of the House and Senate forestalled the act’s progression through the legislative process.

Almost all informed observers agree that legislation prompted by the IOM reports will ultimately be passed. The act was changed little from the 106th to 107th Congresses, but what it will contain for the 108th Congress is a matter of conjecture. A review of this year’s act is important because it will logically be used as a template for future drafts.

The authors address the regulations recommended by the IOM reports, and many of the Institute’s recommendations are included. Some are noticeably missing. Assuming that the current peer review system fails to properly use its deliberations and findings toward the development of best practice standards, the legislation provides for an integrated group of patient safety organizations that are mandated to submit their material to a national data bank where it may be integrated and distributed nationwide to improve care. In contradistinction to the IOM recommendations, incentives for voluntary reporting are provided without mention of mandatory reporting. Even more encouraging, confidentiality is preserved if not enhanced: “notwithstanding any other provision of law...patient safety data shall be privileged and confidential,” and such data “shall not be subject to subpoena, subject to discovery, or admitted as evidence in any civil, criminal, or administrative proceeding.”

Initially, in both the House and Senate versions, disclosure of patient safety data was allowed in criminal proceedings if the data were material to the proceeding, within the public interest, and not available from any other source. Subsequently, the House Ways and Means Committee amended H.R. 4889 to allow unrestricted disclosure in criminal cases, but S. 2590 remains unchanged. Also included is the stipulation that patient safety data shall be de-identified, being presented in a form and manner that prevents the identification of patients, providers, and reporters of errors. Fi-
nally, provisions for legal action against any provider who discloses privileged material are clearly defined.

Organized medicine monitored the progress of the Patient Safety Improvement Act closely. As with most bills, there are good parts and bad. It's hard to find any enthusiasm for yet another national data bank at risk for abuse through subsequent legislative or judicial assault. Nonetheless, it is virtually impossible to envision any better confidentiality provisions.

If you would like to share your personal feelings with elected officials regarding this legislation, the ACS makes it easy. Simply log on to www.facs.org, look for the link “Legislative Action Center” in the left-hand column and click on “Federal.” Then click on “Elected Officials,” and follow the subsequent prompts. You will be given a blank page onto which you may draft a letter or e-mail that the College will send to the officials of your choice. The authors of the Senate bill are James Jeffords (I-VT); Bill Frist, MD, FACS (R-TN); John Breaux (D-LA); and Judd Gregg (R-NH). For the House bill, the authors are Nancy Johnson (R-CT); Bill Thomas (R-CA); Amo Houghton (NY); Ernie Fletcher (R-KY); J.D. Hayworth (R-AZ); Jerry Weller (R-IL); and Dave Camp (R-MI). Unless encouraged by concerned constituents, these authors, being frustrated by the reticence of their colleagues to embrace full confidentiality, may choose to compromise their commitment in the next rendering of the act. The College represents you well in legislative matters, but there is no substitute for personal contacts to properly mold legislative activity.

Conclusion

In summary, peer review has long been employed to enhance the safety and quality of care patients receive. Nonetheless, the system is imperfect, as evidenced by data documenting a plethora of medical errors. To address the problems defined by the recent IOM reports, new legislation has been introduced. To this point, the recommendation of the IOM for more disclosure and transparency with mandatory reporting of medical errors has not been included. Instead, legislation espousing voluntary reporting and additional protection of confidentiality for patients, providers, and reporters of errors has been drafted. Lack of consensus regarding the issue of confidentiality and disclosure, in addition to a very busy agenda, has blocked the passage of this legislation thus far. Nonetheless, new laws governing peer review are expected to come in time.

Because the ultimate balance between disclosure and confidentiality cannot be predicted, those individuals wishing to protect patient safety and avert increased professional liability must remain alert and proactive in the defense of confidentiality. In response to evidence indicating that medical errors are all too common, the health care industry and various government agencies are introducing many new patient safety initiatives, which reflect to some extent the recommendations of the IOM reports. For now, these efforts are proceeding under the very tenuous confidentiality afforded by HCQIA and supportive state legislation.

References


Dr. Griffen is a private practitioner of general surgery, Highland Clinic, Shreveport, LA. He is Chair of the Regent’s Committee on Patient Safety and Professional Liability.
Ohio Chapter surveys members on professional liability issues

by Michael J. Walker, M D, FACS, Columbus, OH

The threat of a medical malpractice lawsuit is part of the life of every physician, especially surgeons in the U.S. Malpractice insurance is considered part of the cost of the "business" of practicing medicine and surgery. The medical liability insurance market cycles like all business. In the past when the cost of medical malpractice insurance escalated, physicians and surgeons either formed their own insurance companies, worked harder to pay the premiums, or attempted to implement tort reform. Some states, such as California and Indiana, have implemented tort reform, but the vast majority of states have not. Even physician-owned insurance companies have been unable to control the increasing cost of malpractice awards. In a time of decreasing reimbursement, all physicians are working harder just to maintain the status quo. The significant increase in malpractice costs at this time has left the medical community with very few options.

Escalating jury awards, along with the general negative effects of 9/11 on the insurance industry, have caused many companies not only to significantly increase medical malpractice premiums, but to drop medical malpractice insurance as a losing venture. As a result, many physicians are scrambling to find malpractice coverage. This situation has created a medical malpractice crisis in our neighboring states of West Virginia and Pennsylvania and an extreme tightening of the malpractice market in Ohio. To assess the impact of the malpractice situa-
tion on Ohio Chapter members, the health policy and advocacy committee surveyed the chapter membership before our annual chapter meeting in May.

Methods and results

Two other ACS chapters—New Jersey and Kentucky—had already developed an instrument to study the same malpractice issues. The Executive Committee of the Ohio Chapter reviewed both surveys for use in Ohio. The survey was distributed to approximately 1,000 Fellows and Associate Fellows about two weeks before the annual meeting. A modified version of the ACS New Jersey Chapter’s survey, it was a one-page form with several questions about the effects of medical malpractice insurance on the individual surgeon.

On short notice, 214 replies were received for a 21.4 percent return, representing the best response to a mailing in the chapter’s recent history. The answers were codified and then entered into a database for further analysis.

Most respondents (72%) were general surgeons. The majority of the respondents also had group coverage (57.9%), while 38.7 percent had solo coverage. Amazingly, 3.2 percent of the respondents did not know what kind of coverage they had. The majority (56%) had 1M/3M coverage, with a large minority (33.6%) having 2M/6M limits. The median premium of all the respondents who filled in a figure was $38,000. Another 15.4 percent of the respondents did not indicate any value.

**Ohio surgeons’ professional liability survey**

Please complete and mail this survey immediately to:
Ohio Chapter, American College of Surgeons
P.O. Box 2307, Dayton, OH 45401-2307
Or fax to: 937/586-3699

1. My specialty: _______________ My coverage is: Solo ___ Group ___
   My coverage limit: $__________ Approx. annual premium: $__________

2. My malpractice rate has been unaffected: Yes ___ No ___
   a) Because my private insurer has not changed my rate: Yes ___ No ___
   b) I am employed and my employer pays the premium: Yes ___ No ___
   c) Other: ___________________________________________________________

3. While my malpractice rate has been increased, it remains at a “tolerable” level:
   a) Less than 10% increase: Yes ___ No ___
   b) 10–40%: Yes ___ No ___
   c) Greater than 40%: Yes ___ No ___

4. Increases in my malpractice premium are unconscionable and I will seriously need to consider:
   a) Early retirement from practice: Yes ___ No ___
   b) Leaving the state: Yes ___ No ___
   c) My carrier’s name: _______________________________________________

5. I have been denied coverage: Yes ___ No ___ By carrier: _____________

6. I have had to lay off staff: Yes ___ No ___ If yes, how many? __________

7. I have dropped the following procedures: _____________________________

8. Have you changed carriers in the last two years? Yes ___ No ___

9. Were terms downgraded at last renewal? (Maximum benefit? Occurrence vs. claims made? Tail coverage?) Yes ___ No ___
   If yes, explain: ______________________________________________________

10. I am willing to tell my story to the legislature or otherwise assist in your efforts to curb the runaway costs of medical malpractice insurance:
   Yes ___ No ___

   If yes, I can be contacted as follows:
   Name: ______________________________________________________________
   Address: ____________________________________________________________
   City: ___________________________ Phone: _____________________________
   Fax: ___________________________ E-mail: _____________________________

Thank you for your response. Collective data such as these are needed to present a credible account to the state legislators and other regulatory authorities. Anonymous results of this poll will be made available to all members. (This survey was modeled after the New Jersey Chapter ACS professional liability survey.)
In response to the survey, the overwhelming majority (90.6%) said that they were being affected by the increase in malpractice premiums, with 85.5 percent of the respondents listing increases in their malpractice rates. Only 9.8 percent of the respondents said malpractice premiums increased less than 10 percent; 47 percent increased 10 to 40 percent, and 43.1 percent of the respondent’s premiums increased more than 40 percent.

A small minority of the respondents (6.5%) had been denied coverage. Denial of coverage did appear to have some significant effects on practice behavior, with 45.8 percent of respondents considering early retirement and 29 percent considering relocation.

In general, respondents have not laid off staff (82.2%) or dropped procedures (85%). Instead, to counteract changes in premiums, 37.3 percent of respondents have changed carriers, and a surprising 26 percent of respondents have downgraded coverage. This issue seems to have electrified the Ohio Chapter members, with 62.6 percent of the respondents willing to devote their time to achieving legislative changes.

Discussion

The Ohio Chapter has had a long-standing interest in professional liability issues. Surveys were conducted in 1969, 1974, and 1981. The 1981 survey was published in the Bulletin.* In contrast to the 1981 survey, which had a return rate of 40 percent and of which only 41 percent of the respondents were general surgeons, approximately three-quarters of our recent respondents were general surgeons, and we considered our return rate of 20 percent to be excellent considering the short turnaround time provided.

In the past, only 21 percent of the respondents had group coverage, whereas now the majority of the recent respondents had group coverage (58%). Reminiscent of a different time, only approximately 25 percent of surgeons paid over $10,000 and only 1 percent paid more than $25,000 according to the previous survey. The median premium for recent respondents was $38,000.

In the 1981 survey, a small minority of surgeons (8.1%) were having difficulty obtaining malpractice insurance, but they were finding insurers. In the current survey, 6.5 percent of our respondents had been denied coverage. Only 27 percent of the respondents in the 1981 survey experienced premium increases of more than 100 percent in a five-year time period. Compare that with 90 percent of our respondents who had increases of greater than 10 percent in the last year, and 40 percent who had greater than 40 percent increases in the last year. Unlike previous surveys, ours did not examine the number of lawsuits filed or attitudes toward malpractice. Unfortunately, in today’s environment, it is just part of practicing medicine.

As mentioned previously, our survey was a modified version of one the New Jersey Chapter conducted. We can compare our results with those of the New Jersey Chapter, thanks to their willingness to share their preliminary results.† Only 47 percent of their respondents were general surgeons. Among New Jersey general surgeons, 69 percent noticed increases of more than 10 percent in their premiums, but only 17 percent reported increases of greater than 40 percent, while 43 percent of the Ohio Chapter respondents had a premium increase of greater than 40 percent.

Our median premium and the mean for the general surgeons in New Jersey were similar at $38,000 and $36,000 respectively. To lower overhead costs, the New Jersey general surgeons were laying off staff at a rate similar to Ohio surgeons, 24 percent and 18 percent respectively. While 37 percent of Ohio surgeons are changing malpractice carriers, 43 percent of New Jersey surgeons were doing so. No mention of early retirement or changing practice sites was made in the New Jersey survey.

The impact of the sharp increase in professional liability premiums may be significant in a state such as Ohio where there is a large rural area that has a difficult time attracting young surgeons. Almost 50 percent of the respondents are considering early retirement or changing practice sites.

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†Personal communication with Robert W. Hobson, MD, FACS, June 2002.

