the ripple effects of medical liability
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At some point in all of our professional lives, we were the house officers in our chosen specialties at our respective training centers. Some specialty programs were more demanding than others in terms of time commitment. Indeed, some house officers were truly hospital residents, who literally lived in the training facility. We wore white coats and pants, and our lives totally revolved around our hospitals and the duties we had as surgical residents.

However, as the old saying goes, times have changed. Today’s young surgeon has a different set of values, and society has voiced concerns about the ability of overextended residents to provide quality care. As a result, the profession has developed new work-hour restrictions for residents. In this column, I will reflect on some of the realities associated with our traditional training practices and on the changes occurring in this area.

The past

In years past, the number of hours residents worked varied from program to program and week to week. Work weeks well in excess of the new 80-hour limit were common. In fact, the typical resident work week was oftentimes in the range of 120 to 130 hours. These long hours were prompted by a number of factors, including the insecurities and uncertainties of young physicians, who found that sticking around the hospital and being available much of the time helped to ease their fears.

Another reason for the long work hours was the enormous workload. Granted, much of this work was redundant and was created just so that residents would be doing something. For example, we can all recall endless rounding on our patients—rounds that were preceded by another set of rounds, which were, perhaps, preceded by another set of rounds by the medical students. The work seemingly never stopped.

Additional time was consumed with waiting for the team to finish in the operating room so that everyone would be available to make rounds. In those years, time was a cheap commodity, and a resident’s time was a particular bargain.

The other major issue in the past was the unavailability of ancillary help in many of our hospitals. This situation resulted in house officers and students being the common means of transporting patients, drawing blood for laboratory studies, and keeping watch over unstable patients. The list could go on and on.

In any event, working long hours and being available to do whatever task needed to be carried out was what our training programs expected of us, and we did our best to meet their demands.

Two problems

In today’s environment, it is unrealistic to place these sorts of demands on residents. Two factors have contributed to the movement toward reduced work hours for residents: (1) public concerns that residents who are overtired may be prone to error; and (2) the increasing emphasis on lifestyles issues among people in the common age range of the typical resident.

The public’s concerns about lengthy resident work hours peaked nearly two decades ago with the highly publicized death of Libby Zion at New York Hospital in the 1980s. In response, the Bell Commission subsequently issued recommendations that were passed into New York State law that, among other mandates, capped residents’ work hours at 80 hours per week.
Over the years, questions have continually arisen about the effects of house officer fatigue in this and other cases, but one fact has become inescapable: many medical students find the time commitment associated with surgical training repellent. Their feelings have perhaps been most forcefully expressed in some of the recent low match rates for training programs in various surgical specialties. In large part, the dismal match rates can be attributed to the commitment and lifestyle that surgical training may entail.

Many of us have been somewhat dismayed by the heightened emphasis that residents are placing on the preservation of their personal time. Nevertheless, it has surfaced as a very real concern for young people today, and we need to listen to their views. Concerns about time, commitment to professional life versus commitment to their personal lives, and the oftentimes disrespectful behavior of some senior physicians are preventing young people from entering our profession.

**Multidimensional responses**

The profession recently has developed necessary changes in the requirements for surgical training, which respond to these issues. After more than a decade of active and vigorous dialogue about work-hour restrictions, the Accreditation Council on Graduate Medical Education has determined that beginning next month, all residents will be restricted to the 80-hour work week now in place in New York, with some specific exceptions for certain programs that request additional time. The debate has ended, and the new standards are an imminent reality.

It is of the utmost importance that training programs comply with these new mandates. Failure to do so could result in the passage of federal legislation restricting resident work hours. In fact, two bills already are pending—one in the House and one in the Senate. This is an issue best addressed by the profession rather than by the government.

Certainly the new rules will create problems. The shift changes, the patient hand-offs, the delegation of responsibilities, and so on, will need to be addressed. Clearly, we will need to shift the emphasis from providing individual care to accentuation on working with teams and within multidimensional systems. We will need to develop protocols regarding hand-offs, and recognize that guidelines will become progressively important as we enter this new phase of medical and surgical training.

As the new system of resident training is implemented, we need to inform the administrations of our teaching hospitals about the reasons for these changes and insist that they get the message that residents can no longer be treated like cheap labor. There must be an appropriate and favorable ratio of educational experience to, frankly, the performance of services without educational value. Hospital administrations must understand these concerns in order to hire the appropriate ancillary staff who can perform the new range of tasks. The days of residents transporting patients, drawing blood, and doing work that does not necessitate a medical degree are over.

The results of the changes in resident work hours and duties may be very powerful and potent. It is up to us to make certain that we attract the best candidates into the surgical specialties in the future. This responsibility must be embraced and supported not only by our profession, but by hospital administrations as well.

**Editor’s note:** To help program directors and other interested and concerned individuals deal with the myriad implications of this change in surgical training, the College is developing a special area of its Web site to address issues of importance and concern. A new Web page on resident hours of duty will be posted later this month on the Division of Education pages. Regular updates for program directors and practical information for addressing the restricted hours of duty will be presented, along with strategies being used by various training programs. The purpose is to facilitate the exchange of ideas and effective approaches. Richard Bell, MD, FACS, and Debra DaRosa, PhD, will serve as editors for the site and will work with an editorial board composed of Gary Dunnington, MD, FACS; Timothy Flynn, MD, FACS; James Hassett, MD, FACS; and Marc Wallack, MD, FACS.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
Thomas R. Russell, MD, FACS, presented the keynote address at the American Society of Anesthesiologists (ASA) Legislative Conference, which was held in Washington, DC, May 5. His remarks focused on interests shared by the College and the ASA and on the many ways in which the two organizations have collaborated in recent years. The audience gave Dr. Russell a standing ovation upon the conclusion of his remarks.

On May 13, Fellows from the Metropolitan Chicago and Illinois Chapters of the College and representatives from College headquarters participated in a rally supporting medical liability reform. The event drew more than 1,500 Illinois physicians to Chicago’s Daley Plaza for the purpose of providing visible support for strong liability reforms like those enacted in California during the mid-1970s. Sponsored by the Chicago Medical Society, this advocacy event raised public awareness of Illinois’ severe medical liability crisis and the impact that it is having on patient access to care. The rally also emphasized support for federal efforts on this issue. For information regarding how your chapter can educate state policymakers on this critical issue, contact jsutton@facs.org.

Through the Board of Governors’ Socioeconomics Issues Committee, the American College of Surgeons has begun to identify, document, and facilitate surgical volunteerism—“out of uniform, out of habitat” provision of surgical care domestically and abroad. The Phase 3 report of the Giving Back Project, based on a 2002 survey completed by 500 Fellows, identifies demographics and characteristics of American surgical volunteers, resources for finding an appropriate opportunity, suggestions for start-up groups, and a partial list of respondents and the organizations they worked with. The report is available on the ACS Web site at http://www.facs.org/about/governors/phase3givingback.pdf

Children’s National Medical Center (CNMC) in Washington, DC, together with the College’s Washington Office staff, offered 11 congressional staffers the opportunity to learn about surgery and the importance of trauma care system development during a Day in Surgery event on April 14. Marty Eichelberger, MD, FACS, and Kurt Newman, MD, FACS, explained to congressional staffers how a developed trauma system works to make sure patients receive the care they need within the “golden hour,” the crucial 60 minutes following a grievous injury that often determines whether a patient lives or dies.
The Centers for Medicare & Medicaid Services (CMS) announced in April its plans to revise procedures for physicians and suppliers to enroll in Medicare and secure a billing number. The stated goal is to simplify enrollment requirements and ensure that only qualified health care suppliers and providers participate in the program.

Of particular importance, the new rules require physicians and suppliers to recertify the accuracy of their information every three years. In addition, any enrolled provider or supplier that does not bill the program for two consecutive quarters will be automatically “deactivated” until they begin submitting bills again. (Special consideration will be given to pediatricians and others who bill Medicare infrequently.)

In a related move, the CMS 855 Provider/Supplier Enrollment Application was revised last November. The CMS 855 is now a set of individualized forms, each geared toward a specific physician or supplier type. The proposed regulation and the revised application may be accessed by going to: http://www.cms.gov/providers/enrollment/forms/.

Medicare has updated the list of procedures that may be performed in an ambulatory surgical center (ASC) effective July 1. The list, which was last updated in 1995, has been revised to include 283 new procedures. In addition, 139 services were deleted from the list.

A link to the file containing revisions to the ASC list is available on the College’s Web site at www.facs.org/newsscope/nso41103.html#1.

On April 30, Sen. John Corzine (D-NJ) reintroduced legislation to limit resident work hours. The Patient and Physician Safety & Protection Act, S. 952, places the following limits on resident work hours: 80 hours per week; 24 hours per shift, plus an additional three hours for transferring patient care (12-hour limit for emergency room shifts); and nights on call in the hospital should be no more than every third night. In addition, the bill would require outside work to count against the 80 hours, at least 10 hours off-duty between scheduled shifts, and at least one full day out of every seven days off, and one full weekend off per month.

The bill further provides “whistle-blower protections” and states that any hospital that violates these restrictions is subject to a civil monetary penalty of up to $100,000 for each residency program in any six-month period.

Senator Corzine’s bill is almost identical to legislation introduced in March by Rep. John Conyers (D-MI). However, Representative Conyers’ bill, H.R. 1228, does not permit an additional three-hour extension of a resident’s shift for the transfer of patient care, nor would it restrict moonlighting or give hospitals an opportunity to submit a corrective action plan in order to avoid paying the monetary penalties. The College opposes both bills.
New members elected to the RUC

New members were elected to the AMA/Specialty Society RVS Update Committee (RUC) at the panel’s spring meeting in April. Of particular interest, Robert M. Zwolak, MD, FACS, was elected to the RUC. Dr. Zwolak has represented the vascular societies as an advisor to the RUC for several years, and he is a member of the College’s General Surgery Coding and Reimbursement Committee.