Dr. Walker is associate professor of surgery at Ohio State University, Columbus, OH, and is Chair of the Health Policy and Advocacy Committee of the Ohio Chapter of the College.
States are in a fiscal crisis and the rising cost of their Medicaid programs imperils other priorities and makes Medicaid a prime target for cutbacks. Low-income and disabled Americans who rely on Medicaid for their health care and the physicians, hospitals, and other providers who serve them are likely to be caught in the financial squeeze. Surgeons should be aware of the effect these cutbacks have on Medicaid benefits, eligibility, and payment.

Medicaid is the major federal-state health insurance program for low-income families, people with disabilities, and the impoverished aged. With an enrollment of more than 47 million, Medicaid has more beneficiaries than Medicare and is almost its equal in terms of total federal and state expenditures (about $155 billion in federal dollars and $98 billion in state dollars in fiscal year 2002). Medicaid is also one of the largest and fastest-growing components of state budgets, comprising approximately 20 percent of all state spending and ranking second only to education in consumption of state revenues.

The sustained prosperity of the late 1990s allowed states to reduce taxes and still expand services. However, the recent recession has created severe shortfalls in tax revenues and has resulted in frantic efforts by state governments to balance their budgets. State “rainy day funds” are drying up and tobacco settlement money that had been reserved for health care purposes is now being diverted to meet other budget needs. To add to the states’ difficulties, there has been an increased demand for Medicaid due to expanded eligibility measures that were implemented in the late 1990s. Coupled with the increased need created by the rise in unemployment, the state budgets are under considerable stress. Medicaid costs are rising because of the general health care cost inflation for providers and increased use and cost of prescription drugs (see Figure 1, p. 16). However, it is important to note that reimbursement to nursing homes and hospitals represents the lion’s share of state Medicaid spending (see Figure 2, p. 16).

To make matters worse, federal matching rates for Medicaid are actually declining for some states. Medicaid is jointly funded by states and the federal government based on a matching percentage determined by the per capita income of the state relative to other states. The rate is redetermined...
annually, but the percent paid by the federal government cannot be less than 50 percent or more than 83 percent. The federal Medicaid matching rates reflect state incomes between 1997 and 1999, which ultimately means that if a state had a higher per capita income during those years, its federal share of program revenues is lower. Proposals in Congress have stalled to temporarily increase the matching rates for all states or those most adversely affected by a payment formula that has not kept pace with current economic realities.

**Recent state action**

These harsh budget realities are forcing states to consider extreme measures to balance their budgets. Such actions could reduce access to services in multiple ways: limiting benefits, raising out-of-pocket costs, restricting eligibility, and reducing provider participation in the Medicaid program.

A recent survey of state Medicaid programs found that the vast majority of states have taken or will soon take steps to reduce Medicaid expenditures. Surgeons should know that 22 states have imposed freezes or cuts in provider reimbursement in fiscal year (FY) 2002, and 29 states are implementing the same measures for FY 2003. Of those 29 states, 17 plan to cut reimbursement to physicians, 20 to decrease hospital payments, and 16 to reduce payments to nursing homes (see Figure 3, p. 17).

Even before these budget adjustments were considered, Medicaid physician payment rates

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**Figure 1**

<table>
<thead>
<tr>
<th>Average annual rate of growth in selected Medicaid expenditures, 1998-2000</th>
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<tr>
<td>All Medicaid</td>
</tr>
<tr>
<td>Inpatient hospital</td>
</tr>
<tr>
<td>Physician, lab, X ray</td>
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<tr>
<td>Outpatient hospital, clinic</td>
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<tr>
<td>Prescription drugs</td>
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<tr>
<td>Nursing facilities</td>
</tr>
<tr>
<td>Home care</td>
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<tr>
<td>Managed care</td>
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</tbody>
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**Note:** All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed (except for “managed care,” which includes a wide range of medical services).


**Figure 2**

<table>
<thead>
<tr>
<th>Medicaid expenditures by type of service, 2000</th>
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<tbody>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Prescription</td>
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<tr>
<td>Plan capitation payments</td>
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<tr>
<td>Hospitals</td>
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<td>Nursing homes</td>
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</tbody>
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States’ FY 2002 and FY 2003 cost-containment strategies to control spending growth

<table>
<thead>
<tr>
<th>Cost-Containment Strategies</th>
<th>Number of States</th>
</tr>
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<tbody>
<tr>
<td>Prescription drug cost controls</td>
<td>32</td>
</tr>
<tr>
<td>Reducing/freezing provider payment rates</td>
<td>22</td>
</tr>
<tr>
<td>Reducing/restricting Medicaid eligibility</td>
<td>18</td>
</tr>
<tr>
<td>Reducing Medicaid benefits</td>
<td>9</td>
</tr>
<tr>
<td>Increasing beneficiary copayments</td>
<td>4</td>
</tr>
</tbody>
</table>


rarely matched Medicare reimbursement and often failed to cover the actual cost of care. This new wave of cuts exacerbates an already difficult situation and could lead to more physicians dropping out of the program. The Medicare Payment Advisory Commission’s recent physician access survey found that the proportion of practices open to all new Medicaid patients dropped from 48 percent in 1999 to 37 percent in 2002.

Although some state cost-cutting strategies may produce greater efficiencies in their Medicaid programs, many are likely to reduce the number of poor people who are eligible for Medicaid or, for those poor who remain eligible, reduce available services or increase out-of-pocket costs. In FY 2002 and 2003, 26 states have either implemented or plan to implement eligibility reductions. Massachusetts, for example, will eliminate Medicaid coverage for about 50,000 long-term unemployed individuals as of April 2003. Missouri will drop almost 33,000 people by lowering the threshold at which parents become eligible for Medicaid. In the same period, 24 states have made or will implement benefit reductions, including cutbacks in adult dental care, home health, podiatric, chiropractic, and vision services. In addition, 19 states have established or will implement new copayments for services, including physician care. These cutbacks will be significant for patients, but may also mean a greater demand for charity care and higher uncompensated care loads for physicians and hospitals.

It’s ironic that the state budget crunch may also reverse or at least slow the shift to managed care for Medicaid beneficiaries. An estimated 12 to 13 million Medicaid beneficiaries currently are enrolled in managed care plans. Although many state Medicaid programs would like to direct more of their eligible populations to managed care plans, it may be difficult because the states do not have the budgets to handle private plan rate increases. Increased pharmaceutical and other health care costs may also encourage some states to pursue limited risk models to hold the line on managed care plans. Plans, reluctant to assume limitless exposure, are pushing back and asking the states to assume responsibility for more expensive procedures and products. Ultimately this means that Medicaid contracts are in flux; surgeons may end up dealing directly with the state Medicaid office rather than a health plan for payment for certain cases. It is hoped that these new configurations or ceilings might limit plans’ exposure and insulate them from some of the impact of rising pharmaceutical and other health care costs.

**Federal initiatives**

In the midst of state Medicaid cutbacks, the Bush Administration has proposed an initiative to give states more flexibility in designing their Medicaid programs as well as their State Children’s Health...
Insurance Programs (SCHIPs) (see sidebar, this page). The new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative encourages states to develop comprehensive approaches to increase the number of individuals with health insurance coverage. These eligibility expansions must be done using current-level Medicaid and SCHIP resources and remain budget-neutral. As of November 2002, six state HIFA proposals had been approved and another three were pending.

The Bush Administration says that the HIFA waivers are intended to expand the number of people who are insured under Medicaid and SCHIP. Opponents of these waivers, including Medicaid patient advocacy groups, say that HIFA waivers will reduce access for the optional populations already covered by Medicaid and SCHIP. This could occur either as a result of actual reductions in the generosity of the benefits or because program beneficiaries will be unable to afford the increased copayments outlined in the waiver proposals.

**Future prospects**

Although Medicaid was not a major election issue in most 2002 congressional races, the declining health of state Medicaid programs is likely to persist as a concern for the new Congress. Governors will continue to press for increases in federal payments for their Medicaid programs, although they are competing with equally problematic and pressing demands on the federal budget. The Bush Administration’s efforts to give states more flexibility in running Medicaid and SCHIP through HIFA and other types of waivers are likely to go forward. For surgeons, 2003 promises few improvements in Medicaid reimbursement rates. It could also be a year in which many low-income Americans experience erosions in their benefits as some new populations gain access to scaled-down Medicaid as a result of the HIFA waivers.

**References**

1. There are certain populations, referred to as “mandatory” that states must cover. Other populations, termed “optional,” may be covered at a state’s discretion. Likewise, some benefits are mandatory and others, such as prescription drugs, are optional. It is the optional populations and benefit categories that are the targets for Medicaid spending reductions.


**SCHIP**

SCHIP was designed in 1997 as a capped entitlement to states that elect to provide health insurance coverage to uninsured children with family incomes generally below 200 percent of the federal poverty level. SCHIP was allotted $40 billion to be used over a 10-year period. States receive an “enhanced” match from the federal government (a higher match than they receive for Medicaid) to finance their SCHIP coverage. States may cover SCHIP-eligible children through their Medicaid programs or separate programs that meet specific benefit and other criteria, or through a combination of both. In fiscal year 2001, about 4.6 million children were enrolled in SCHIP.

**Dr. Fuchs** is a principal partner with Health Policy Alternatives, a Washington, DC, consulting firm that advises the College.
In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

This month’s column picks up where we left off last month regarding materials that need to be included in a practice’s privacy manual to ensure the confidentiality of patient information, especially when others may be able to access it. Following are some suggested items for inclusion.

- Assurances from business associates to safeguard confidential information that your practice shares with them. A business associate is defined as a person or organization that is not a member of your staff but performs a function that uses confidential information from your practice. A good example of a business associate might be a health care clearinghouse that submits the practice’s claims. Plumbers, electricians, office equipment repair people, and mail carriers are not considered business associates. In most cases, companies that provide janitorial services are not considered business associates, unless the practice has contracted with them to handle or shred medical records. Practices will need written contracts or similar agreements with business associates that list the permitted and required uses and disclosures of confidential information. Practices may look at the sample contract language on the U.S. Department of Health and Human Services (HHS) Office of Civil Rights Web site listed in “Sample Business Associate Contract Provisions.” (See “Tip for privacy officer” on page 35.)

- Procedural and physical safeguards to protect and ensure the security of confidential information. What are the practice’s procedures for patients’ and other visitors’ access to the office beyond the waiting room? How are the records maintained and secured? What measures do you take to ensure the security of the confidential information when it is housed on your computer system or transmitted by modem or fax? If there is a fire, flood, or computer breakdown, what is your contingency plan to recover and secure the records? You will have to document the answers to these questions in writing and include the documentation in the privacy manual.

- Access and audit control. Each practice must establish and document levels of staff access to patient records. During this process it is important to ensure the staff understands what the practice considers to be unauthorized use, disclosure, modification, and destruction of confidential patient information. In electronic medical records systems, there must be a mechanism for identifying and tracking who has accessed or attempted to access confidential information. The privacy manual must specify who may access the log and how the log will be reviewed to identify potential weaknesses or actual breaches of security. Because of the required privacy provisions, there is good reason to believe that all electronic health systems will soon have auditing capability. At the present time, there is no comparable requirement for paper medical records.

- Training. All members of the staff must be trained to handle your practice’s policies and procedures for handling confidential information. This training needs to be targeted to the appropriate level that allows them to perform their duties. Training could be done individually or in a staff meeting to discuss how the practice will handle privacy concerns or by having the staff review the practice’s notice of privacy policies. During training, the practice’s privacy officer should emphasize that the practice is open to staff observations of lapses in compliance with privacy procedures and that staff members should feel comfortable approaching the privacy officer about their observations.

- What if confidential information is disclosed? A practice is obligated to make a reasonable effort to mitigate any harm that might result from the use or disclosure of confidential information in violation of its policies and procedures. A practice also must impose sanctions against staff members or business associates who do not comply with policies and procedures. Practically, sanctions could mean, at a minimum, retraining on privacy policies and perhaps noting the violation in an... continued on page 35
Keeping current

What’s new in ACS Surgery: Principles and Practice

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of ACS Surgery: Principles and Practice, the practicing surgeon’s first and only Web-based and continually updated surgical reference. See the box below for a special announcement for ACS Fellows, Associates, and Candidates.