Also of interest, William L. Rich III, MD, FACS, an ophthalmologist who is also a member of the College’s Health Policy Steering Committee, was selected chair of the RUC. The RUC is a broadly representative panel of physicians and surgeons who review and make recommendations to CMS on Medicare fee schedule relative value units for new, revised, and existing procedure codes.

College backs plan to avert 4.2 percent cut

CMS is projecting another cut in physician payment next year. In a March letter to Glenn Hackbrath, chair of the Medicare Payment Advisory Commission (MedPAC), the director of CMS’s Center for Medicare Management, Thomas Grissom, projected a -4.2 percent update for 2004. CMS attributes this reduction to the increased volume and intensity of physicians’ services and a lower real gross domestic product per capita than previously estimated.

MedPAC’s recommendation suggests that the Secretary of Health and Human Services establish an update framework similar to those used for other Medicare services. In addition to changes in the input prices, the framework would include components to reflect changes in all other factors affecting the cost of delivering physician services, including changes in the volume and intensity of physician services due to new technology, site of service shifts, and practice patterns, among others. Physician updates would be based solely on beneficiary needs and the cost of providing physician services.

Congressional budget resolution identifies priorities

On April 11, Congress completed consideration of the fiscal year (FY) 2004 budget resolution that will guide the federal spending decisions made in coming months. While the resolution does not call for spending reductions in Medicare or Medicaid, it does call upon the committees with jurisdiction over these programs to identify by September 2 changes in law that would achieve savings through the elimination of waste, fraud, and abuse. In addition, the General Accounting Office is required to submit a report by August 1 on legislative changes that would allow the committees to “improve the economy, efficiency, and effectiveness of programs” within their jurisdictions.

Also of interest, the resolution:

- Earmarks $400 billion for Medicare reform with prescription drug coverage.
- Provides a $50 billion reserve fund over 10 years to increase access to health insurance for the uninsured.
- Increases Medicaid spending by 9 percent in 2004, and earmarks a $8.9 billion reserve over five years for Medicaid reform.
The ripple effects of the medical liability crisis

by Jennifer Razor, JD,
Government Affairs Associate,
Division of Advocacy and Health Policy
Medical liability is crippling the nation’s health care delivery system. Throughout the country the meteoric rise in liability premiums is threatening patients’ access to care. Faced with a lack of affordable, available insurance coverage, some surgeons are being forced out of practice.

From a policy perspective it is important to examine the ripple effects that the liability crisis is having throughout the entire health care system. Rising premiums and increased liability exposure are shaping surgeons’ practices in a variety of ways. This article addresses four areas where increased litigation is redefining surgical practice: reporting of medical errors, treatment of uninsured patients in trauma cases, participation in Medicare, and involvement in advocacy activities.

Reporting medical errors

Surgery has never lost sight of its fundamental responsibility to be the patient’s quality care advocate and provider. The College’s vision for the future includes the analysis and expansion of tools to help consumers and clinicians identify areas for improvement and best practices. Improving surgical care is central to the College’s mission. To accomplish this goal, the organization must encourage surgeons and all other health professionals to report and evaluate medical errors within a safe environment.

An increasingly hostile legal environment makes achieving these objectives difficult. Current law does not offer federal protection for information submitted to patient safety reporting systems. Without this important safeguard, use of these systems is stymied, further reducing opportunities to identify trends and implement corrective measures. The College firmly believes that information developed in connection with reporting systems should be privileged for purposes of federal and state civil and administrative proceedings.

Sound health care policy promotes the growth of reporting programs and fosters confidential collaboration with other health care reporting systems. Legislation that would nurture these activities includes laws allowing physicians to develop a nonpunitive culture for reporting errors. In an environment centered on safety, surgeons can focus on preventing and correcting systems failures and not on individual or organizational culpability.

The success or failure of strong medical liability legislation does not change the legal status of reporting system information. Accordingly, the College endorsed the Patient Safety and Quality Improvement Act, H.R. 663, which passed the House of Representatives in March by a vote of 418-6. This legislation would enable surgeons and other health care providers to study why medical errors occur so that the necessary changes can be made to prevent future mistakes. To achieve this goal, the bill creates a voluntary error reporting system in which providers may freely discuss medical errors with patient safety organizations (PSOs). This bill also creates a national patient safety database so that knowledge about errors may be shared.

A similar bill has been introduced in the Senate. The Patient Safety and Quality Improvement Act, S. 720, introduced by Sens. Jim Jeffords (I-VT), Bill Frist, MD, FACS (R-TN), John Breaux (D-LA), and Judd Gregg (R-NH), includes a broad set of protections for physicians as well. The College anticipates that lawmakers will be able to arrive at a truly bipartisan compromise on this issue and enact these important protections.

Treating the uninsured

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals with emergency departments to provide emergency care to anyone who needs it. Under the law, all patients with similar medical conditions must be treated consistently. The law applies to hospitals that accept Medicare reimbursement and to all patients, not just individuals covered by Medicare.

An estimated 40 million people are without health insurance in the U.S. Many of them receive medical care in trauma centers and emergency departments, critical components of the nation’s health care safety net. As a result, a large number of emergency department visits are uncompensated.

Pursuant to EMTALA, surgeons provide trauma care to any patient who needs it, regardless of
ability to pay or insurance status. They also pay for liability insurance for every patient that they treat, regardless of whether they are compensated.

The rise in premiums is just one concern. Many trauma centers report that it is increasingly difficult to find specialists to serve on on-call backup panels because the threat of lawsuits, particularly litigation associated with high-risk trauma patients, continues to weigh on their minds. Meanwhile, the number of emergency room visits is increasing, and Medicare reimbursements are projected to decrease again, adding to the burdens of trauma centers.

In the past year, trauma centers in Las Vegas, NV, and Orlando, FL, have been forced to close their doors at some point due to these increased burdens. More closures may be inevitable.

Rep. John Shadegg (R-AZ) has recognized the additional strain that the liability crisis is placing on the nation’s trauma centers as a result of their EMTALA obligations. As H.R. 5—the Help Efficient, Accessible, Low-Cost, Timely Health Care Act (HEALTH)—made its way to the floor in the House, Representative Shadegg offered an important amendment. This addition, which was excluded from the House-passed version of the bill, would have applied the protections included in the Federal Tort Claims Act (FTCA) to services that physicians furnish to uninsured individuals.

The federal government provides direct medical care through many departments, including the Veterans Affairs system, the Indian Health Service, and the Public Health Service. This care results in a limited number of medical negligence claims, which are subject to a special set of rules because of government immunity. In 1992, Congress extended those FTCA protections to federally supported health centers. Representative Shadegg’s amendment would have extended those protections to emergency departments as well.

Because of the added burdens EMTALA placed on surgeons, the College supports the extension of FTCA protections to the services they provide to the uninsured. Hence, the College will continue to work with Representative Shadegg and other members of Congress to enact this important protection.

Medicare participation

Declining reimbursement only exacerbates the problems created by increasing liability premiums. Early estimates by the Centers for Medicare & Medicaid Services (CMS) project a 4.2 percent cut in the 2004 physician update. Because many insurers set payment based on the Medicare fee schedule, it is critical that the entire health care system—not just Medicare—account for these costs appropriately.

In recognition of the growing liability crisis, CMS implemented an 11.3 percent increase in the Medicare Economic Index (MEI) update for professional liability insurance in the 2003 physician fee schedule. Although the College supported this increase, there is heightened concern that specialties being hit hardest by rising insurance costs are not getting the help they need. Because the MEI applies equally to all fee schedule services, it does not channel new money to those providers who actually account for the higher “resource inputs” by paying higher premiums. Medical liability premiums are a major resource input, the cost of which falls outside physicians’ control.

CMS also fails to take into consideration that those specialties experiencing the greatest liability premium hikes are, coincidentally, the same ones that have been experiencing net pay decreases for a number of years. This situation results from the transition to a single conversion factor, followed by the phase-in to the generally lower resource-based practice expenses. Certain surgical specialties—such as neurosurgery, general surgery, thoracic surgery, obstetrics-gynecology, and orthopaedics—pay the highest premiums as a matter of course and are suffering disproportionately from the current escalation in premium rates. Yet, any MEI adjustment, like this year’s increase, applies broadly and cannot direct funds to those specialties that are actually experiencing the increases.

The College continues to work with Congress and the Administration to better account for the increase in premiums. We believe that new mechanisms should be considered to examine the adequacy of Medicare reimbursement for physician liability insurance costs. In addition, the College has urged CMS to make necessary revisions in the malpractice relative value units.
in time for implementation with the 2004 Medicare fee schedule—a year ahead of the federally mandated five-year review.

Advocacy activities

Advocacy is an important responsibility for every physician. Skyrocketing liability premiums have sent many surgeons to the streets in protest. From Florida to Nevada, and Texas to New Jersey, surgeons have flooded state houses and town hall meetings to express their concerns.

In some areas, physicians have engaged in a collective work stoppage to generate favorable press coverage and public support for liability reform. These types of events pose serious legal risks. They may lead to governmental investigations and enforcement actions, private lawsuits, and even criminal prosecutions.

Federal and state antitrust agencies have brought dozens of investigations and enforcement actions against physicians who allegedly engaged in group boycotts. Arguably, work stoppages aimed at bringing attention to the liability crisis are not merely attempts to withhold services as conceived by the antitrust laws. But the Supreme Court has held that a boycott that affects competition directly is not immune to the antitrust laws, even if a principal purpose of the boycott is to influence legislation.