V. Operative management

29. Organ procurement. Sander S. Florman, MD; Thomas E. Starzl, MD, PhD, FACS; and Charles M. Miller, MD, FACS. The authors discuss the current state of organ procurement in their newly revised chapter. Among other topics, they cover cadaveric and live organ donor evaluation, perioperative management, and the donor procedures themselves.

The evaluation process for a living kidney or liver donor should proceed in a logical and stepwise fashion, beginning with the confirmation of ABO blood group compatibility. Blood testing should be comprehensive and should include, at a minimum: a full set of blood chemistries; a complete blood count; a coagulation profile; thyroid function tests; serologic tests for hepatitis virus (A, B, and C), HIV, cytomegalovirus, Neisseria gonorrhoeae, α1-antitrypsin, ferritin, ceruloplasmin, α-fetoprotein, antinuclear antibodies, antimitochondrial antibodies, and anti-smooth muscle antibodies; a lipid profile; serum protein electrophoresis; urinalysis; and pregnancy testing. An electrocardiogram (ECG) and a chest X ray should also be obtained. Additional tests should be ordered as clinically indicated on an individual basis.

Imaging studies must include computed tomography or magnetic resonance imaging (MRI) for estimating hepatic volumes and for determining details of the hepatic arterial, hepatic venous, and portal venous anatomy. With MRI scanning, cholangiography is also possible. Some centers may require endoscopic retrograde choledangiopancreatography (ERCP) for complete biliary tract evaluation, angiography for complete vascular evaluation, or both. Many centers require that potential donors undergo liver biopsy in specific circumstances (for example, a history of alcohol abuse, obesity, or hypercholesterolemia), and some require this of all potential donors. Matching an appropriate donor with an appropriate recipient is a complex task and requires an under-
standing of and an appreciation for multiple variables, including the severity of portal hypertension in the recipient, the volume of liver required by the recipient, and the anatomy of the donor (including the hepatic portal and venous anatomy as well as the biliary anatomy). Successful transplantation and donor outcome depend on appropriate matching.

The criteria for heart and lung donors are generally more strict than those for liver and kidney donors. Donors are usually younger, have no history of cardiac disease, and have a reasonably normal chest X-ray and ECG; in addition, they are closely matched to recipients with respect to height, weight, and chest circumference.

Echocardiography is useful for evaluating cardiac wall motion and may play a key role in deciding whether to use the heart for transplantation. For certain potential donors, coronary angiography is necessary. In general, the donor’s heart should be slightly larger than the recipient’s because recipients often have cardiomegaly. The arterial oxygen tension ($P_{O_2}$) of lung donors should be at least 350 mm Hg during ventilation, with a fraction of inspired oxygen ($F_{O_2}$) of 1. In addition, bronchoscopy is frequently useful in the evaluation of lungs for donation.

**VI. Special perioperative problems**

10. Clinical and laboratory diagnosis of infection. David C. Evans, MD, FACS, and Jonathan L. Meakins, MD, DSc, FACS. In their revised chapter, the authors review the approach to diagnosis of surgical infection, including red flags for infection, diagnostic tests, therapy for uncomplicated sepsis, and approaches to specific infections in complex surgical patients.

An example of a red flag is pain that persists or is disproportionate to the expected response. Whenever a surgical wound that was healing favorably for the first five to seven days becomes more painful, a deep surgical site infection (SSI) must be suspected and ruled out, even if other signs are absent. Unexplained muscular pain is often the first harbinger of deadly necrotizing soft tissue infection caused by gram-positive bacteria (such as group A streptococci), the early recognition of which may be lifesaving and limb-preserving.

Sometimes pain is referred, and the painful area appears normal on examination. Pneumonia that presents with abdominal findings is a classic example, as is the shoulder-tip pain with a normal range of motion seen in patients with a subphrenic abscess.

Drs. Evans and Meakins also give specific advice on key details, such as how best to culture a central venous catheter (CVC). A CVC may be cultured in one of several ways, the most common of which is the roll-plate method. Because it is theoretically possible that this technique may fail to detect bacteria harbored within the catheter lumen, some authorities advocate the more sensitive sonication method, in which the catheter segment is immersed and agitated in a medium to produce a broth that contains bacteria from both the internal and the external surfaces of the line. This technique is both more costly and more time-consuming, in that it requires quantitative cultures that are deemed positive only when more than $10^3$ colony-forming units are detected.

More often, blood drawn through the CVC or cultured from an exit-site exudate is compared with peripheral cultures, and thus there is no need to remove the line. If quantitative cultures are done, a line blood culture showing five to 10 times more growth than the peripheral sample strongly suggests that the catheter is the source of the bacteremia. A less costly method that renders quantitative cultures unnecessary focuses on the speed of bacterial growth; if growth in catheter-drawn blood is faster than that in peripherally drawn blood, a primary line infection is likely. On its own, a line blood culture is not sensitive or specific enough to be diagnostically useful.

**VII. Special preoperative problems**

20. Acquired immunodeficiency syndrome. Kathleen Casey, MD, and John Mihran Davis, MD, FACS. The authors bring the basic approach to diagnosis and treatment of HIV disease from the surgeon’s perspective, including prevention of disease transmission and prophylaxis after occupational exposure.

According to the authors, the use of double gloves has been shown to minimize the possibility of contact with patient blood due to small defects in the gloves and reduces the likelihood of blood contact with skin when a glove puncture occurs.
The following are additional precautions health care workers should take when handling any potentially infectious materials:

1. Wear gloves when handling body fluids.
2. Wear a gown to prevent contamination of clothing.
3. Wash hands after contact with body fluids.
4. Place fluid from a potentially contaminated host in two impervious containers.
5. Clean spills with either a 1:10 dilution of 5.25 percent sodium hypochlorite in water or with some other type of sterilant.
6. Wear masks and protective eyeglasses when there is a possibility of aerosolization of material.

Even health care workers who do not have exfoliative dermatitis or an open wound should wear gloves during patient care. Evidence suggests that the affinity of HIV for Langerhans cells may permit the virus to invade a host through intact skin or mucous membranes.

A two-drug postexposure prophylaxis (PEP) regimen is probably adequate in the following situations: the source is known to be HIV-positive but is thought to have a relatively low viral load; the source's HIV status is unknown, but he or she is known to participate in high-risk activity; or the worker sustains either a minor percutaneous or mucous membrane exposure. A three-drug regimen would be advised in cases involving more severe percutaneous exposure; when there is extensive exposure of intact skin or mucous membranes; or when the source is thought to have a high viral load. Because all the drugs used for PEP can have significant side effects, even in the short term, the potential risks of two-drug or three-drug therapy should be weighed against the likelihood of acquiring an HIV infection. In cases in which the source patient can be identified but the HIV status is unknown, a rapid HIV test, such as the single-use diagnostic system (SUDS), should be employed. If the results are negative, PEP should not be given. If rapid testing is not available, PEP may be offered until conventional tests show that the source patient is HIV-negative.

For the choice of agents, the 1998 Centers for Disease Control guidelines suggest zidovudine and lamivudine (3TC) for two-agent therapy, with the addition of indinavir or neffinavir for three-drug therapy. Zidovudine and 3TC are now available in a combination pill that is taken twice a day, which makes it a more convenient alternative; however, the increasing prevalence of the 184 mutation that confers 3TC resistance makes this less likely to be effective in situations involving patients who have been treated with 3TC. Newer drugs, such as efavirenz, may offer more tolerable alternatives to adding a protease inhibitor, as was recommended in the past. The 2001 guidelines leave the choice more open to local expertise.

Looking ahead

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

- “Blood culture and infections,” by Donald E. Fry, MD, FACS.
- “Ultrasonography: Surgical applications,” by Grace S. Rozycki, 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: Principles and Practice, WebMD Reference, New York, NY.
TRICARE offers three plans for military personnel

by the Division of Advocacy and Health Policy

TRICARE is a health benefit program for active-duty and retired members of the military and their families. TRICARE covers not only the Army, Navy, Marine Corps, Air Force, and Coast Guard, but also the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration. Active-duty personnel have only one option for health care, but, as the name TRICARE implies, three options are available to retirees and family members of active-duty personnel and retirees.

TRICARE Prime

TRICARE Prime is the prong of TRICARE that provides care for active-duty personnel, but it is also an option for family members and retirees, if space is available. It is an HMO consisting of military physicians and perhaps some civilian physicians nearby.

TRICARE Prime enrollees also have a point-of-service (POS) option, which means an enrollee may get TRICARE-covered services outside the TRICARE Prime network of providers without a referral from their primary care manager and without authorization. Hence, any physician could see a TRICARE patient; however, these physicians must be certified by the regional carrier that processes claims. Many of the physicians who provide care to TRICARE patients do so on a fee-for-service basis, but others are in a network of preferred providers and practice near military facilities. Civilian physicians may be enrolled in an HMO that is a part of TRICARE.

Additionally, to discourage use of non-network providers, the charges to TRICARE patients who go out of network are higher. An annual deductible and a copayment of 50 percent of the TRICARE allowable charge are the responsibility of the patient. In addition, the physician has the option of charging the patient up to 15 percent more than the allowable charge.

TRICARE Standard

TRICARE Standard provides care on a fee-for-service basis. The patient is responsible for the deductible and copayment. Individual providers who “participate” in TRICARE Standard agree to accept the “allowable charge” as their full fee for care provided. Other physicians may charge up to 15 percent more than the allowable charge. Surgeons need a statement that a bed in a military hospital is unavailable in order to provide civilian inpatient care in areas surrounding military hospitals. Patients generally are responsible for filing their own claims.

TRICARE Extra

TRICARE Extra is a network of preferred providers that enrollees, including members of TRICARE Standard, may use at a discounted cost share. The cost share for active-duty family members is 15 percent of the fee for which the TRICARE Extra network provider has contracted to provide the medical service. All other eligible persons pay a 20 percent cost share of the contracted fee.
addition to the copayment, the patient must satisfy an annual deductible for outpatient care.

Other options
The Uniformed Services Health Plan (USHP) is one of two options for a limited number of enrollees. The USHP is for all but active duty personnel living in certain areas. They are served by seven community-based health plans, such as Martin’s Point Health Care and Johns Hopkins Community Physicians, plans that are neither HMOs nor insurance companies. The areas covered include the East Coast from northern Virginia to Maine, southeast Texas and southwest Louisiana, the greater Cleveland area, and the Puget Sound/Washington State area.

Another option available to a select group of enrollees is TRICARE for Life. It acts as a secondary payer to Medicare for those members who have Medicare Part B coverage. Of course, people who have this option may be seen by any physician, regardless of his or her affiliation with TRICARE. Certain services, such as chiropractic services, will be covered by Medicare but not by TRICARE for Life. For more information on TRICARE, go to http://www.tricare.osd.mil/provider/.

CHAMPVA
CHAMPVA is the Department of Veterans Affairs’ (VA) version of TRICARE Standard, in which the VA shares the cost of covered health care services with dependents or survivors of certain veterans. Although the benefits are similar to TRICARE Standard, the program is administered by a separate agency and has significantly different requirements for prior authorization and claims filing procedures. Administration of CHAMPVA, including the processing of claims, is the responsibility of the Veterans Affairs Health Administration Center in Denver, CO. For more information on CHAMPVA, go to http://www.va.gov/hac/champva.html.

Delay in 2003 Medicare fee schedule
The 2003 payment rate for Medicare’s physician fee schedule will not go into effect until March 1, 2003. Because of the change in the customary effective date for Medicare participation and payment rates, there are some points of which you and your staff must be aware.