Surgeons are, of course, free to organize advocacy campaigns to promote liability reform. Lobbying activities are important, and widespread participation in the campaign to enact these necessary reforms is critical. However, physicians who participate in collective action must be mindful of potential legal risks.

The surgeon’s role includes informing patients, other physicians, employers, and payors about the operation of the health care market. That responsibility, however, must be carried out within the constraints of the antitrust laws. Earlier this year, the Federal Trade Commission (FTC) issued an advisory opinion that this type of activity can be accomplished without interfering with competition.

The advisory opinion, issued in response to a request by a physicians’ group, specifically concerns the proposed formation and operation of a health care advocacy group. The petitioning
physicians intended to establish the group to undertake a campaign to inform and educate the general public about a number of issues that the physicians believe relate to the quality and cost of health care services in their community of Dayton, OH. The group planned to provide information on many practice-related issues by sponsoring talks in the community, communicating directly with employers, and working with the media to spread information to the general public.

In most instances, physicians’ collection and publication of such information and their advocacy of a point of view on issues affecting the organization, delivery, and financing of health care services would neither impair competition nor violate the antitrust laws, according to the FTC. The advisory letter cautioned, however, that the antitrust laws forbid competitors from setting prices or determining quality and output levels of the products or services available to consumers.

According to the FTC, to the extent that the venture helps to better inform patients, employers, and payors, as well as physicians, about the operation of the local health care market—while avoiding anticompetitive conduct by physicians—the group’s effect is likely to be procompetitive. If, however, the physicians use the organization or its activities as a vehicle for collective action that unreasonably limits competition among the doctors, the advisory letter warned, then the organization and its members may be subject to legal action.

### Summary of H.R. 5


<table>
<thead>
<tr>
<th>Noneconomic damages</th>
<th>Limits awards for unquantifiable noneconomic damages, such as pain and suffering, to $250,000.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statute of limitations</td>
<td>Limits the number of years a plaintiff has to file a health care liability action to no later than three years after the date of injury. Extends the statute of limitations for minors injured before age six.</td>
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<tr>
<td>Collateral source offsets</td>
<td>Jury may be made aware of any payments of collateral source benefits that have already been made.</td>
</tr>
<tr>
<td>Joint and several liability</td>
<td>Ensures that a party will only be liable for his or her share of culpability instead of making a party responsible for another’s negligence.</td>
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<tr>
<td>Attorney contingency fees</td>
<td>Limits according to sliding award scale: 40 percent of first $50,000; 33.3 percent of next $50,000; 25 percent of next $500,000; and 15 percent of any amount over $600,000.</td>
</tr>
<tr>
<td>Periodic payment of future damages</td>
<td>Past and current expenses paid at time of judgment. Future damages, if $50,000 or more, paid over time.</td>
</tr>
<tr>
<td>Punitive damages</td>
<td>Allows punitive damages to be the greater of two times the amount of economic damages awarded or $250,000. Does not cap punitive damages.</td>
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<tr>
<td>State flexibility</td>
<td>Allows states that have already enacted damage caps, whether larger or smaller than those provided for in the HEALTH Act, to retain such caps. Establishes a ceiling on noneconomic damages and guidelines for the award of punitive damages, only in those states where the state legislature has failed to act. A state legislature may also act at any time in the future to impose caps different from those provided for in the HEALTH Act.</td>
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Conclusion

The College actively supports federal legislation aimed at ending the medical liability crisis, such as the HEALTH Act, sponsored by Rep. Jim Greenwood (R-PA) and modeled after California’s liability reforms. This legislation would cap noneconomic damages at $250,000, reduce the statute of limitations, limit attorneys’ contingency fees, require proportional damages among defendants, and allow for collateral source offsets and periodic payments of future damages. (For a more complete synopsis of H.R. 5 see the box on page 12.) With a strong victory, the House passed H.R. 5 March 13 by a vote of 229-196.

The ACS continues to lobby aggressively for a Senate companion to H.R. 5. Last summer, the Senate rejected a more moderate set of reforms by a 57-42 vote. Nevertheless, the College remains hopeful that Senate Majority Leader Bill Frist, MD, FACS (R-TN), will broker a compromise that encompasses surgeons’ concerns.

Until that meaningful liability reform is enacted, the liability crisis will persist, and it must be addressed immediately. This article contains just a sampling of areas affected by the crisis.

Note: This article is designed as an educational tool only and should not be construed as legal advice. Should a legal question arise regarding the issues discussed in this article, Fellows should consult an attorney.

References

1. 42 U.S.C. § 139dd.
The visionaries who brought physician assistants (PAs) into the surgical suite observed that these professionals were well suited to working with surgeons. At the time, surgeons were facing the dual challenges of learning and applying rapidly developing, sophisticated surgical technology and meeting demands to manage costs. Two contemporary issues that will shape the future of surgery are the downsizing of the surgical physician workforce and recent mandates limiting the work hours of surgical residents. In both circumstances, PAs, working with the supervision of physicians, can provide the collegial support that surgeons desperately need.

This fact has been discussed in recent editorials by leaders of the surgical profession, including Keith D. Lillemoe, MD, FACS, of the Johns Hopkins Medical Institutions in Baltimore, MD. His editorial, “The training of the surgeon II—The sequel,” focuses on the current dilemma of meeting patient needs in an era of reduced resident work hours. He states, “One would have to be in complete denial to believe that significant hours cannot be eliminated by creative use of house staff extenders, elimination of noneducational scut-laden rotations, appropriate well structured cross-coverage of inpatient services, and, most important, a ‘mind set’ change among the surgical faculty and hospital administration.” Lillemoe predicts “significant opportunities for change” ahead.
John M. Daly, MD, FACS, of Weill Medical College of Cornell University, New York, NY, also discusses these problems in an editorial. Among his comments Dr. Daly wrote, “The quality of time spent is more important than quantity and a balance between family and work must be maintained.”

Peter J. Fabri, MD, FACS, Past-Chair of the Governors’ Committee on Allied Health of the American College of Surgeons, stated, “Medicine and surgery as we knew it is going to change.”

Has the crisis come upon the surgical profession like a thief in the midnight hour? Starting with the death of Libby Zion in New York City in 1984, medicine in America was put on notice. The Bell Commission rendered its verdict in 1989, reducing the hours a resident could work in New York State. In October 1998, a commentary in Archives of Surgery discussed dollar replacement value of surgical residents to community teaching hospitals, comparing the cost of supporting junior faculty with the cost of replacing surgical residents with PAs. The author was a strong proponent of increasing PA participation in patient care at teaching hospitals, calling for the creation of mechanisms for the simultaneous training of PAs alongside physicians.

Value of PAs

Surgeon/intensivist Marvin A. McMillen, MD, FACS, of Chicago, IL, pointed out that in 1998 residents worked 80 to 100 hours per week. A national census of PAs conducted by the American Academy of Physician Assistants (AAPA) that same year revealed that PAs in all specialties worked an average of 48.7 hours per week, excluding call.

Stephen Crane, PhD, MPH, CEO of AAPA, makes the point that PAs as employees can provide continuity of care. Dr. Crane wrote, “From the perspective of a hospital interested in providing continuity of quality care, a patient interested in an alert staff and a surgeon interested in having a team player who knows to place late night telephone calls when a case is beyond his or her experience or education, physician assistants make sense.”

Dr. Crane also eased the fears of surgeons who think that this nonphysician provider will endanger the surgical residency concept that has been in place for the last hundred years. He stated, “Surgical PAs will never replace residents. This is because good surgeons are still essential to the delivery of quality medical care in the United States, and good surgeons are the outcome of good residency programs. Patients need experienced surgeons and surgeons need a strong medical team working with them—one that includes physician assistants.”

Dr. McMillen supported Dr. Crane’s position, stating, “I unequivocally recommend physician assistants as the optimal assistants, based on my experience of their high educational qualifications, their involvement in comprehensive patient care both in and outside the operating room, and their demanding profession standards.”

PAs have already responded to the reduction of residents in surgery. The percentage of PAs practicing in surgery has increased from 18.8 percent of the PA population of 29,000 in 1997 to 21.7 percent of 43,000 PAs in 2002.

Education and preparation

It would be redundant to explain the genesis of the PA education. The AAPA 2002 Annual Physician Assistant Census provides a demographic snapshot of the approximately 43,000 PAs in clinical practice that year. Active duty PAs who are commissioned officers, reservists, and veterans made up 21.6 percent of the profession in 2002.

In addition to their broad medical care training, PAs may enhance their education through postgraduate surgical programs. A complete list of the various postgraduate programs can be found on the Association of Postgraduate PA Programs Website, www.appap.org. A summary of one such program can be found in the box on page 16.

Reimbursement

Reimbursement policies for services provided by PAs sometimes are confusing. Michael Powe, AAPA director of reimbursement, stresses, “First, surgeons should be aware of the wide range of services for which the PAs are covered in the office, hospital and operating room. While PA practice is governed by state law and guidelines implemented by hospitals, major payors such as Medicare, Medicaid, and private insurance companies generally reimburse for those services provided by PAs that would otherwise have been provided by a surgeon. PAs, within their scope of practice, have access to the same Current Procedural Terminology (CPT) codes that surgeons use.”
**Program description and history**

The Norwalk/Yale PA Surgical Residency was developed jointly by the departments of surgery at Norwalk Hospital and the Yale University School of Medicine in 1975. The program combines the strengths of both institutions to provide an intensive didactic and clinical curricula that prepares the graduate PA to competently and confidently pursue a career as a surgical PA.

The curriculum, designed exclusively for PAs, enhances surgical skills and knowledge and expands upon the education obtained in PA school. Emphasis is placed on the total care of the surgical patient, preoperatively, intraoperatively, and postoperatively.

**Curriculum**

The 12-month residency combines an ongoing didactic curriculum with clinical rotations. During the three months at Yale University School of Medicine, the PA residents have clinical rotations in anesthesiology and choice of two electives. The didactic component consists of a clinically oriented anatomy course with cadaver dissection, animal surgery lab, physiology, pharmacology, EKG course, and computer instruction.

At Norwalk Hospital nine months are spent on clinical services in general surgery, orthopaedics, GU surgery, neurosurgery, plastic surgery, ENT, thoracic and vascular, and surgical intensive care. The didactic curriculum consists of a comprehensive daily lecture series designed to gain understanding of the pathophysiology of surgical disease, a course in medical writing, medical ethics, ICU management, teaching rounds, trauma rounds, surgical grand rounds, and surgical journal club.

**Summary of Norwalk/Yale PA Surgical Residency Program**

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<td>Surgical department symposiums</td>
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| Yale University School of Medicine (three months) |
| Didactic: |
| Animal surgery lab |
| Cadaver anatomy lab |
| Physiology |
| Pharmacology |
| EKG course |
| Computer instruction |

**Clinical:**

- One month GU surgery
- One month orthopaedic surgery
- One month surgical ICU

Electives may be done in any discipline including radiology, cardiology, cardiothoracic surgery, pediatric surgery, surgical intensive care, emergency medicine/trauma, sports medicine, pulmonary medicine, neurosurgery, gross pathology, plastic surgery/burns.

**University/institution affiliations**

Norwalk Hospital is a community teaching hospital serving seven communities in Fairfield County, CT. Yale University School of Medicine is a major university medical center in New Haven, CT. The program combines the academic and clinical strengths of both institutions. The Norwalk/Yale residency has a longstanding reputation of quality and excellence in its teaching program.
A second important point, according to Powe, is the fact that PAs are routinely paid for providing evaluation and management (E/M) services in the office or in the hospital, preoperative surgery examinations, and serving as first assistants at surgery. "One aspect of a PA's ability to bring more efficiency to the practice has to do with providing postoperative services," he stated. “Certain postoperative services provided to patients in the global surgical time frame are not separately billable. However, when those services are delegated to the PA, the surgeon is able to engage in other medical or surgical duties (for example, treating new patients or performing a surgical procedure) that are billable, thus leading to increased revenue flowing into the practice.”

Medicare covers services provided by PAs at 85 percent of the physician fee schedule. It also requires only general supervision, such as electronic communication between the surgeon and the PA. Powe advises surgeons to “always check with your state law, which may have more stringent supervision requirements. In the office or clinic settings, the ability to bill ‘incident to’ the surgeon at 100 percent of the Medicare fee schedule is available when Medicare’s more restrictive rules are followed.”

He also noted, “Many private payors require that services performed by PAs be billed under the name of the supervising physician (often PAs aren’t separately credentialed or issued provider numbers by these payors). Always check with the particular payors to ascertain their rules for billing.”

A 1995 study by the American Medical Association’s Center for Health Policy Research demonstrated that a practice with a PA (or certain other nonphysician health professionals) resulted in an increase in net income of nearly 18 percent.10 The same report also showed a one-week reduction in the number of weeks physicians work per year.

Contractual PAs

In these times of negligible reimbursement for first-assistant services, many surgeons have chosen to forgo the opportunity to assist each other on nights, holidays, and weekends. Surgeons are being stretched to greater limits every year, and their family time has been a tremendous casualty. Some hospital administrators have been asked to supply the department of surgery with capable PA first assistants on weekends. Administrators are opting to hire PAs on a contractual basis, whereby the hospitals are not responsible for payroll or malpractice or health insurance. A contract is negotiated for a set “on call” fee and a per-case fee. In states where the laws permit, some PAs have started groups that provide first assistant services. John Byrnes, PA-C, is a director of one of these services, in Orlando, FL. Mr. Byrnes said, “The utilization of the contractual surgical physician assistants to provide first assisting services on covered procedures provides experienced and quality assisting at no cost to the institution. The PA is assisting in lieu of another surgeon, and the assisting fee is payable by the patient's insurance carrier such as Medicare, and the PA is responsible for all applicable payroll and withholding taxes, as well as for all benefits such as malpractice insurance, health and disability premiums, and retirement accounts. Since the assisting services are on an ‘as-needed basis’ only, there is no ongoing overhead of salary/benefits to the institution because it is simply a fee-for-service that is provided, that is, no service—no fee.”

Additional information

Two PA organizations were represented in the exhibit hall at the 2002 American College of Surgeons Clinical Congress in San Francisco, CA. One of these organizations, the AAPA, represents all physician assistants in every specialty in the U.S. The AAPA has produced issue briefs that describe in detail the training, education, scope of practice,
reimbursements issues, and state laws covering the practice of PAs. These issue briefs can be obtained by going to the Academy’s Web site at www.aapa.org or by contacting the AAPA department of government and professional affairs at 950 N. Washington St., Alexandria, VA 22314-1552; tel. 703/836-2272.

Another source of information on surgical PAs is the American Academy of Surgical Physician Assistants (AASPA). This is one of the AAPA-recognized specialty organizations. By going to the organization’s Web site, www.aaspa.com, a surgeon or administrator may view a brief job description for PAs in surgical specialties and information on potential methods of utilization. The AASPA may also be contacted by calling 888/882-2772.

Summary
Recent surveys performed by the AAPA estimate that in 2002 approximately 183 million visits were made to PAs and 223 million medications were prescribed or recommended by PAs. The AAPA estimates that just more than 46,000 PAs currently are in clinical practice, with New York and California having the largest numbers of practicing PAs.11

Helen Keller said, “The most pathetic person in the world is the person who has sight but no vision.” Most individuals accept life and its shortcomings, but visionaries are different. They see not only that which is evident, but also that which exists in imagination. Visionary physicians and surgeons who aided in the creation of the physician assistant and use of PAs in surgery include: Eugene Stead, MD; John Kirklin, MD, FACS; E. Harvey Estes, Jr., MD; Richard Smith, MD, FACS; and Marvin Giledman, MD. They believed that well-educated nonphysicians could work alongside physicians as a team and, thus, expand the delivery of health care in America.

PAs have crossed into the new millennium with new challenges. Together, as a team with supervising surgeons, PAs can meet the challenges and establish new alliances that will alleviate today’s constraints. As Rear Adm. Kenneth P. Moritsugu, MD, MPH, Deputy Surgeon General, said, “Physician assistants are ideal partners and professionals in the nation’s health system. They are colleagues with physicians to assure improved access to quality health care in a cost-effective manner.”12

References

Mr. Condit is a physician assistant in surgery, Bronx, NY.
First the good news: President Bush has announced plans to expand Medicare coverage and “reform” the program’s funding and administration. “Healthcare reform must begin with Medicare, because Medicare is the binding commitment of a caring society.” The bad news is that little of a specific nature has been said about how these goals might be achieved.

It is of considerable concern, especially to surgeons and other physicians involved in the delivery of essential care, that politicians still seem committed to the concept that Medicare’s administration must somehow be closely linked to the private managed care industry if it is to survive. This concept is dubious at best.
Historical facts
As we anxiously await the final proposal that is ultimately developed for legislative acceptance, it would be of value to keep a few important historical considerations in mind, including the following:

- The legislation that created Medicare passed in 1965 with the approval of a Republican Congress. Even 40 years ago, the insurance industry could not afford to stay in the business of providing payment for the hospital care of seniors and the disabled—our most expensive populations to treat. At the time, Medicare was a near-perfect answer. Not only did it take economic heat off the private insurance industry, but also it was a terrific way to win the support of the rapidly expanding and increasingly potent senior citizen lobby. Eventually, even our historically conservative medical profession came to appreciate the expanded access Medicare offers.

- Private managed care, with the introduction of capitation and gatekeeping, promised not only to control the cost of care but also to expand access. Neither promise has been kept. While health care inflation was initially and dramatically slowed for healthy working Americans in the early 1990s, private capitation has subsequently proven an inadequate control for the long term.

- Similarly, private managed care has failed to control health care expenditures for U.S. employers, and our economy is continually hurt by the financial burden of an employment-based health insurance system. In particular, small businesses (such as medical practices) experience the economic hardship of providing health insurance for employees. These costs are then passed on to consumers/patients. We all pay in one way or another, but physicians seem to be especially hard hit by this system. We pay as employers, as providers, and again if we become patients.

- Capitation hasn’t even secured the economic success of the health insurance industry. Simply put, in any humane technocratic society, inflation in the cost of health care delivery cannot be capped. Over time, the population grows, ages, and becomes more treatable and, therefore, more expensive to treat. The managed care industry’s promises of cost control and corporate profit mostly depended on restricting access to care. However, as with cost, access to essential care cannot be arbitrarily capped. Promises became pipe dreams, and HMOs are now looking to back out of all but the most lucrative markets.

- For good or bad, the managed care mentality pervades American society. The capitation and gatekeeping mindset even affects our view of fee-for-service practice and historically uncapped public health systems (like traditional Medicare and the Veterans Affairs health care system). Managed care fails here as well and for the reasons already stated.

- Especially with respect to managed health care delivery, so-called free market competition does not produce greater efficiency and cost control. This is a well-documented phenomenon; and the culprit is the unnecessary (or necessary—depending on your point of view) reduplication of costly staffing, structure, and technology in the HMO system. When mutually exclusive systems of care exist in any given area, competition leads to rising costs of care.

“What is happening to Medicare is but a symptom of the financial illness afflicting the rest of health care delivery in the U.S.”
• As recently as 1997, Congress introduced Medicare+Choice in an attempt to expand Medicare coverage and control costs by turning administration and payments over to private HMOs. The plan has been a miserable failure, not only for Medicare recipients but also for the HMOs. Only about 11 percent of seniors have stuck with the program, and HMOs are dropping out with the slightest provocation. Giving Medicare patients access to essential outpatient services only through an HMO forces them into care from new unfamiliar medical practices. 