- The enrollment period for Medicare participation will run from January 9 through February 28, 2003. The enrollment materials you received from your carrier incorrectly advised you that any change to your participation status was to be made by December 31, 2002. Review the August 2002 Bulletin article, “Selecting the best Medicare payment option” (http://www.facs.org/fellows_info/bulletin/cebuhar0802.pdf) for details of your choices for participation. The decision that you make about participation in the Medicare program will be irrevocable for 2003.
- If you change your participation option, you should start to prepare claims under your new option as soon as you have submitted your participation agreement or disenrollment to the carrier.
  - Claims for services provided in January and February will be paid at the 2002 rates. You should submit these claims to your carrier as quickly as possible to ensure reimbursement at the 2002 payment level.
  - If you are incorrectly reimbursed for any claims, you will receive an automatic adjustment after July 1, 2003. Incorrect reimbursement may occur if you change your participation option or prepare and submit claims late in February.
  - 2002 payment amounts will be applied toward a patient’s $100 deductible in January and February. Beginning March 1, the 2003 rates will be applied.
  - Avoid reporting services provided in January and February with new 2003 CPT codes. Any claims containing CPT codes introduced in 2003 will be held until March for payment and will be paid according to the 2003 rates. Your practice may consider delaying the transition to the 2003 CPT codes until after March 1. Remember that you are required to use them on April 1.

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 there are topics that you would like to see 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.
April 12-15, 2003

31st Spring Meeting
to be held in New York

The American College of Surgeons invites you to attend its thirty-first annual Spring Meeting, which will take place April 12-15, 2003, at the Hilton New York, New York, NY.

To emphasize its strong commitment to and support of general surgery, the American College of Surgeons’ Division of Education devotes the annual Spring Meeting to the interests and needs of the practicing general surgeon.

The Advisory Council for General Surgery has planned a program for the 2003 Spring Meeting that will be of interest to all general surgeons. The meeting will focus on applying knowledge and skills. Richard J. Finley, MD, FACS, will moderate the Town Meeting, “Changes in Surgical Practice: Getting Ahead of the Game,” to be held on Saturday, April 12, 2003. This session will highlight the important clinical advances as well as evolving practice-related issues that are critical in surgical practice.

The 2003 Excelsior Lecture entitled “Is Surgical Science Dead?” will be presented by Clyde F. Barker, MD, FACS. The lecture will take place Sunday, April 13, 2003.

A number of skills-oriented postgraduate courses are scheduled, including: Image-Guided Breast Biopsy; Ultrasound for Surgeons; Breast Ultrasound; Ultrasound in the Acute Setting; Stereotactic Breast Biopsy; Mobile and Wireless Computing: Practical Application; Mastering Surgical and Office-Based Coding; and Media Training for the Surgeon. General sessions on vascular access, professionalism in clinical practice, and endovascular surgery will be complemented by core didactic courses in minimal access surgery and vascular surgery.

The Spring Meeting in New York will surely provide high-quality educational sessions and opportunities for practicing surgeons to network. Make plans to attend this educational meeting. Information regarding the general sessions, postgraduate courses, and registration information will be mailed to Fellows in February. Registration will be available online and posted on the ACS Web site at www.facs.org.

For further information about the program content, please contact the Division of Education.

- Kathy Stack, Academic Administrator, 312/202-5433.
- Ajit K. Sachdeva, MD, FACS, FRCSC, Director, 312/202-5405.
Preliminary program
Program is subject to change.

General Sessions
Saturday, April 12

8:00–11:30 am  
Techniques and Technologies in the Assessment of the Acutely Injured Abdomen: Who Needs What and When?  
MODERATOR: Grace S. Rozycki, Atlanta, GA

1:00–5:00 pm  
Welcome and Opening Remarks  
A Town Meeting—Changes in Surgical Practice: Getting Ahead of the Game  
MODERATOR: Richard J. Finley, MD, FACS, Vancouver, BC

Sunday, April 13

8:00–11:00 am  
Vascular Access  
MODERATOR: A. Fredrick Schild, MD, FACS, Miami, FL

8:00–11:00 am  
Prospering in the New Millennium: Practical Strategies for Practice Management  
MODERATOR: Martin B. Durtschi, MD, FACS, Ketchum, ID

11:15 am–12:15 pm  
Excelsior Surgical Society/Edward D. Churchill Lecture: Is Surgical Science Dead?  
INTRODUCER: Paul Friedmann, MD, FACS, Springfield, MA  
LECTURER: Clyde F. Barker, MD, FACS, Philadelphia, PA

1:30–5:00 pm  
Minimal Invasive Breast Surgery  
MODERATOR: V. Suzanne Klimberg, MD, FACS, Little Rock, AR

1:30–5:00 pm  
Professionalism in Clinical Practice  
MODERATOR: Paul Friedmann, MD, FACS, Springfield, MA

Monday, April 14

8:00–11:30 am  
Endovascular Surgery for General Surgeons: Current State of Practice  
MODERATOR: Gregorio A. Sicard, MD, FACS, St. Louis, MO

1:00–5:00 pm  
Open vs. Laparoscopic Colon Surgery  
MODERATOR: Heidi Nelson, MD, FACS, Rochester, MN

ACS Advisory Council for General Surgery

CHAIR: Paul Friedmann, MD, FACS, Springfield, MA  
VICE-CHAIR: Joyce A. Majure, MD, FACS, Lewiston, ID

John L. Cameron, MD, FACS, Baltimore, MD  
James Edney, MD, FACS, Omaha, NE  
David V. Feliciano, MD, FACS, Atlanta, GA  
Richard J. Finley, MD, FACS, Vancouver, BC  
Michael J. Hart, MD, FACS, Seattle, WA  
Nathalie Johnson, MD, FACS, Portland, OR  
A. Letch Kline, MD, FACS, Gulfport, MS  
Sally M. Knox, MD, FACS, Dallas, TX  
John K. MacFarlane, MD, FACS, Vancouver, BC  
Mark A. Malangoni, MD, FACS, Cleveland, OH  
J. Patrick O’Leary, MD, FACS, New Orleans, LA  
Juan C. Paramo, MD, Aventura, FL  
Victor E. Pricolo, MD, FACS, Providence, RI  
J. David Richardson, MD, FACS, Louisville, KY  
Charles F. Rinker II, MD, FACS, Bozeman, MT  
A. Frederick Schild, MD, FACS, Miami, FL  
Jon A. van Heerden, MD, FACS, Rochester, MN

STAFF:  
Paul E. Collicott, MD, FACS, Chicago, IL  
Director, Division of Member Services  
Mark Peterson, Chicago, IL  
Administrator

Earn up to 32 hours of Category 1 CME credit in General Sessions

7:00–9:30 pm  
Highlights from the 2002 Clinical Congress Video-Based Education Sessions in San Francisco, CA  
INTRODUCER: Stuart D. Wilson, MD, FACS, Milwaukee, WI
Tuesday, April 15

8:00-11:00 am
**Image-Detected Breast Cancer: State-of-the-Art Diagnosis and Treatment Discussion**
*MODERATOR: Melvin J. Silverstein, MD, FACS, Los Angeles, CA*

8:00-11:30 am
**Recruitment and Retention of Residents**
*MODERATOR: Richard K. Spence, MD, FACS, Birmingham, AL*

8:00-11:30 am
**Spectacular Cases from Residents**
*MODERATOR: John K. MacFarlane, MD, FACS, Vancouver, BC*

1:00-5:00 pm
**Clinical Palliative Care in the Trenches**
*MODERATOR: K. Francis Lee, MD, FACS, Springfield, MA*

1:00-5:00 pm
**Surgical Jeopardy**
*MODERATOR: Mark W. Bowyer, MD, FACS, Burke, VA*

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**Postgraduate Courses**

The Spring Meeting offers a variety of postgraduate courses. This year there are skills-oriented courses and didactic courses.

**Skills-Oriented**

**Image-Guided Breast Biopsy (Core Lectures)**
*Saturday, April 12, 8:00 am-12:30 pm*
*CHAIR: Philip Z. Israel, MD, FACS, Marietta, GA*

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

**Skills-Oriented**

**Mastering Surgical and Office-Based Coding**
*Saturday, April 12, 8:00-11:30 am (session I) and 1:00-4:30 pm (session II)*

**Didactic**

**Resuscitation and the Immediate Critical Care of the Trauma Patient**
*Saturday, April 12, 8:00-11:30 am (session I) and 1:00-4:30 pm (session II)*
*CHAIR: R. Lawrence Reed, MD, FACS, Maywood, IL*

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**For additional fees:**

- Earn up to 30 hours of Category 1 CME credit in skills-oriented postgraduate courses.
- Also earn up to 30 hours of Category 1 CME credit in didactic postgraduate courses.

**CO-CHAIRS:**

John T. Preskitt, Jr., MD, FACS, Dallas, TX
Charles P. Shoemaker, MD, FACS, Newport, RI

The objective of this course is to build on the key concepts discussed in the ACS basic coding course by introducing cases using surgical modifiers, followed by hands-on coding scenarios. Evaluation and management scenarios will be introduced and the attendee will code cases identifying the appropriate category of codes and appropriate modifiers to various scenarios. Surgeons and their staff with two years’ solid coding experience may attend.

At the conclusion of the advanced coding program, participants will be able to: (1) understand when to apply modifiers to surgical procedures and office encounters, (2) analyze physician profiles and identify profiles that may pose risk to the physician or practice, (3) understand the American Medical Association’s definition of the surgical package and Medicare’s definition of the global surgical package, and (4) identify the types of explanation of benefits (EOBs) that are important for the physician to review.
Critical care of the trauma patient begins with resuscitation, and includes the interrelated management of fluids, ventilation, sedation, coagulopathy, temperature maintenance, monitoring, and the unique needs of the patient with brain injury. This course will examine a number of current issues in critical care from the perspective of the initial resuscitation, and provide an update on current techniques, protocols, and developing technology.

Skills-Oriented
**Stereotactic Breast Biopsy**
Sunday, April 13, 8:00 am–12:00 pm (Session I) and 1:00-5:00 pm (Session II)
**CHAIR:** Darius S. Francescatti, MD, FACS, Chicago, IL

(Prerequisite: Image-Guided Breast Biopsy)

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

Skills-Oriented
**Mobile and Wireless Computing: Practical Applications**
Sunday, April 13, 8:00-11:15 am (Session I) and 1:30-5:00 pm (Session II)
**CO-CHAIRS:**
  - David A. Krusch, MD, FACS, Rochester, NY
  - Ronald Bruce Hirschl, MD, FACS, Ann Arbor, MI

This session will highlight the role of personal data assistants (PDAs) and the use of interactive information for the surgeon’s daily practice. The afternoon session will feature a hands-on demonstration of the use and function of PDAs.

Skills-Oriented
**Ultrasound for Surgeons**
Sunday, April 13, 1:00–5:00 pm
**CHAIR:** Lawrence N. Diebel, MD, FACS, Detroit, MI

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

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

Skills-Oriented
**Breast Ultrasound**
Monday, April 14, 8:00-11:30 am (Session I) and 1:00-5:00 pm
**CO-CHAIRS:**
  - Richard E. Fine, MD, FACS, Marietta, GA
  - Edgar D. Staren, MD, PhD, FACS, Toledo, OH

(Prerequisite: Ultrasound for Surgeons)

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

Didactic
**Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons**
Monday, April 14, 8:00-11:30 am (Session I) and 1:00-4:30 pm (Session II)
**CO-CHAIRS:**
  - Charles D. Mabry, MD, FACS, Pine Bluff, AR
  - Frank G. Opelka, MD, FACS, Boston, MA

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

Didactic
**Minimal Access Surgery**
Monday, April 14, 8:00-11:30 am (Session I) and 1:00-4:30 pm (Session II)
CHAIR: Myriam J. Curet, MD, FACS, Stanford, CT

The objective of this course is to provide general surgeons with information on established and emerging minimal access surgical techniques. Two major focuses will be robotics and bariatric surgery. The course will review the use of robotics in various surgical procedures in one session. Different surgical approaches to laparoscopic bariatric surgery, including Roux-en-Y gastric bypass, lap-band, biliopancreatic diversion, and duodenal switch will be emphasized in another session. Other topics will include current status of ventral and inguinal hernia repairs, laparoscopic solid organ procedures, hand-assist laparoscopic surgery, minimally invasive approaches to common bile duct pathology, and laparoscopic foregut surgery.

Didactic
Vascular Surgery 2003
Monday, April 14, 8:00-11:30 am (Session I) and 1:00-4:30 pm (Session II)
CHAIR: Robert W. Hobson III, MD, FACS, Newark, NJ

The objective of this course is to provide an update for the practicing surgeon on the available techniques to improve the quality and outcomes of hemodialysis access surgery. Presentations will include management of complications of vascular diseases and methods and devices used to treat them.