“[Medicare patients] shouldn’t be forced to give up their doctor or join an HMO to get the medicine they need.”

Again, it has been repeatedly proven that the cost of care must increase over time and private managed care, with capitation and gatekeeping, ultimately fails to control costs and improve access to care for American patients. Further, managed care is an economic failure for the insurance industry and American business enterprise. Further yet, managed care as we know it seems void of social purpose. The fundamental managed care reality in all of this is that it is difficult to profit on delivering health care to people with high medical expenses.

**Systemwide problems**

What is happening to Medicare is but a symptom of the financial illness afflicting the rest of health care delivery in the U.S. Privatizing the administration of essential care has consistently failed. Our patients know it. U.S. industry knows it. Even HMOs now know it, despite the fact that capitation allows them to cut losses and quickly bail out of paying for expensive health care. Take away the prospect of short-term profits, and the managed care industry will vanish like the old-time street hustlers.

With unusual bipartisan foresight, “Medicare was created precisely because we decided that the government should step in where private insurers, for their own very good business reasons, would not [and should not] dare tread,” according to new analyst E.J. Dionne. Far from 20/20, the current state of our political hindsight is in desperate need of a corrective lens.

There is little question that traditional Medicare has been the best value in providing essential inpatient care to senior citizens and people with disabilities. There is little question that these patients should have funded access to prescription medications and other essential outpatient care as part of the Medicare program. Why, then, is the U.S. political process so persistent in sacrificing our entitlements on the altar of the private marketplace? This question is certainly rhetorical to many.

If the privatization of a program as essential as Medicare (the flagship of American public health care) continues it will fail, and many other health care programs will soon be undermined. Indeed, it is becoming apparent that privatization may undermine the value of all essential health care delivery.

**References**


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**Dr. Danto** is clinical professor of surgery, University of California-Davis, and a practicing general surgeon in Truckee, CA.
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Keeping current

What’s new in ACS Surgery: Principles and Practice

by Erin Michael Kelly, New York, NY

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

IV. Preoperative preparation

8. Patient safety in surgical care: A systems approach. Robert S. Rhodes, MD, FACS. In his new chapter, Dr. Rhodes provides an evaluation of current data on patient safety and on the quality of surgical care in the context of system failure, with an emphasis on how and where a systems approach might contribute to improving surgical care.

Not surprisingly, communication between various members of a surgical team is one of the keys to improvement. In the operating room, teams consist of crews from nursing, surgery, and anesthesia; the various crews often have fundamentally different perceptions of their respective roles (referred to as suboptimal situational awareness). Anesthesiologists and nurse anesthetists are much more likely to feel that a preoperative briefing is important for team effectiveness than surgeons and surgical nurses are, whereas surgeons and surgical nurses are more likely to feel that junior team members should not question the decisions of senior staff members. Such varying perceptions may not only compromise patient safety, but represent lost opportunities for teaching or learning. Unfortunately, it is often difficult to achieve consensus on how optimal team coordination should be managed.

The importance of teamwork in the OR is illustrated by a study that analyzes the time needed to learn minimally invasive cardiac procedures. On the fast-learning teams, the members had worked well together in the past, went through the early learning phase together before adding new members, scheduled several of the new procedures close together, discussed each case in detail beforehand and afterward, and they carefully tracked results. Of particular interest was the fact that surgeons

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on the fast-learning teams were less experienced than those on the slow-learning teams but more willing to accept input from the rest of the team. Subscribers may view the full text of “Patient safety in surgical care: A systems approach” at www.acssurgery.com.

V. Operative management

9. Gastroduodenal procedures. E. Ramsay Camp, MD, and Steven N. Hochwald, MD. The authors cover operative technique and troubleshooting for gastroduodenal procedures for benign disorders, including omental patch of duodenal perforation (Graham patch), vagotomy and pyloroplasty, and antrectomy; gastric procedures for cancer, including resection of high-grade dysplasia or carcinoma in situ, resection of early and advanced gastric cancer, and laparoscopic staging; and duodenal procedures for cancer, including local resection of duodenal tumors, resection of distal duodenal tumors, and ampullectomy.

For example, the authors describe the technique for local resection of duodenal tumors: The duodenum and the head of the pancreas are extensively mobilized by dividing the retroperitoneal attachments. Any small tumor that is palpable on the lateral aspect of any portion of the duodenum can be resected. A longitudinal duodenotomy is made 0.5 cm away from the tumor. The tumor is grasped and everted. A full-thickness portion of the duodenal wall is resected with the tumor. Stay sutures may be placed on the duodenum as the wall is being resected to preserve orientation for closure.

Frequently, the duodenum can be closed transversely so as not to narrow the lumen. Stay sutures are placed at the ends of the duodenotomy, which is then held transversely. The walls are approximated with Allis clamps, and a transverse anastomosis stapler is applied to close the duodenal wall below the clamps. Alternatively, the duodenal wall may be closed longitudinally with a single layer of interrupted 3-0 absorbable sutures. If the duodenal opening is large, transverse closure may be impossible because there would be too much tension on the suture line. In this situation, the duodenal wall is closed longitudinally with the TA stapler. Omentum is placed over the duodenal closure.

Small duodenal lesions may not be palpable, in which case intraoperative endoscopy may be required for localization. Surgeons should prepare for this possibility before the operation. Lesions on the medial side of the duodenum can still be resected locally if the head of the pancreas can be mobilized away from the duodenal wall. Fine blood vessels running between the head of the pancreas and the medial duodenal wall should be carefully divided to allow exposure of the duodenum. During this dissection, the location of the ampulla can be determined more accurately by inserting a Fogarty catheter into the cystic duct, down the common bile duct, and through the ampulla into the duodenum. This step requires that the gallbladder be removed and the cystic duct isolated. Subscribers may view the full text of “Gastroduodenal procedures” at www.acssurgery.com.

VII. Care in the ICU

9. Nutritional support. Rolando H. Rolandelli, MD, FACS; Dipin Gupta, MD; and Douglas W. Wilmore, MD, FACS. In their new chapter, the authors review nutritional management of hospitalized patients, including pharmacologic recommendations for stress in surgical patients, enteral and parenteral nutrition, metabolic monitoring, and home nutritional support. They also discuss such topics as early oral feeding in patients following elective operations, nutritional pharmacology, immunonutrition, and the current guidelines.

Nutritional support is required in patients with various disease processes who fall into one of the following general categories:

- The patient has been without nutrition for 10 days. In a well-nourished individual, body stores are generally adequate to provide nutrients during shorter periods of stress without compromising physiologic functions, altering resistance to infection, or impairing wound healing. The provision of nutrients becomes more important as body stores become eroded because of inadequate food intake and accelerated catabolism. In general, deficits occur in surgical patients after seven to 10 days of partial starvation; nutritional intervention should be initiated before this time.
- The duration of illness is anticipated to be more than 10 days. In patients whose illness is...
Practices that submitted Medicare claims in late February may find that their reimbursement is incorrect. Claims for services performed in January and February should be paid based on 2002 rates, but carriers installed the higher 2003 payment rates when they took effect March 1. Medicare carriers should automatically adjust payment for these claims after July 1, so they are paid at the 2002 rates.

We have seen that 2003 rates generally reflect a 1.6 percent increase over 2002 rates. The payment for 2002 claims at 2003 rates translate as overpayment for Medicare claims. Overpayment would particularly be likely for surgeons who changed their Medicare participation status from participating to nonparticipating.

Part B carriers will recoup overpayment for January and February 2003 Medicare claims using normal carrier procedures for solicited refunds. This means that practices that were overpaid will receive an invoice letter from their Part B carriers requesting a refund. When making payment, include a copy of the letter with the repayment check.

CMS resource Web page
The Centers for Medicare & Medicaid Services (CMS) have redesigned their Web page, “Physicians Information Resource for Medicare.” The Web page offers easy access for anyone who wants to search Medicare resources through an alphabetical listing of links. The current major topics include physician participation and enrollment in Medicare, policies and regulations, program integrity, medical review, Part B carrier and regional CMS contact information, payment and billing, educational materials, and opportunities. Material about Medicare and related CMS publications, such as the “Medicare Resident and New Physician Guide,” can be downloaded in Adobe Acrobat (pdf) format.

Searchable databases provide official CMS guidance on Medicare and the aspects of the Health Insurance Portability and Accountability Act (HIPAA) over which CMS has jurisdiction. CMS maintains Medicare and HIPAA “frequently asked questions” Web pages. These resources offer easy-to-understand answers about the basics of both programs and let interested parties register to receive e-mail notification if new information is posted for a specific question. It also offers opportunities to advise CMS about the usefulness of the information.

The newest database is the “Physician Fee Schedule Look-Up.” This program allows you to search the Medicare fee schedule by CPT and HCPCS code for fee schedule amounts and geographic practice cost indices (GPCIs) for every carrier and payment locality. It also contains payment policy information. The user can look up a single HCPCS code, a list of up to five codes, or a range of codes and retrieve payment information by the national relative value unit base. If fee schedule payment amounts in a surgeon’s state differ by locale, it also allows the user to retrieve information by specific carrier and state locality. We would offer a word of caution in that the

continued on page 44
The College’s headquarters city, Chicago, IL, will host the 89th Annual Clinical Congress October 19-23. The theme of this year’s meeting is Tomorrow’s Surgery: What You Need to Learn Today.

New this year are the days and times for the following events. The Annual Meeting of Fellows and Initiates will take place Sunday, October 19, from 1:45 to 2:30 pm. The Convocation Ceremony will take place Sunday, October 19, from 6:00 to 8:00 pm.

The Clinical Congress is sure to provide the latest on surgical research, practice competencies, and professionalism, and allow surgeons to acquire new knowledge and skills to provide optimal care to surgical patients today and to prepare for tomorrow’s practice environment. Educational highlights include sessions on:

- Thermal Ablation of Malignant Tumors—Too Hot to Handle?
- Acquiring Skills to Perform New Procedures: Principles, Challenges, and Opportunities.
- Laparoscopic Colon and Rectal Surgery—Where Are We and Where Are We Going?
- Trauma Surgery in Military and Urban Areas of Warfare.
- Recognition, Management,
and Prevention of Operating Room Catastrophes.
  • Controversies in Inguinal Hernia Surgery.
  • Safety for Office-Based Surgery.
  • Graduate Surgical Education in the Era of the 80-Hour Workweek.
  • Genomics and Proteomics in Surgical Research.
  • Special programs for medical students and surgery residents.

Further general information and the preliminary program for this year’s Clinical Congress may be found next month in the Bulletin. Additional information regarding the meeting is also available on the College’s Web site at www.facs.org.

Questions regarding the educational activities should be directed to Kathy Stack, tel. 312/202-5433.

Committee on Diversity issues plans, agenda, seeks input

The ACS Board of Regents recently created the Committee on Diversity Issues (CDI) “to study educational and professional needs of underrepresented surgeons and to seek relevancy and support by the American College of Surgeons through mission, policies, and programs.”

At present, items on the CDI’s agenda include the organization of a mentoring program and the sponsorship of a general session for the 2003 Clinical Congress entitled Minority Recruitment and Minority Health Care Delivery. The session will discuss the multifaceted aspects of health care delivery to minority populations.

Topics will include: a general statement on the health care problems in the U.S.; the creation of an Office of Racial Disparity at the National Institutes of Health; mechanisms to attract and maintain minority students; and an overview of racial disparity in surgical health care delivery, focusing on vascular and cardiac surgery.

For the CDI to be effective, it must identify underrepresented surgeons and determine their concerns and their suggestions for improvement. Fellows are encouraged to contact the College for future direct individual communications.

For further information, contact committee Chair Myriam Curet, MD, FACS, at mcuret@stanford.edu, or Peg Haar, ACS Division of Member Services, 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5312, e-mail phaar@facs.org.

American Pediatric Surgical Association announces burn wound management study

The American Pediatric Surgical Association (APSA) Outcomes Center is recruiting burn centers, children’s hospitals, trauma centers, and community hospitals for a study designed to identify current burn wound management strategies in children 14 years of age and younger with 20 percent total body surface area, partial thickness scald burns.

Supported by a grant from the Health Resources Services Administration/Maternal Child Health Bureau, this prospective study was designed to identify current clinical practice and to document treatment success based on defined outcomes. Data will be collected on wound care, burn depth, scar management and appearance, and resource utilization. Age-appropriate assessment tools will be used to measure pain, anxiety, and quality of life.

Data submission will begin this summer, and center recruitment will remain open through September 2003. For more information, contact apsa@facs.org.
Oliver H. Beahrs, MD, FACS

Fellow of the American College of Surgeons since 1951. Retired general surgeon. ACS Past-President, Former Chair of the ACS Board of Regents and Chair of the Board of Governors. Emeritus Faculty, Mayo Clinic.

"I have been a member of the College for over 50 years. This has been a privilege for me, and I feel obligated to the College for contributing to my professional activities and ongoing surgical education...."

"We need to emphasize the many benefits membership in the American College of Surgeons affords surgeons so that future generations will support the College and also receive these same opportunities."

"I personally feel that I have benefited greatly professionally, scientifically, and socially because of membership in the College."

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

We invite you to consider joining Dr. Oliver Beahrs in the Fellows Leadership Society of the American College of Surgeons.

For information about joining the Fellows Leadership Society, please contact the College's Development Office via telephone at 312/202-5376, via e-mail at fholzrichter@facs.org, or by visiting the ACS Web site at www.facs.org.
Project HOPE seeks surgical education materials

Project HOPE is an international health education nongovernmental 501(c)(3) organization based in Virginia which works in more than 30 developing nations worldwide to provide services and training at all levels of the health care spectrum.

One of its current programs involves assisting the Egyptian Ministry of Health to establish a state-of-the-art medical library at the newly opened National Training Institute in Cairo.

Materials in key subjects such as surgery are much needed and highly valued by the local health care community, who generally cannot afford to purchase books or subscribe to medical journals. As such, the medical library is actively seeking current educational materials—surgical texts, journals, and media resources.

The Pfizer Foundation will assist in the shipping of donated materials to the library.

For further information, please contact Jack Blanks, regional director-Asia/Middle East, Project HOPE, 255 Carter Hall Lane, Millwood, VA 22646; VA tel. 540/837-2100, CA; tel. 916/987-5462; e-mail jblanks@projecthope.org.
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NTDB™ data points

Who pays for trauma care?

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

The one certainty about trauma care is that the need for it continues no matter what socioeconomic conditions exist around us. Even with today’s economy moving along at its slow pace, trauma centers are operating at full speed. Trauma care is an expensive commodity.

However, because trauma strikes our younger and more productive members of society, this initial cost is outweighed by the enormous economic benefits of returning these victims to a productive life. On the other side of the coin is the ever-increasing number of uninsured individuals.

This national public health issue is placing a severe strain on many health care delivery systems. Add to this the liability insurance crisis, and we have a serious situation facing us. As depicted in the figure below, the single largest category is self pay.

Throughout the year we will be highlighting these data through brief reports that will be found monthly in the Bulletin. For a complete copy of the National Trauma Data Bank Annual Report 2002 visit the Web at http://www.facs.org/dept/trauma/ntdbannualreport2002.pdf.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mNeal@facs.org.
The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the “From my perspective” columns written by Executive Director Thomas R. Russell, MD, FACS.

Britain’s NHS

I was astounded by the recent article in the February Bulletin by Dr. Josef Fischer.

The intemperate language, the hyperbole, and the vilification of economists and media were unhelpful. I wonder to whom Dr. Fischer talks. I detect little evidence of American “self-hate.” On the contrary, I see a people with some self-doubt but free to debate ideas and challenge assumptions and authority. I find few signs of envy of an increasingly challenged Canadian health system and certainly none of the British National Health Service (NHS).

Dr. Fischer is right on one point; the NHS is starved for funding. But its problem is that it’s monolithic and government-owned. There is no real competition within the NHS. This lack of competition strangles innovative thinking about the delivery of health services. Dr. Fischer apparently believes, however, that the fundamental problem with the NHS is that it employs its doctors. He contrasts the work ethic of professionals and employees, failing to recognize that it’s possible to be both. Why does he have such a low opinion of the physicians who are employed by provider organizations, the Veterans Affairs, the U.S. Public Health Service, the armed services and, in particular, our medical schools?

Dr. Fischer goes on to describe as a “disgrace” that patients from the United Kingdom (U.K.) may go to continental Europe for surgery. Is that any more disgraceful than more than 40 million, largely employed, Americans without health insurance and entirely dependent for their medical care on the emergency departments of our most distressed hospitals? And this despite the fact that we spend more than twice the proportion of our gross national product on health care.

Dr. Fischer resorts to quoting the Daily Mail to make the point that a patient can die of neglect in the U.K. I suppose this has never happened in the U.S. No one should fear that anything akin to the British NHS would be imposed on the U.S. In this country, we progress by incrementalism, not by socialist revolution. The solution to our developing crisis in health care delivery and the sad fact that we do not have a health care system will be difficult, complex, and protracted. It will not be helped by vitriolic polemics focused on the past splendors and status of the medical profession. The American Medical Association led us down that path when Medicare was being proposed and has never recovered its reputation. Our focus must be on what is best for our patients, not ourselves.

Max M. Cohen, MD, FACS

I read with interest Dr. Josef Fischer’s generally well-informed article “Whither goest?”: A Look at Britain’s National Health Service” (NHS) in the February Bulletin. Two points were of concern to me as a British surgeon-in-training.

First, I take issue with Dr. Fischer’s comment that those retiring from the NHS in the mid-1970s were the last to enter it as “professionals.” The current NHS workforce comprises a majority of doctors and nurses who would fall under Dr. Fischer’s definition of a professional. Implementation of the European working time directive has clearly had an impact on working practices, which is of concern both in terms of service provision and training, particularly in the surgical specialties. However, the statement that England has a physician workforce that train and work as “employees” is simply not true.

Second, the National Health Service (NHS) is by no means “totally free” for citizens or residents, being funded by the general public themselves. Although it is free “at the point of delivery,” this is far from a semantic difference to the British taxpayer.

Mark Duxbury, MA, MRCS (Ed)

Regarding Dr. Fischer’s comments in the February Bulletin, our problems today are not all due to “gurus” and “self-hate” specialists who believe everything is better somewhere else. We doctors have a great deal of responsibility for our current predicament. Individually and collectively, as organized medicine, we have blindly embraced “fee for service” and “individual choice.” I became aware of the American Medical Association (AMA) growing in Little Rock, AR, where the AMA carried out a campaign of terror against a group of doctors doing business for capitation fees in a small private hospital. During the intervening 70 years, the AMA has not spent a dime on trying to improve the methods of delivery of health care. They spent millions on defeating Murray-Wagner-Dingell.

It’s been over 50 years since that consummate politician, Harry Truman, smelling the wind from the grass roots, first proposed some type of national health system. Regrettably the doctors never seemed to have any sense of smell. Certainly none of them nor their organizations have ever seemed to realize the tremendous public desire that the system needed change. We lost our golden opportunity, to influence and develop a system of care that did not leave out a disgraceful 41 percent of the people. No other civilized country in the
world allows almost half of its population to depend on emergency rooms, scanty free clinics, including those of the medical schools and social service groups, both public and private. Even when states like Oregon showed us a way to develop a safety net for all in a democratic fashion as the schedule was set up in a town meeting fashion, we did not catch on. Big business and big government took it away from us. They created a new rich class of CEOs, accountants, and lawyers for HMOs and managed care.