Skills-Oriented
Ultrasound in the Acute Setting
Tuesday, April 15, 8:00-11:00 am (Session I) and 1:00-5:00 pm (Session II)
CHAIR: Amy C. Sisley, MD, FACS, Baltimore, MD
(Prerequisite: Ultrasound for Surgeons)

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

Special Experiential Course
Bariatric Surgery Primer
Monday, April 14, 8:00 am-5:00 pm, 6:30-9:00 pm, and Tuesday, April 15, 8:00 am-5:30 pm
CHAIR: Henry Buchwald, MD, FACS, Minneapolis, MN

This intense, two-day course will feature didactic presentations, panels, and live interactive closed-circuit TV sessions to provide a broad overview of bariatric surgery. Participants will be able to describe the epidemiology, etiology, and incidence of morbid obesity and outline the physiologic basis for bariatric surgery. Criteria for identification of appropriate surgical candidates will be outlined, and various bariatric surgical procedures such as laparoscopic adjustable gastric banding, vertical banded gastroplasty, gastric bypass, and duodenal switch will be presented. The pre-, intra-, and postoperative care associated with each procedure will be described, along with the possible postoperative complications and their appropriate management and prevention strategies. In addition, principles underlying a multidisciplinary approach to bariatric surgery and the consequences of post-bariatric weight loss will be discussed. Six live, interactive, closed-circuit TV operations, primarily featuring laparoscopic techniques, will be performed by world-renowned surgeons. The course will also include presentations regarding insurance, billing, coding, and liability issues relating to bariatric surgery, and the ethical perspectives on elective surgery for metabolic disease. A special evening presentation by an international expert and dinner are included as part of the course.

The Spring Meeting will conclude at 5:00 pm on Tuesday, April 15, 2003.

The American College of Surgeons sponsors this conference to promote advances in surgery and other areas of science. The information presented through the programs and exhibits is not verified or endorsed by the American College of Surgeons. Presenters and exhibitors are solely responsible for content.

Make plans now to attend this important meeting. Information regarding the general sessions, postgraduate courses, and registration information will be mailed to Fellows in February. Registration will be available next month online at www.facs.org.
Registration information

Registration includes a name badge and entrance to all sessions other than postgraduate courses. Registered attendees may purchase postgraduate course tickets based upon availability. Advance registration is strongly encouraged and open to all physicians and individuals in the health care field. You can register by one of the following methods:

Online: Register online at www.facs.org/2003springmeeting/. Visa, MasterCard, or American Express payment of all applicable fees must be paid at the time of your online registration.

By fax: Complete the registration form (see p. 33-34) and fax to 800/682-0252 or 312/202-5003. Visa, MasterCard, or American Express payment of applicable fees must be included on your faxed registration. Purchase orders are not accepted. Your registration will not be processed without the appropriate payment information. You do not need to mail the original registration form from this program if you submitted your registration by fax.

By mail: Complete and mail the registration form to: American College of Surgeons, Attn: Registration Services, P.O. Box 92340, Chicago, IL 60675-2340. Payment of all applicable fees must accompany your registration. If payment is submitted by check, make payable to: American College of Surgeons.

The deadline for advance registration is March 13, 2003. Registrations received and postmarked after March 13 will be billed according to the fees indicated on the registration form.

Formal, written confirmation will be mailed to all advance registrants upon successful processing. Prior to the meeting, each advance registrant will receive an official name badge, attendance verification card, and postgraduate course ticket(s), if applicable. Postgraduate course syllabi will be distributed on site in New York.

If you are unable to register in advance, bring the completed registration form with proper credentials and payment information to the on site registration area of the Hilton New York.

Cancellation: Registration fees will be refunded if

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*New! Guest physicians: The ACS will apply $150 of your registration fee toward the Fellowship application fee. An application for Fellowship will be sent to you upon receipt of your registration. Simply complete the application and return it by June 16, 2003, and you will be on your way to becoming a member of the American College of Surgeons, enjoying the many benefits of membership.

†The American College of Surgeons is pleased to offer discounted registration fees for residents and medical students. Please submit a letter verifying your educational status with your completed registration form to expedite processing. Residents should obtain a letter from their program directors, and students should contact their department chairs.
a written request is received at the College and post-marked no later than March 13, 2003. A $50.00 handling fee will be retained. Cancellations received after March 13 will not be eligible for refunds.

Registration location and hours
All advance and on-site registration activity will be held at the Hilton New York.

Saturday, April 12 ..........7:00 am–5:30 pm
Sunday, April 13 ............7:00 am–7:00 pm
Monday, April 14 ..........7:00 am–5:00 pm
Tuesday, April 15 ..........7:00 am–12:00 noon

Registration fees and credentials
Please note the various registration fees and credentials required for processing your registration in the table on the previous page.

The American College of Surgeons reserves the right to cancel any regularly scheduled session prior to the start of the meeting.

General sessions
The registration fee includes admittance to the general sessions. Please indicate on the registration form those sessions for which you are requesting an admittance ticket. Ticket requests will be filled on a first-come, first-processed basis.

Technical exhibits
To enhance the educational value of the meeting, more than 40 companies will display products or services related to the practice of surgery. Your registration includes a reception on Sunday, April 13, 5:00–7:00 pm, in the exhibit hall. Spouses/guests will receive a ticket for the reception if they register under the appropriate registration category.

Technical exhibits will be open Sunday, 12:00 noon–3:30 pm and 5:00–7:00 pm for the reception. The exhibit hall will be open Monday, April 14, 10:00 am–3:30 pm.

Social program
A Social Program will be offered for the Spring Meeting in New York. A nonrefundable fee is required for participation; the fee entitles you to purchase event tickets, attend scientific sessions, view technical exhibits, and attend the Sunday evening Exhibit Hall Reception. Registered Social Program spouses and guests will also receive a travel tote bag.

Because tour capacities are limited, advance registration is strongly encouraged. For further information, please visit the ACS Web site at www.facs.org.

ACS Candidate Group
members pay no advance registration fee!

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

CME credit
The American College of Surgeons designates this education activity for a maximum of 32 hours in Category 1 credit toward the American Medical Association Physician’s Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Audio tapes
Selected postgraduate courses, general sessions, and named lectures will be recorded live and will be available for purchase on audiocassettes. Additional information will be available on site in New York at the National Audio Video booth near the registration area.

Postgraduate course syllabi on CD-ROM
A CD-ROM containing 14 select postgraduate course syllabi from the 2002 Clinical Congress will be available for purchase at the Spring Meeting registration desk.

Accommodations
The thirty-first annual Spring Meeting will be held at the Hilton New York, conveniently located at Rockefeller Center, near Broadway theatres, a block from Fifth Avenue, and close to cultural attractions for which New York is famous. All guest rooms have voice mail, computer dataports, hairdryers, irons/ironing boards, coffee makers, refreshment centers, and individually controlled temperature units. The hotel recently completed a $90 million renovation and features an 8,000 square foot health club, four restaurants and lounges, concierge service, and business center.

Reservations can be made by calling the hotel directly at the number listed below. Please indicate that you will be attending the ACS Spring Meeting in order to obtain the special group rates.
Hotel information:

Hilton New York
1335 Avenue of the Americas
New York, NY 10019
Hotel main phone: 212/586-7000
Hotel reservations: 212/261-5870
Hilton reservations: 800/HILTONS
Hotel guest fax: 212/315-1374
ACS group rates: $230 single/$258 double

Reservations made after the housing deadline of March 13, 2003, or after the room block fills, are subject to space and rate availability.

A deposit of one night’s stay is required when making your reservation, payable via check or credit card. The deposit is refundable if the reservation is cancelled at least 48 hours prior to your scheduled arrival date.

Please also note that after check in, an early departure fee of $100 will apply if you choose to check out prior to your scheduled departure date.

Transportation

Special meeting saver airfares are available on United or Delta Airlines. Choose from the following savings options:

- Receive a 5 percent discount off lowest applicable domestic published fares.
- Receive a 10 percent discount off the published unrestricted coach fares.
- Obtain a 5 percent additional discount on the above fares if tickets are purchased at least 30 days (on United) and 60 days (on Delta) in advance.

Area/zone fares based on geographic location are also available with no Saturday night stay required. Minimum stay (one to two nights) varies by airline; seven-day advance purchase required. (Zone fares not available through online ticket purchase; please call numbers below.)

These special discounts are available by calling either official airline directly (either independently or through a travel agent). Be sure to indicate the name of the meeting to which you will be traveling and refer to the ACS file numbers to obtain the special fares.

United Airlines 800/521-4041
7:00 am-10:00 pm (ET) 8:00 am-11:00 pm (ET)

ACS File 501CR

Delta Air Lines 800/241-6760

ACS File 193001A

Car rental

Avis is designated as the official car rental company for the 2003 Spring Meeting. Special meeting rates and discounts are available on a wide selection of cars. To receive these special rates and discounts, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

Avis reservations
800/331-1600
Web site: www.avis.com
AWD number: B169699

In February, you will be able to register online at www.facs.org.

Register online now at www.facs.org and avoid late registration fees.

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Registration Form

American College of Surgeons
31st Annual Spring Meeting
April 12–15, 2003
Hilton New York, New York, NY

Deadline for advance registration is March 13, 2003. Payment must accompany registration. Avoid additional fees. Register early!

American College of Surgeons
Attn: Registration Services
PO Box 92340, Chicago, IL 60675-2340

Mail registration form to:

Registration Fees: Appropriate Status Must Be Checked

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Postgraduate Course Fees: Please Indicate Selection(s) Clearly

101  SC 1  Image-Guided Breast Biopsy (Core Lectures) $250
102  SC 2  Mastering Surgical and Office-Based Coding $350
103  SC 3  Stereotactic Breast Biopsy* Prerequisite: SC 1 $750
104  SC 4  Mobile and Wireless Computing: Practical Applications $425
105  SC 4a—Sunday AM lecture; Sunday PM workshop $425
106  SC 4c—Sunday AM lecture; Monday PM workshop $425
107  SC 5  Ultrasound for Surgeons $250
108  SC 6  Breast Ultrasound* Prerequisite: SC 5 $1,000
109  SC 7  Ultrasound in the Acute Setting* Prerequisite: SC 5 $750
110  SC 8  Bariatric Surgery Primer $850
201  PG 9  Resuscitation and the Immediate Critical Care of the Trauma Patient $300
202  PG 10a Charting a Sound Course for Surgical Practices (small practice <15) $450
203  PG 10b Charting a Sound Course for Surgical Practices (large practice >15) $450
204  PG 11  Minimal Access Surgery $400
205  PG 12  Vascular Surgery 2003 $300

*Additional information about prerequisite courses can be found in the postgraduate course section.

Registration Fee $ ________
Postgraduate Course Fee $ ________
Total Due $ ________

Telephone (________) ____________________________________ Fax (________) ____________________________________
E-mail __________________________________________________________________________________________________
Payment Information

Payment must accompany your registration. Make checks payable in U.S. funds to: American College of Surgeons.

If paying by credit card, please complete and ensure legibility.

- Visa
- MasterCard
- American Express

Credit Card Number

Exp. Date (mm/yy)

Card Issued To

Signature

Americans with Disabilities Act

Check here if special services are required due to a disability.

An ACS staff person will contact you. Please provide a daytime phone number or e-mail address.

phone (_______)

e-mail _________________________

Surgical Specialty (Please Indicate)

- General Surgery
- Cardiothoracic Surgery
- Colon and Rectal Surgery
- Gynecology and Obstetrics
- Neurological Surgery
- Ophthalmic Surgery
- Orthopaedic Surgery
- Otorhinolaryngology
- Pediatric Surgery
- Plastic Surgery
- Urological Surgery
- Vascular Surgery
- Other:

Cancellation Policy

Registration fees will be refunded if a written request is received at the College and postmarked no later than March 13, 2003. A $50.00 handling fee will be retained. Registrations postmarked after March 13, 2003, will not be eligible for refunds.