Oddly and stupidly, when the FCC foolishly thought that the professions of law and medicine were just like business and competition would be improved by advertising, there was also a group of doctors who agreed, and, began to practice just like businessmen. Patients were told by appointment secretaries to bring either cash, a checkbook, or insurance. As the federal government created a group of private hospital chains by differential payment based on their debts for Medicare payments, many doctors moved out of city-county and not-for-profit hospitals to these private hospitals to escape their free service obligations.

However, Joe Sixpack is not that dumb. We lost more public respect. When the feds and Congress started lowering fees paid, prices went up and repeatedly they were lowered from the top down. Prices cannot be controlled from the top down. Everything that enters the system has to have price control to be effective. Now everything is really nasty. Reimbursements have been lowered to the point where some folks think they cannot waste time driving back and forth on rounds. One never knows when he or she goes to the hospital whether they will see their doctor or some stranger called a hospitalist. Others have taken up boutique medicine for only high-paying clientele. Whining and in-temperate essays will not cure the problem. Doctors of goodwill have to design a new system. If that involves some kind of basic Oregon-type care system—not unlimited care as in Medicare, as no country in the world is rich enough to furnish unlimited care on demand—and a second system for the insured and well-to-do, let us accept the political incorrectness and get to work.

Allen Y. De Laney, MD, FACS

Dr. Fischer responds

Dr. Cohen wonders with whom I talk. He must read different papers than I sometimes do, notably the New York Times and other organs of the so-called elite liberal left (not my term but that of others). Continued grasping at straws and the ultimate destruction of the system that was a fairly reasonable system—except for its inability to deal with the uninsured—seems almost complete. One thing is true: whoever one speaks with, nobody is happy with the system now; not physicians, not employers, and not many of the patients.

The purpose of my article was not a critique of the NHS. It is monolithic and chronically underfunded, despite the fact that a lot of money may very well be put into it. The system is probably so completely dismembered it would be very difficult to see whether or not that system could ever be put right. The demoralization of individuals who worked in the NHS is probably complex, partially due to the fact that they are employees. I do not denigrate the value of individuals who work for the Veterans Affairs because their study of quality is way ahead of the private sector. Whether the care and internal medicine in the nation’s health medical schools is better than the private sector I think is open to debate, since at least in the private sector patients see their physicians. In many of the medical schools, whose deans have devalued the practice of clinical medicine in terms of the almighty research dollar, patients are often seen by the third-year students and the final say is with the intern with varying degrees of supervision from the faculty.

The American College of Surgeons and all of us are working on the issue of the uninsured. The uninsured do receive care. It is not optimal. It is frequently catch as catch can and does involve the emergency rooms of our most distressed hospitals.

However, there are two groups in the uninsured. The first is the core uninsured—16 to 20 million individuals who are truly indigent. They do not qualify for Medicare because they do work and are largely “medically indigent.” These individuals constitute the core problem. The difference between the oft-quoted 43 million and 20 million, for example, is those people who are voluntarily uninsured: largely young, perhaps self-employed individuals who perhaps have the option of purchasing health insurance or not purchasing health insurance. They believe they are invulnerable and will never need health insurance. In any system in which universal insurance is either arrived at or imposed in some other fashion in this country, they will be required to purchase health insurance.

Finally, I agree that the imposition of whatever system will follow some debate, but I do not think that it will be long and protracted. Nobody is happy with the current system despite its expense. I believe we are headed to a conclusion over the next three to five years. The current Administration seems to favor the inter-
vention of the private insurers as a mechanism by which to achieve this. From my own standpoint, and these are only personal views, they are part of the problem, and the 21 percent of overhead that they consume is part of the problem, not part of the solution. That 21 percent could probably be used to insure the truly uninsured.

Regarding Mr. Duxbury’s remarks, I think we probably differ as to the meaning of professional. Professional to me is one who does the task at hand regardless of the amount of time that needs to elapse to get this job done. We are also in danger of losing the professionalism of our own workforce, particularly in surgery, because of the 80-hour work week. There is little question as to discomfort in the surgical environment. Perhaps in the future residents and surgical staff will no longer be allowed to work as much time as it takes to fix the problem. I also believe that despite how one is trained, and despite the best of one’s intentions, if there is a temporal relationship to the amount of time that one spends at work in doing a given task, then inevitably one becomes an employee. Here Mr. Duxbury and I differ.

I agree that the NHS is of course funded by taxpayers and is by no means free. Nonetheless, the NHS has been chronically underfunded at 6.8 percent of the gross national product and despite the well-meaning intentions of the current government to infuse it with billions of pounds, it is probably too far gone from the standpoint of the capital infrastructure to be totally salvaged.

In response to Dr. De Laney, I would agree that the ready acceptance of the health gurus and the desire to look elsewhere, such as the Canadian system and the NHS, represents a perceived difficulty on the part of the medical profession. It is unfortunate that Dr. De Laney gets some of his facts wrong, because he has a point with respect to the uninsured. However, his facts are incorrect. Dr. De Laney refers to a disgraceful 41 percent of the people. I believe the hard-core uninsured in the country represent between 16 and 20 million. The remainder, the difference between the 41 and 43 million—where I think he derived his 41 percent—are voluntarily uninsured. In any system that is evolving, which currently is being discussed by the ACS Health Policy Steering Committee, these individuals will have to pay for health care. We are discussing where we will get the money to insure the other 16- to-20 million individuals who have no means to pay for health care. All of us agree that they should be cared for. They are cared for one way or another by an ever-increasing stress on our urban and very frequently unprofitable institutions.

I also agree with Dr. De Laney that we should be interested in our patients rather than reimbursement. I believe that a system could evolve in which physicians and payors (namely, industry) meet patients’ needs rather than their wants. The College may propose such a system in the future if and when it goes through the usual process of full discussion.

Regarding Oregon: As part of dealing with the question of the uninsured, the Health Policy Steering Committee did speak with some of the individuals who are involved with the Oregon health system. Despite what Dr. De Laney thinks, the Oregon health system was not torpedoed by the CEOs and the rich, but by single-interest groups that ultimately bankrupted the system. (This at least from those who were intimately involved.)

There is enough blame for all to go around. However, if the federal government intended to have medicine become a commodity, subject to market forces, then it should have been allowed to float free as true market forces could be allowed to do. The problem was that it was really not a market force system, but a market system in which there was government intervention.

We all remember the “overcompensated procedures” and a whole series of top-down initiatives whose sole purpose was the redistribution of funds from surgery to primary care in the mistaken belief that by putting enough money into primary care, the system would go from intervention once the disease was established to prevention. That is a laudable goal, but probably would require a more disciplined patient body than currently exists in this country. However, there are some hopeful signs, notably in the area of diabetes and heart disease, in which the use of the statins seems to be decreasing the number of cardiac cases, which are required of cardiac intervention.

Despite my points of agreement with Dr. De Laney, the fact remains that the health gurus and the health economists, who have one thing in common—that they have been absolutely totally wrong for 30 years—still hold sway. In any market economy, this certainly would not be the case.

Finally, it may of interest to readership that I have received dozens of letters from interested readers, mostly complimentary, and raising valid points of discussion. I have responded to each one in kind.

Josef E. Fischer, MD, FACS
Commitment to surgery
The following comments are in regard to the point/counterpoint feature by Drs. Trunkey and...
Mabry in the March issue of the Bulletin.

I remember when Dr. Trunkey gave his Scudder sermon in 1989 about the lack of general surgeon commitment to trauma care. His comments are much the same now, but this time I have enough courage to respond to such a pillar of academic trauma thinking as Dr. Trunkey.

Why do any surgeons take emergency room call? (1) It’s the right thing to do as trauma and emergency surgery are important parts of general surgery. (2) Everyone should share the burden. (3) Hospitals require it. I did it every other night for 19 years without getting paid for taking call. Now there is a stipend for trauma coverage and I deserve it—it’s lousy work, risky, poorly reimbursed, and it jeopardizes my ability to deliver quality care the next day. The strains that after-hours calls place on surgeon and family are obvious, yet multiple studies try to discredit this obvious fact.

I would be more receptive to criticism if it did not come from the ivory tower. Academic surgeons get paid for call—it is called a salary—and in Dr. Trunkey’s case, it is paid by the taxpayer. He has a legions of house staff in front of and behind him to field the calls and do the post operative care. Few in private practice have this luxury.

In small hospitals across the country general surgeons provide call coverage at great personal expense with little hope of reimbursement. The availability of compensation for this work reflects just what it is—work. For an academic salaried surgeon who has never dealt with the challenges of private practice, let alone responded to emergencies with almost no hope of getting paid, to criticize those who have done this night after night breeds the kind of resentment so many private practitioners have toward academia.

Steven C. Elerding, MD, FACS

The articles by Drs. Trunkey and Mabry in the March Bulletin were interesting. They debated the results of consorting with the devil but never named him.

Neither individual mentioned the phenomenon that led to our profession’s fall from grace and the almost universal negative perception of medicine, at least in our country. That phenomenon is the embracing of corporate medicine by physicians. Physicians, in private practice and in academia, are perceived as having sacrificed their patients’ welfare for the promise of more business (patients), certain payments, and favored competition over those physicians who would not join. In exchange for these enticements, all they had to do was give up their prerogative to manage the patient as they thought best and also give up the sine qua non of our profession—the completely unfettered role as our patients’ advocate. Our patients and the public perceive that our profession has abandoned them for selfish aims. And, I might add, this is the perception of many physicians as well.