General Sessions - All sessions included in registration fee.

- GS01—Techniques and Technologies in the Assessment of the Acutely Injured Abdomen
- GS02—A Town Meeting: Changes in Surgical Practice—Getting Ahead of the Game
- GS03—Vascular Access
- GS04—Prospering in the New Millennium: Practical Strategies for Practice Management
- GS05—Excelsior Surgical Society/Edward D. Churchill Lecture: Is Surgical Science Dead?
- GS06—Minimally Invasive Breast Surgery
- GS07—Professionalism in Clinical Practice
- GS08—Highlights from the 2002 Clinical Congress Video-based Educational Sessions
- GS09—Endovascular Surgery for General Surgeons: Current State of Practice
- GS10—Open versus Laparoscopic Colon Surgery
- GS11—Image-Detected Breast Cancer: State-of-the-Art Diagnosis
- GS12—Recruitment and Retention of Residents
- GS13—Spectacular Cases from Residents
- GS14—Clinical Palliative Care in the Trenches
Nominations for the Board of Regents sought

During the October 2002 meeting of the Board of Regents, an ad hoc committee on the structure, composition, and terms of the Board of Regents made recommendations to the Board. One of the recommendations was the addition of new seats on the Board so that all specialties having Advisory Councils will have representation. The Board approved this recommendation and added three new seats.

The 2003 Nominating Committee of the Board of Governors has the task of selecting nominees for five seats on the Board of Regents that will need to be filled during the 2003 Clinical Congress. The following suggested guidelines are used by the Nominating Committee when reviewing the names of potential nominees for election to the Board of Regents.

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.
- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.
- Recognition of the importance of their representing all who practice surgery.
- The College encourages consideration of women and other underrepresented minorities.
- Individuals who are no longer in active surgical practice should not be nominated for election or reelection to the Board of Regents.

The surgical specialties that should be given priority consideration are:

- Colorectal
- General
- Neurological
- Orthopaedic
- Pediatric
- Vascular

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Please submit nominations to memberservices@facs.org. The deadline for submitting nominations is March 17, 2003.

IN COMPLIANCE, from page 19

employee's record. Depending on how serious or flagrant the disclosure was, it could even lead to the dismissal of a staff member or the cancellation of a contract with a business associate.

When developing, organizing, and refining the practice’s policy manual, remember that the contents of the manual must include procedures to address each item listed in the “Notice of Privacy Practices.”

Tip for privacy officer

There is another resource for HIPAA privacy guidance. The Secretary of the HHS has assigned oversight of HIPAA privacy compliance to the Office of Civil Rights (OCR). A practice may want to bookmark OCR’s Web site (http://www.hhs.gov/ocr/hipaa/assist.html) to review or download the document “Frequently Asked Questions About the HIPAA Privacy Rule.” This document will be updated as OCR responds to questions posted on its Web site or develops additional guidance on privacy issues.

As a rural surgeon, it is difficult for me to leave a busy practice where coverage is sometimes a challenge. My colleagues were very supportive and encouraged me to take advantage of the Oweida Scholarship opportunity. I focused my educational pursuits on technology issues in surgery, since training and support for these endeavors are not always available in a rural practice.

I attended four postgraduate courses during the 2002 Clinical Congress in San Francisco, CA—the basic ultrasound for surgeons course, the basic course on computers in surgery, handheld devices for surgeons (a basic course on using personal data assistants, or PDAs), and the course on breast diseases. Each of these courses broadened my understanding of computers and the ever-increasing role of software in a surgical practice. In some ways, it is analogous to learning a new language with seemingly endless applications.

The course on breast disease was an excellent update on the current state of breast imaging, biopsy techniques, and an in-depth analysis of current controversies. I also attended general sessions, including the opening session, the session on bioterrorism, and sessions on palliative care and “surgical frontiers.” The sessions provided a whirlwind of information, with many thought-provoking questions and scenarios, and I appreciated the opportunity to immerse myself in a challenging and education-packed week.

The other aspect of the Clinical Congress that I have always enjoyed is networking with other surgeons and visiting with surgery professors as well as residency classmates. In addition, the technical exhibits provide an opportunity to examine new instruments and methods and preview new publications. I did take advantage of these opportunities, attending the scholarship luncheon, the Fellows Leadership Society luncheon, the University of Florida Woodward Society meeting, the University of New Mexico surgery department reception, and the Association of Women Surgeons’ networking breakfast.

The benefits of the scholarship for a rural surgeon include updates in many controversial areas of surgical practice, the opportunity to gain credentialing in new methods such as surgical ultrasound, and training in technology issues—since support and resources are often unavailable in a rural setting.

A. Brent Eastman, MD, FACS, a Regent of the College, asked me what programs might be most beneficial to a surgeon in a rural setting. I gave this question a great deal of thought and asked some of my colleagues for their ideas. It seems that there are times when resources and experience limit a rural surgeon’s ability to provide optimal care to patients. In some circumstances, such as patients requiring a Whipple procedure or cardiovascular surgery, the need to refer is clear. Yet there are many conditions in general surgery where the need to refer a patient is not so obvious.
For example, many rural surgeons manage patients with severe pancreatitis. At what point should a patient be referred for gastroenterology and interventional radiology support? In another example, women with breast calcifications are still managed by needle localization breast biopsy in the rural setting. Even if stereotactic equipment were available in our practice, neither the radiologists nor the surgeons have the experience to perform stereotactic biopsy. Should all of these patients be referred to a breast center?

I address these issues as a surgeon who wishes to maximize utilization of our own resources while still providing quality care to our patients. Providing programs in which specific conditions are addressed and referral algorithms are proposed would be very beneficial to rural surgeons and to our patients.

I would like to extend my sincerest thanks to the American College of Surgeons and the Scholarships Committee for the opportunity to attend the Clinical Congress and for providing a forum where surgeons can share ideas, experiences, and technical assistance with one another.

Dr. Wilkie is chief of general surgery, Gallup Indian Medical Center, Gallup, NM.
Announcing...

CME online

Web casts of general sessions from the Clinical Congress

NOW ONLINE

Offered by the
American College of Surgeons
Division of Education

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 six online general sessions from the Clinical Congress. These sessions are offered in the form of a Web cast at 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:

| GS 08:    | New Technology:     |
| GS 10:    | Patient Safety      |
| GS 21:    | Damage Control in Trauma and Emergency Surgery: New Applications |
| GS 23:    | Programa Hispanico  |
| GS 34:    | Should Axillary Dissection Be Abandoned? |
| GS 40:    | Management of Metastatic Disease of the Liver |
Surgery resident travels to Honduras with mentor, Dr. Field

by Stig Somme, MD, New Orleans, LA

Author’s note: After finishing his surgical training under Rudolph Matas, MD, FACS, at Tulane University, Richard J. Field, Sr., MD, FACS, returned to his hometown of Centreville, MS. With real missionary spirit and the purpose of bringing the best medical care to his area of Southwest Mississippi, Dr. Field, Sr., with his brother Sam Field, MD, established Field Hospital in 1928.

Many years have passed, but the original missionary spirit has remained at Field Hospital. Thus, when Baptist Medical Missions International contacted Richard J. Field, Jr., MD, FACS (see endnote), in 1998 about the possibility of medical missionary trips to Honduras, he gladly offered the services of the surgical team at Field Hospital.

During their first expedition to Honduras that same year, the surgical team found the health care needs overwhelming in the rugged mountainous region. Three more trips to this underserved area followed. Each one proved extremely productive.

Before the fourth trip, Dr. Field realized that the trips to Honduras would provide a great opportunity for a senior surgical resident to use and improve his or her skills under Dr. Field’s supervision. J. Patrick O’Leary, MD, FACS, chairman of the department of surgery at Louisiana State University (LSU) School of Medicine in New Orleans, LA, shared this opinion and made it possible for the author to join the Field Hospital team in Honduras last year. Details about this experience follow.

In January 2002, I joined the team from Field Hospital to spend several days in the mountain village of Sula, Honduras, about two hours by bus from San Pedro Sula. The local hospital has 20 beds and an emergency room.

Dr. Field, my mentor for this experience, has practiced surgery for 50 years. At age 76, he still operates every day at Field Hospital in the small rural community of Centreville.

Having been on three previous trips, Dr. Field knew the region’s surgical needs and how we could maximize our usefulness to the people in the village. Gallbladder pathology is common in Honduras, as it is among native populations in the U.S. The results of untreated gallbladder disease can range from discomfort to death.

We confined ourselves to two operations, open cholecystectomy and hernia repair, which lead to few postoperative complications. We knew going in that we wouldn’t do any bowel
surgery because of the postoperative care that would be required and that we wouldn’t be available to provide. In all, our team performed 13 open cholecystectomies and seven hernia repairs in four days.

The trip

We left New Orleans on January 27, 2002, on a nonstop two-hour flight to San Pedro Sula, Honduras. In the time it takes to fly from New Orleans to Chicago, we traveled to a different world.

A yellow school bus from the hospital picked us up at the airport for the two-hour ride to Sula. The drive through the mountains was beautiful, but the poverty was apparent. We passed several villages where the houses were little more than walls and a roof. None had running water or electricity.

Along the way, we saw armed military personnel. Our interpreter explained that their presence was the result of a recent rash of armed robberies of cars and buses along the main highway.

The village

Sula is situated in a valley of the Santa Barbara region, and tree-covered mountainsides surround it. Most villagers are farmers, although some are gold miners who came and stayed in the wake of a significant discovery some years ago. However, if anyone ever found gold in Sula, it was not manifest in the village, which showed no signs of affluence at all.

Our accommodations for four days were in the small but well-equipped mission house on the hospital grounds. The house, about 100 yards from the hospital, was once a home of missionaries. The hospital building was an orphanage until the Baptist Medical Mission bought it and transformed it into a medical facility.

The experience

On Monday, our first operating day, a line of patients who had traveled from all across Honduras greeted us. Our arrival had been announced on radio broadcasts throughout the country weeks before, and we had 22 patients scheduled for the first day. To our relief, only half of them showed up. We had one operating room assigned to us, but another was available to us when the local gynecologist was not using the room. When we were able to get two rooms, the local OR nurse and the local nurse anesthetist assisted in the extra room.

We got up at 6:00 am, had breakfast, started organizing at 7:30 am, and began the first case at 8:00 am. We usually finished between 6:00 or 8:00 pm. Sometimes Dr. Field would scrub in with me, and sometimes he would use the other OR. But he was always close at hand if I needed anything, and if he wasn’t operating himself, he would check in on my cases.

All the cholecystectomies were performed using a subcostal incision. Most patients did well postoperatively, but one patient had severe cholecystitis and developed an ileus. The hospital was not equipped to deal with this complication, so we improvised. We first placed a single lumen tube in the stomach and let gravity handle the drainage. Later, we found an old suction unit that worked, and we used a nasogastric sump suction tube.

In that one patient’s case, we found ourselves far removed from modern American medicine, which has plenty of antibiotics, a wealth of experience in nasogastric tubes, and nurses skilled in the use of them. Intravenous crystalloids were available, but we couldn’t check serum chemistries to replace deficiencies. The hospital was equipped to perform complete blood counts, but nothing else.

In spite of the lack of medical amenities, the staff in Honduras overall provided good care to the patients. Of all the patients we saw in the preoperative holding area before their surgeries, we had to cancel only a few surgeries because of risks to the patients. One was a young woman with Graves’ disease, whose hyperthyroidism was not controlled well enough to perform a thyroidectomy.

Postoperatively, patients received bedside care from family members who came with them. The hospital’s nursing staff just couldn’t stretch thin enough to care for all the patients our visit brought to the hospital.

The hospital normally has one physician in-house to cover the emergency room. During the week we were there, two physicians were available to help in the work-up, surgical evaluation and clearance, and postoperative care of the increased number of patients. We made rounds with the local “doctores” and clarified questions about postoperative care.
Our team took pulsoxymeters, muscle relaxants, antinausea medication, and endotracheal tubes. Dr. Field always takes his entire surgical team, including a nurse anesthetist and a recovery nurse. That was a great luxury—to have a team that has worked together for so long and that provides well-tested care.