S. Angier Wills, MD, FACS

I wish to thank Dr. Mabry for his clear and insightful comments in the March Bulletin. He speaks clearly and loudly for the practicing surgeon who is strongly trying to uphold his or her professionalism and commitment to his fellow man in the face of a sea of changes.

I often feel that academics have let us down, and have readily joined the voices of criticism under the easy mantel of upholding the public good. They must look to themselves, as well as to outside forces, to understand the declining appeal of surgery as a profession in the U.S.

My thanks to Dr. Mabry for his vigorous defense of our profession.

Joseph A. Gurri, MD, FACS

In the March 2003 issue of the Bulletin, Dr. Donald Trunkey introduces the twin topics of commitment and ethics in modern medicine in what is a most lively and compelling colloquy between himself and Dr. Charles Mabry. Unfortunately, surgery notwithstanding, both authors fail to allude to the single greatest change in the practice of medicine in the last hundred years—not do they express a transparent concept of what ethics really are.

The single greatest change in medicine affecting commitment is the ubiquitous presence of women. They will be the first to tell you that the studies are correct that report that women in the workplace miss twice as much time on the job as men do. I hasten to add this is for perfectly good, understandable, proper, and acceptable reasons. Women, after all, are the keepers of the keg of civilization. But this, and woman’s profound influence on the way we now practice, must be factored into any convincing study of commitment, and no longer avoided or whispered sotto voce.

Drs. Trunkey and Mabry confuse ethics with morals, as many people do. Ethics is a noun and an ethic is an absolute shibboleth that was written in stone 5,000 years ago as commandments for all of us to live by. These are things you learn at home, grow up as part of your person, part of your soul, your culture, and can’t really be taught in surgical seminars. If you read the Hippocratic Oath, or the Hindu Oath quoted by Dr. Trunkey, they mostly deal...
with how to behave. These are matters of morals or mores, and as such are arguable. Added to the confusion are adjectives like “unethical” or “noble”—because adjectives are modifiers, and modifiers are confusing. Abraham Lincoln knew this. In his Gettysburg Address of 266 words, there are only 12 adjectives. And 190 of the words are one syllable.

We should all discourse more like Abraham Lincoln.

James C. Neely, MD, FACS

Dr. Mabry, many thanks for your comments in the March Bulletin. As a declining solo practitioner, I agree with your position completely. As a youngster, I was told that the College’s origin was in part a response to “ambulatory” or peripatetic surgery, where the technician would cut and run (and share the loot with the locals). The push for ethical surgery where the cutter was a real doctor and had pre- and postoperative responsibility was a major goal of the College’s founders. I was brought up to believe this patient-surgeon relationship was the foundation of “ethics.”

Fifty years later, ambulatory surgery is hip, but the patient is the traveler often to the fabled “academic health center” where the residents cut, the patient runs back to the boonies, and the administrator divides the loot. When dollars get tight some (few) surgeons will compromise and loosen their ethical responsibility for patient care as well as a procedure. With the same economic pressures institutions of “health” and academic health centers will be told by their managing administrators and politicians to do it our way. Surgeons will all do as they’re told or leave.

I’m glad someone spoke up for real ethics before the Fellowship is used as another body regulating our metamorphosis and submission.

Esmond Braun, MD, FACS

I applaud the remarks of Dr. Mabry in response to Dr. Trunkey in the March Bulletin. It appears to me that in the early stages of the destruction of the practice of surgery in this country the academics were strangely silent—particularly as things like resource-based relative value scale and the reduction in reimbursement for assistants at surgery were introduced. Now that their ox is being gored, they suddenly sit up and take notice.

In the 27 years since I completed my residency, there have obviously been many changes in the way we practice surgery and in the external forces that are influencing the way we practice surgery. At the present time, however, the most destructive influences to my altruism and my desire to practice good quality, cost-efficient surgery is the almost overwhelming effect of government, insurance companies, nurse case managers, corporate payors, peer review organizations, and the general public. It really added insult to injury to hear Dr. Trunkey suggest that surgeons were becoming unethical and business-minded and that academia could somehow solve these problems.

What medicine and surgery really need is for the multitude of negative external forces to simply get off our backs and allow us to practice the kind of surgery that we were taught to do. Barring that, the quality of the people entering surgery and the quality of medical care provided by surgeons will continue to deteriorate. Even Dr. Trunkey won’t be able to prevent that.

C. Thomas Jewell, MD, FACS

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Indiana Chapter announces new programs

Earlier this year, the Indiana Chapter established an educational fund. Now, chapter members are being asked to contribute. In correspondence to the members, James Madura, MD, FACS, ACS Governor, wrote, “If we are to continue in the future as a vehicle for collaborative education and legislative efforts in Indiana, we will all need to pitch in and help.” For more information on donations to the Indiana Chapter, contact Carolyn Downing, Executive Director, at 800/257-4762, or via e-mail at cdowning@ismanet.org.

The Indiana Chapter also announced a new section of its Web site for members to post information on surgical positions available within the state. Chapter members who would like to post job openings on the site should contact the chapter’s Web master, Wayne Moore, MD, FACS, at infacs@attbi.com.

To post information about a position, the following information should be included: the city, the name of the practice, a brief description of the position, the name of the contact person, and contact information, such as phone number, fax number, or e-mail address.

Chapter anniversaries

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Lebanon Chapter shows support for residents

Recently, the Lebanon Chapter distributed its new publication, Guide for Surgical Residents, to all surgical residents. The text was written by Michel Daher, MD, FACS, chapter President-Elect, and was supported financially by an award of $1,000 from Chahine Abousleiman, MD, FACS, a Past-President of the Lebanon Chapter.

For more information about this new publication, please contact Dr. Daher at mndaher@inco.com.lb.

Metropolitan Washington meets, issues awards

The Metropolitan Washington (DC) Chapter conducted its 2003 annual meeting March 8. In addition to presenting a half-day education program and an early-morning session spotlighting “spectacular cases,” the chapter also issued various awards.

This year, the Zehner Traveling Fellowship Award was given to Rebecca S. Evangelista,
MD.* This award, which is named for Harry B. Zehner, Jr., a founding member of the chapter, is presented annually to an outstanding local resident who has been nominated by his or her training director. The award of $3,000 may be used to visit another residency program to exchange ideas and to observe surgical techniques in the resident’s field or to attend a postgraduate training program.

Other surgical residents also were recognized for their participation in the Residents’ Competitive Forum during the chapter’s annual business meeting. Residents presenting winning papers included:

Clinical Award: First place: Steven Finkelstein, MD,* National Cancer Institute; Second place: Martin Makary, MD,* Georgetown University Hospital.

Basic Science Award: First place: Steven Finkelstein, MD,* National Cancer Institute; Second place: Michael Woll, MD,* Walter Reed Army Medical Center.

Finally, the 2003-2004 officers of the Metropolitan Washington Chapter were elected. They are as follows: Mary Maniscalco-Theberge, MD, FACS, President; Douglas Schwartzentruber, MD, FACS, Vice-President; and Debra Ford, MD, FACS, Secretary-Treasurer.

CAS-ACS calls on chapters

The Council of Representatives, the governing body of the ACS Candidate and Associate Society, has requested that each chapter appoint at least three surgical residents to serve as representatives on the council. Resident representatives should include one general surgeon and two surgeons in other specialties. Chapters should appoint their representatives as soon as possible, and send their names to Peg Haar at phaar@facs.org, or via fax at 312/202-5023.

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known to have a moderately prolonged course, nutritional support should be considered essential care. Thus, individuals with severe peritonitis or pancreatitis, major injury (injury severity score > 15), or extensive burns (> 20% total body surface area) are candidates for nutritional support because of the known duration of their illness. (The duration of illness in chronically malnourished patients also would be expected to exceed 10 days.)

- The patient is malnourished (loss of > 10% of usual body weight over three months). In general, the degree of weight loss can be used as an index of nutritional deficiency. Recovery may be compromised in patients who do not have adequate body nutrient stores because of an existing nutritional deficit. The patient should receive nutritional support when the weight loss approaches or exceeds 15 percent of usual body weight: percent weight loss = (usual weight - present weight) × 100/usual weight.

Patients who do not meet one of these three general indications should be reassessed after seven days to identify those individuals who develop complications after admission to the hospital and require nutritional support. Serum proteins with a short half-life, such as prealbumin, transferrin, or retinol-binding protein, are useful markers to assess the response to therapy. Subscribers may view the full text of “Nutritional support” at www.acssurgery.com.

Looking ahead

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

- “Cardiopulmonary monitoring,” by James W. Holcroft, MD, FACS, and John T. Anderson, MD, FACS.
- “Carotid arterial procedures,” by Wesley S. Moore, MD, FACS.
- “Venous thromboembolism,” by John T. Owings, MD, FACS.

* Denotes membership in the Candidate Group.
program does not contain a legend to explain some of the accessible information. For instance, codes for surgical procedures provide payment policy indicators for assistants at surgery, but unless the user already knows what indicator code “2” means, it is difficult to understand CMS payment policy for a specific procedure.

CMS also offers subscriptions to its Physician ListServ. Individuals who register their e-mail addresses with ListServ, which is managed by the National Institutes of Health, will receive updates directly from CMS when changes to Medicare policies are announced. The Web address for “Physicians Information Resource for Medicare” is http://www.cms.hhs.gov/physicians.

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

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

Original Scientific Articles:
- Cost of Urgent Cholecystectomy
- FDG-PET for Rectal Cancer Recurrence

Palliative Care:
Cancer Cachexia

Symposium:
Controversies in DCIS of the Breast

What’s New in Surgery:
- General Thoracic Surgery
- Otolaryngology

Next month in JACS

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