This trip represented something I have wanted to do since I entered medicine, and I found the work very rewarding. Being a native Norwegian, I was a world away from the familiar, but it was exciting and stimulating. At LSU, I might get to do 10 operations in a busy week. In Honduras, I did double that in four days. Because most cholecystectomies are done laparoscopically now, most residents don’t have a chance to learn the traditional method. I know a sixth-year resident who’s done only two.

It was a great learning experience, and Dr. Field is a wonderful mentor. I would do it again and would recommend a similar experience to other residents.

Anyone interested in participating in this type of surgical endeavor may contact either Dr. R. J. Field, Jr., at 601/645-5361, or Herbert P. Kinsey, MD, FACS, at 251/937-1755.

Dr. Field is director of the Field Clinic and chairman of surgery at the Field Hospital in Centreville, MS. A former Regent and Second Vice-President of the American College of Surgeons, he also is clinical professor of surgery at Tulane University, LSU, and the University of Mississippi School of Medicine. In 2002, the department of surgery at the University of Mississippi School of Medicine established the Richard J. Field, Jr., Annual Lectureship in Surgery in honor of Dr. Field’s many contributions to surgery in that state and the nation.

Dr. Somme is a third-year surgical resident at Louisiana State University and a member of the ACS Candidate Group.

Nominations sought for ACS surgical volunteerism award

The American College of Surgeons, through its Board of Governors’ (B/G) Committee on Socioeconomic Issues, seeks to identify and promote volunteer programs to which surgeons contribute, as well as to create communication and linkage between those opportunities and surgeons wanting to give something of themselves back to society.

A new component of the College’s Giving Back Program will be recognition of an individual or organization making a significant contribution to surgical care through organized volunteer actions by an award to be presented at the annual Clinical Congress.

Candidates for this award may practice their surgical volunteerism either in a domestic (urban, rural) or international setting. All surgical subspecialties are eligible for consideration.

Nominations should be limited to 500 words, briefly describing the nature of the surgical activity, location, scope and number of patients served, status of the volunteer surgeons (active, retired), frequency of service, funding sources, and relation to ACS, other professional organizations, missions, or charitable institutions.

Please consider an estimate of the impact of the program upon patients, including continuing care, and upon other local providers.

Nominations must be received by March 17, 2003, to be considered this year. Please direct nominations to Andrew L. Warshaw, MD, FACS, Chair, B/G Committee on Socioeconomic Issues, Massachusetts General Hospital—WHT 506, 55 Fruit St., Boston, MA 02114-2696.
From the ACS Archives

Papers chronicle Franklin Martin’s life

by Susan Rishworth, Archivist

One of the jewels of the ACS Archives in Chicago, IL, is the papers of Franklin H. Martin, MD, FACS, 1847-1935—the man most responsible for the establishment of the American College of Surgeons. Dr. Martin was a meticulous record keeper and saver, and thanks to the diligence of certain members of the staff over the years, many of his papers have been preserved.

Although Dr. Martin did leave a two-volume autobiography, The Joy of Living: An Autobiography, which was published in 1933, the actual original source materials and artifacts he left behind provide a much broader view of his life. Recent visits to the Murphy Auditorium building, where 60 old filing cabinets contain many of these old records of the College, have revealed many items of interest pertaining to the life of Dr. Martin.

Dozens of photos, many still in original frames, are stamped “From Franklin H. Martin’s Office.” They include portraits of surgeons prominent in his day, and some prominent in earlier times. A period of his life that was obviously of great pride to him is documented by photos of him with the Advisory Commission of the Council of the National Defense, to which he was appointed by President Woodrow Wilson in 1916, and on which he served with other such civilian notables as Samuel Gompers, Bernard Baruch, and Julius Rosenwald.

Another artifact that traces Martin’s actual case records is contained in four large custom-bound volumes entitled variously “Case Books on Laparotomy,” 1891-1900; “Gynecology—Postgraduate Medical School of Chicago, Dearborn Street,” 1896-1902; and “Gynecology—Office Record” 1902-1908 and 1909-1917. These volumes include records of dozens of operations, treatments, and results of treatment for all those years, as noted in quite some detail. Not only do these volumes give material on Dr. Martin’s career as a gynecological and obstetrical surgeon, but they also shed light on the state of such practice in those days, and also of medicine and surgery in Chicago.

Dr. Martin and his wife, Isabelle Hollister Martin, kept detailed diaries, and some of these from the years 1914, 1918-
1921, and one from the 1890s, have been preserved, detailing their lives during these periods. Carefully labeled in binders by year and volume number in year, presumably by the Martins, these documents and artifacts include travel memorabilia, photos, news clippings, and social and official correspondence and family memorabilia. Dr. Martin also kept a personal collection of published articles and war-related publications and filed them by topic. One binder is labeled “Dr. Martin’s overseas data,” and includes a table of contents listing correspondence and reports while he was a member of the Council of National Defense.

A particularly valuable resource for the history of medicine in Chicago is material on the various medical schools and hospitals that Dr. Martin was associated with in Chicago. Financial records of the Postgraduate Medical School are found there, as well as minutes from the board of directors of the Chicago Charity Hospital, and records of the Chicago Medical College, the Woman’s Hospital of the State of Illinois, and the Shore Inn Company, planned as a deluxe hospital. All these records together span the years 1869-1910, a period in which original source materials for the history of medicine in Chicago are fairly rare.

The condition of many of these items is very fragile, so access will need to be restricted until better methods of preservation are implemented. Meanwhile, interested Fellows may review the papers of Dr. Franklin Martin by contacting Susan Rishworth, College Archivist, at 312/202-5270.
Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents during 2002.

At the February 8, 2002, meeting of the Board of Regents:

- A general surgeon from Jerome, ID, was placed on probation. The period of probation will run until such time as the surgeon has a full and unrestricted license in all states in which he is licensed; until he has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada; and until his practice pattern has been reviewed and approved by the Central Judiciary Committee (CJC). Both the state of Utah and the state of Idaho have placed this surgeon’s license to practice medicine on probation for five years following allegations that he had used his position as a physician to engage in improper, inappropriate, unprofessional, and unethical sexual contact with a patient and that he had prescribed excessive and inappropriate amounts of controlled substances to the same patient.
- A general surgeon from Amarillo, TX, was censured following a finding of negligence by the Arizona Board of Medical Examiners and the immediate surrender of his license in that state. In a reciprocal action, this surgeon also surrendered his license to practice medicine on probation for five years following allegations that he had used his position as a physician to engage in improper, inappropriate, unprofessional, and unethical sexual contact with a patient and that he had prescribed excessive and inappropriate amounts of controlled substances to the same patient.
- A general surgeon from Harlan, KY, was expelled from the College. In 1987, Dr. Sawaf was convicted of two felony counts of filing a false income tax return and failing to file a return. His Michigan license to practice medicine was suspended in October 1997 and subsequently placed on five years probation with terms and conditions. In 2002, he was convicted of writing prescriptions for unfounded purposes in the U.S. District Court in the state of Kentucky.
- A general surgeon from Hollywood, FL, was admonished. This surgeon was reprimanded and fined by the state of Florida following allegations of failing to practice medicine with the level of care, skill, and treatment that is recognized by a reasonably prudent similar physician as being acceptable.
- A general surgeon from Jefferson City, MO, was placed on probation until such time as he has a full and unrestricted license to practice medicine. The state of Missouri placed this surgeon’s license on probation for 10 years following termination of hospital privileges, in part due to a failure to comply with earlier disciplinary requirements.
- An obstetrician/gynecologist from Wahpeton, ND, was placed on probation for two years. This surgeon’s license in the state of North Dakota was suspended for three months with terms and conditions including a permanent restriction from providing services related to artificial insemination. These actions were taken following allegations that this surgeon had provided artificial insemination services contrary to acceptable medical standards; that there was a failure to keep or provide appropriate documentation in medical records for the delivery of said services or for the processing of the donated semen; that there was a failure to provide appropriate documentation in the medical records for the screening or testing procedures required to ensure patient safety; and that the surgeon obtained a fresh semen sample from a donor and delivered it to a recipient in the parking lot of a retail establishment.

At the June 8, 2002, meeting of the Board of Regents:

- A urologist from Pasadena, CA, was censured following a reprimand from the state of California for allegedly failing to maintain adequate and accurate medical records due to the dictation of an unusual operative
report with questionable pre- and postoperative diagnoses and nonstandard narrative text.

- A general surgeon from Providence, RI, was placed on probation. This surgeon was reprimanded and placed on probation for three years by the Rhode Island Department of Health after working as a medical consultant for certain online pharmacies and receiving financial remuneration for each prescription written for patients with whom the surgeon had not had a face-to-face consultation or previously established doctor/patient relationship.

- Tran Tien Huyen, a general surgeon from Santa Ana, CA, was expelled from the College. This surgeon was charged with gross negligence, failure to maintain adequate medical records, and repeated negligent acts by the Medical Board of California and was placed on probation for two years with terms and conditions.

- A plastic surgeon from West Orange, NJ, was placed on probation until such time as the surgeon has a full and unrestricted license in all states in which he is licensed; until he has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada; and until his practice pattern has been reviewed and approved by the CJC. The New Jersey State Board of Medical Examiners ordered the surrender of this surgeon's license for a minimum of six months following an admitted relapse into a prior substance abuse problem.

- An obstetrician/gynecologist from New York, NY, was censured. This surgeon's license is on probation for two years with conditions resulting from charges of gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion related to the care of a patient in 1996 and 1997.

- A plastic surgeon from Leawood, KS, was placed on probation until such time as the surgeon has a full and unrestricted license in all states in which he is licensed; until he has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada; and until his practice pattern has been reviewed and approved by the CJC. This surgeon's license to practice medicine in the states of Kansas and Missouri has been placed on probation following allegations of failing to adhere to the applicable standards of care to a degree that constitutes ordinary negligence in the treatment of three patients.

- A general surgeon from Vidalia, GA, was placed on probation until such time as the surgeon has a full and unrestricted license in all states in which he is licensed; until he has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada; and until his practice pattern has been reviewed and approved by the CJC. This surgeon's license to practice medicine in both New York and New Jersey is on probation following a finding of negligence by the New York Department of Health.

- Scott E. Gilbert, MD, an otolaryngologist from Tulsa, OK, was expelled from the College. Dr. Gilbert's license to practice medicine in the states
of Oklahoma and Kansas has been revoked based upon findings that he was guilty of substance abuse, poor quality of care, and aiding and abetting the unlicensed practice of medicine.

- A plastic surgeon from Delray Beach, FL, was placed on probation until such time as the surgeon has a full and unrestricted license in all states in which he is licensed; until he has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada; and until his practice pattern has been reviewed and approved by the CJ C. This surgeon’s license was placed on probation for five years in the state of Washington following a finding that he had sexual contact with a patient, altered medical records in two cases, misrepresented facts during an investigation, betrayed the physician-patient privilege, and engaged in acts of moral turpitude.

Postgraduate Courses You Can Take Anywhere

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.
2004 Australia and New Zealand Chapter Travelling Fellowship available

The International Relations Committee of the American College of Surgeons announces the availability of a travelling fellowship, the Australia and New Zealand (ANZ) Chapter of the American College of Surgeons Travelling Fellowship.

**Purpose**

The purpose of this fellowship is to encourage international exchange of surgical scientific information.

**Basic requirements**

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

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

**Activities**

The Fellow is required to spend a minimum of two or three weeks in Australia and New Zealand:

- To attend and participate in the Annual Scientific Congress of the Royal Australasian College of Surgeons, which will be held in Hong Kong, China (May 2-7, 2004).
- To participate in the formal convocation ceremony of that congress.
- To attend the ANZ Chapter meeting during that congress.
- To visit at least two medical centres in Australia and New Zealand before or after the Annual Scientific Congress of the Royal Australasian College of Surgeons to lecture and to share clinical and scientific expertise with the local surgeons.

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and the President or designated representative of the ANZ Chapter of the American College of Surgeons. The surgical centers to be visited would depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Australia and New Zealand.

His or her spouse is welcome to accompany the successful applicant. There will be many opportunities for social interaction, as well as these professional activities.

**Financial support**

The ANZ Chapter and the College will provide the sum of $12,000 to the successful applicant, who will also be exempted from registration fees for the Annual Scientific Congress. He or she must meet all travel and living expenses. Senior chapter representatives will consult with the Fellow about the centres to be visited in Australia and New Zealand, the local arrangements for each centre, and other advice and recommendations about travel schedules. The Fellow is to make his/her own travel arrangements in North America, as this makes available to him reduced fares and travel packages for travel in Australia and New Zealand.

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

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

The closing date for receipt of completed applications is April 1, 2003. The successful applicant and an alternate will be selected and notified by August 2003. The formal announcement of the recipient will be made during the 2003 Clinical Congress of the American College of Surgeons in Chicago, IL, October 19-24.
The American College of Surgeons offers International Guest Scholarships to competent young surgeons who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $8,000 each, provide the scholars with an opportunity to visit clinical, teaching, and research activities in North America, and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons’ Clinical Congress.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, FACS(Hon), former College Director. More recently, a bequest from the family of Abdol Islami, MD, FACS, and gifts from others to the International Guest Scholarship endowment fund have enabled the College to expand the number and the amount of the scholarship award.

The scholarship requirements are:

- Applicants must be graduates of schools of medicine.
- Applicants must be at least 30 years old, but no older than 41, on the date that the completed application is filed.
- Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
- Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of the applicant’s country.
- Applicants whose careers are in the developing stage are deemed more suitable than those who are serving in senior academic appointments.
- Applicants must submit a fully completed application form provided by the College, either from the Web site or in paper format. The application must be typewritten and in English. Submission of a curriculum vitae only is not acceptable.
- Applicants must provide a list of all of their publications and must submit, in addition, three complete publications (reprints or manuscripts) of their choice from that list.
- Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment, or a Fellow of the American College of Surgeons residing in their country. The chair’s or the Fellow’s letter is to include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted in envelopes sealed by the recommenders. These letters are to be submitted with the completed application form.

**Previous recipients**

Donald Kaminski, MD, FACS, Surgery; Thomas G. Peters, MD, FACS, Surgery; John Charles Baldwin, MD, FACS, Thoracic Surgery; Richard Allen Prinz, MD, FACS, Surgery; Jack L. Cronenwett, MD, FACS, Surgery; Keith T. Oldham, MD, FACS, Pediatric Surgery; Jon S. Thompson, MD, FACS, Surgery; Irving Louis Kron, MD, FACS, Thoracic Surgery; Michael S. Sweeney, MD, FACS, Thoracic Surgery; Bauer E. Sumpio, MD, FACS, Vascular Surgery; Michael William Mulholland, MD, FACS, Surgery; Nick Scott Adzick, MD, FACS, Pediatric Surgery; Douglas B. Evans, MD, FACS, Surgical Oncology/Endocrine Surgery; Stanley Waite Ashley, MD, FACS, Surgery; William M. Kuzon, Jr., MD, FACS, Plastic/Reconstructive Surgery; Douglas S. Tyler, MD, FACS, Surgery; and Christopher R. Forrest, MD, FRCSC, FACS, Plastic/Craniofacial Surgery.

**International Guest Scholarships available**

The American College of Surgeons offers International Guest Scholarships to competent young surgeons who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $8,000 each, provide the scholars with an opportunity to visit clinical, teaching, and research activities in North America, and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons’ Clinical Congress.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, FACS(Hon), former College Director. More recently, a bequest from the family of Abdol Islami, MD, FACS, and gifts from others to the International Guest Scholarship endowment fund have enabled the College to expand the number and the amount of the scholarship award.

The scholarship requirements are:

- Applicants must be graduates of schools of medicine.
- Applicants must be at least 30 years old, but no older than 41, on the date that the completed application is filed.
- Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
- Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of the applicant’s country.
- Applicants whose careers are in the developing stage are deemed more suitable than those who are serving in senior academic appointments.
- Applicants must submit a fully completed application form provided by the College, either from the Web site or in paper format. The application must be typewritten and in English. Submission of a curriculum vitae only is not acceptable.
- Applicants must provide a list of all of their publications and must submit, in addition, three complete publications (reprints or manuscripts) of their choice from that list.
- Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment, or a Fellow of the American College of Surgeons residing in their country. The chair’s or the Fellow’s letter is to include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted in envelopes sealed by the recommenders. These letters are to be submitted with the completed application form.

**Previous recipients**

Donald Kaminski, MD, FACS, Surgery; Thomas G. Peters, MD, FACS, Surgery; John Charles Baldwin, MD, FACS, Thoracic Surgery; Richard Allen Prinz, MD, FACS, Surgery; Jack L. Cronenwett, MD, FACS, Surgery; Keith T. Oldham, MD, FACS, Pediatric Surgery; Jon S. Thompson, MD, FACS, Surgery; Irving Louis Kron, MD, FACS, Thoracic Surgery; Michael S. Sweeney, MD, FACS, Thoracic Surgery; Bauer E. Sumpio, MD, FACS, Vascular Surgery; Michael William Mulholland, MD, FACS, Surgery; Nick Scott Adzick, MD, FACS, Pediatric Surgery; Douglas B. Evans, MD, FACS, Surgical Oncology/Endocrine Surgery; Stanley Waite Ashley, MD, FACS, Surgery; William M. Kuzon, Jr., MD, FACS, Plastic/Reconstructive Surgery; Douglas S. Tyler, MD, FACS, Surgery; and Christopher R. Forrest, MD, FRCSC, FACS, Plastic/Craniofacial Surgery.
Applicants may submit a photograph (passport size is preferable).

The International Guest Scholarships must be used in the year for which they are designated. They cannot be postponed.

Applicants who are awarded scholarships are expected to provide a full written report of the experiences provided through the scholarships upon completion of their tours.

An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation. The scholarships provide successful applicants with the privilege of participating in the College’s annual Clinical Congress in October, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses plus admission to all lectures, demonstrations, and exhibits, which are an integral part of the Clinical Congress. Assistance will be provided in arranging visits following the Clinical Congress to various clinics and universities of their choice.

In order to qualify for consideration by the selection committee, all of the requirements must be fulfilled.

Formal American College of Surgeons International Guest Scholar applications forms may be obtained from the College’s Web site (www.facs.org), or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

Completed application forms for the International Guest Scholarships for the year 2004 and all of the supporting documentation must be received at the office of the International Liaison Section prior to July 1, 2003, in order for an applicant to receive consideration by the selection committee. All applicants will be notified of the selection committee’s decision in November 2003. Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing.

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.

<table>
<thead>
<tr>
<th>Level</th>
<th>Date</th>
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<th>Level</th>
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<td>Basic</td>
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<td>Los Angeles, CA</td>
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<td>July 17, 2003</td>
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<td>Atlanta, GA</td>
<td>Advanced</td>
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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.
Contributions sought for 2003 Clinical Congress

Video-based education programs
The Committee on Video-Based Education, Division of Education, would like to invite submissions of videotapes of operations from general surgery and surgical specialties for consideration for presentation at the eighty-ninth annual Clinical Congress, to be held October 19-23, 2003, in Chicago, IL. Requirements for video submissions are posted at www.facs.org, or a videotape information form may be requested from Gay Lynn Dykman, Video-Based Education Administrator, at 312/202-5262 or gdykman@facs.org. The submission deadline for videotapes is February 14, 2003.

Papers sessions
The Program Committee, Division of Education, would like to invite submissions of abstracts for clinical paper presentations at the eighty-ninth annual Clinical Congress to be held October 19-23, 2003, in Chicago, IL. These paper presentations include clinical work that has not been previously presented or published elsewhere. (Basic laboratory research should be submitted to the Committee for the Forum on Fundamental Surgical Problems—see page 45.) The Program Committee will consider only those abstracts where the principal author or a coauthor is a Fellow of the College. The following instructions should be strictly adhered to:

1. The abstract should provide adequate information and objective data to evaluate the abstract properly.
2. The abstract must be limited to one 8-1/2" x 11" page, with 1" top and bottom margins and a left margin of 1-1/2". (It is permissible to single-space the abstract.)
3. At the top of the page please include the full title of the abstract and complete names and academic degrees of all authors, and indicate a surgical category based on the list below that best represents the overall topic of the paper.
   - Adrenal Surgery
   - Bariatric Surgery
   - Breast Surgery
   - Cardiac Surgery
   - Colorectal Surgery
   - Esophageal Surgery
   - Gastric and Duodenal Surgery
   - Liver, Biliary Tract, Pancreas Surgery
   - Minimal Access Surgery
   - Neurological Surgery
   - Noncardiac Thoracic Surgery
   - OB/GYN Surgery
   - Perioperative and Critical Care Surgery
   - Skin, Plastic and Reconstructive Surgery
   - Small Intestinal Surgery
   - Surgical Education
   - Surgical Oncology
   - Thyroid and Parathyroid Surgery
   - Transplantation
   - Trauma Surgery
   - Vascular Surgery
   - Other
4. At the bottom of the page, a footnote should be included to provide the principal author’s mailing address, telephone number, e-mail, fax number, and, where pertinent, medical school affiliation and other institutions from which the work originates.
5. The original and one copy of the abstract should be submitted.
6. Photographs should not accompany the abstract.
7. The deadline for the receipt of abstracts is March 3, 2003. They should be mailed to: Camille Kidd Moses, Program Committee, Division of Education, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Quality of the paper and a balanced program remain the committee’s principal criteria for evaluating the abstracts received. Because of the competitiveness of the scientific program, it is unlikely that an author would be selected to present his or her work in two successive years. Questions regarding the submission process should be directed to Ms. Moses at 312/202-5325.

Scientific exhibits
The Program Committee, Division of Education, would like to invite submissions of abstracts for
Contributions to the 2003 Surgical Forum are requested

The Committee for the Forum on Fundamental Surgical Problems, Division of Education, invites surgical investigators in training to submit abstracts to be considered for presentation during the Surgical Forum at the eighty-ninth annual Clinical Congress, Chicago, IL, October 19-23, 2003. The Surgical Forum program highlights abstracts reporting original work performed by surgical investigators in training.

Accepted abstracts will appear in a supplement of the Journal of the American College of Surgeons (JACS), a publication recognized by Index Medicus. Full manuscripts may be subsequently submitted to JACS or other journals. Abstracts are reviewed and selected by the Forum Committee for each surgical specialty. Abstracts are graded by committee members most familiar with the abstract’s designated category. Following the grading, the full committee selects the abstracts to be presented at the Clinical Congress.

The submission process will begin on December 1, 2002, and the deadline for submission is March 1, 2003. Notice of acceptance or rejection will be mailed to the principal author of each abstract by May 1. Please read the following specifications.

**Submission guidelines**

- Abstracts should be submitted via the ACS web site at: http://www.facs.org/sfabstracts/index.html.
- Submission begins on December 1, 2002. A reference number will be generated upon receipt of the electronic submission.
- The deadline for submissions is 5:00 pm (CST) March 1, 2003.
- Abstracts may not be submitted to any other venue; if duplicate submission is detected the abstract will be deleted before review.

**Notification of selection**

The principal author will be notified in writing about abstract selection by May 1, 2003. If you have questions, please contact kkoenig@facs.org or directly at 312/202-5336.
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/sfabstracts/
• Final Decision: May 2003 (principal author will be contacted).
• Format: Follow Author Instructions, Online Submission.
• Questions: kkoenig@facs.org or: 312.202.5336.

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**, March 24-26, 2003, Las Vegas, NV.
• **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/traumtg.html or by contacting the Trauma Office at 312/202-5342.

Next month in *JACS*

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

Ravdin Lecture in the Basic Sciences:

Artificial Organs: Basic Science Meets Critical Care

Original Scientific Article:

Early Breast Cancer Detection in a Medically Underserved Urban Community

Collective Review:

Dieulafoy’s Disease

What’s New in Surgery:

• General Surgery: Burns and Metabolism
• Vascular Surgery