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About the cover...
This month’s cover story explores whether a gulf is developing between the business aspects of practice and surgeons’ dedication to patient care. More specifically, in “What price commitment? Point/counterpoint” (p. 8), Donald D. Trunkey, MD, FACS, and Charles D. Mabry, MD, FACS, debate whether the economics of modern surgical practice have led to an erosion of the profession’s ethics. Dr. Trunkey asserts that the growing emphasis on the bottom line has damaged the profession, while Dr. Mabry maintains that surgeons remain altruistic despite financial pressures. (Briefcase photo © Anthony Saint James/PhotoDisc.)
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From my perspective

As efforts to develop a better health care delivery system continue, it is becoming clearer than ever that the quality and the cost of medical services are the major issues that the College as a professional organization and each of us as individual surgeons will need to directly address in the foreseeable future. Currently, we are surrounded by all of the problems that have beset the health care system for some time because of these two overarching concerns. On the one hand, we are trying to deliver the best care, while at the same time we are continually told that we are not fulfilling the public’s expectations. On the other hand, our payments are repeatedly cut while our expenses, such as malpractice insurance premiums, rise at rapid rates.

Balancing the demand for greater public accountability for the quality of the care we provide with legal and regulatory burdens has left us in a position that many surgeons find untenable. How do we resolve these conflicts?

The quality movement

The goal of delivering quality patient care is the cornerstone on which the College was founded, and it is one to which all surgeons aspire in their day-to-day activities. Improving surgical care is central to the College’s mission, and it is our responsibility to develop standards that we know work, apply them in our practices, and share our knowledge with other clinicians.

However, more and more frequently, consumer groups are airing their distrust of the medical community’s willingness to provide meaningful data and to police itself. Patients are heightening their demands for reports on physician and hospital performance.

In response, the government, through the Centers for Medicare & Medicaid Services (CMS), is now beginning to publish for public consumption an analysis of the efficacy of care provided in nursing homes. No doubt, the next step will be the issuance of reports on care provided in hospitals and by health care professionals. In addition, private-sector groups—such as the Leapfrog Group, which is a business coalition, and the National Quality Forum (NQF)—continue to inundate the profession with requests for outcomes data that can be released to the public.

The College is striving to be an active force in these efforts by engaging in an ongoing dialogue with CMS and by joining the NQF. In addition, we continue to work diligently in advising the Joint Commission on Accreditation of Healthcare Organizations as it attempts to develop a certification process that is more meaningful in light of modern expectations.

Finally, the College is most anxious to assist in bringing the Veterans Affairs’ National Surgical Quality Improvement Plan into the private sector. We believe that this program, which analyzes outcomes in a risk-adjusted way by comparing observed with expected outcomes, addresses some of the problems in our health care system.

Current approaches

Some groups that are actively participating in the quality movement are focusing their studies on the relationship between volume and outcome. For example, the Leapfrog Group has documented many cases which demonstrate that oftentimes
volume does make a difference. This consortium maintains that if a patient undergoes a complex procedure done in a high-volume center by a surgeon who has performed the operation frequently, he or she will experience a better outcome.

Not all efforts to link volume with quality are taking place at the national level. For example, the Center for Medical Consumers, a not-for-profit group in New York City, has released a report indicating that patients who underwent procedures at hospitals where the operations are infrequently performed and by surgeons who have rarely performed them were more likely to experience injury or death. The state health department has responded to the center’s request that the agency limit which hospitals and physicians provide certain services by noting that low-volume facilities can and do provide quality care and that further research in this area is necessary.

Practice guidelines also are becoming increasingly popular. Just last month, the Kaiser Permanente Group began publishing a large number of their practice guidelines and making information about best practices available to the public.

Clearly, as society continues its search for reliable outcomes data and quality care, the individual surgeon will be responsible for tabulating and making available information about the procedures they perform. As part of its activities, the College’s Division of Research and Optimal Patient Care will be developing the tools that surgeons will need to use to meet these new demands.

The road ahead

For many years now, efforts to reform our health care system have largely been translated into cost cutting. As a result, surgeons have seen their expenses rise while their reimbursement has dropped. This situation obviously cannot continue. It is putting too much stress on the system.

There are so many ways in which we could decrease costs without taking payment away from physicians and other providers. The waste in our current health care system, the overuse of technology, and some of the futile care that is delivered at the end of life—not to mention the administrative costs of running this complex system of practicing defensive medicine to avoid malpractice allegations—must be addressed. These factors likely have been the driving forces behind ever-increasing health care expenses. By shifting our focus toward improving the quality of care and examining health care information, we can do much to make the system more effective and efficient.

We all welcome the chance to engage in this important dialogue on quality and cost. The College is developing exciting new instruments to monitor and improve surgical care. While we struggle to generate meaningful data that can truly help us to improve the quality of patient care, however, we recognize and encourage other stakeholders to realize that human disease processes seldom respond to assembly-line principles. Improving quality of care will require careful examination of all components of our system and of how they intertwine and affect each other in complicated ways.

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.
The College was a sponsor of the American Medical Association’s Nathan Davis Award dinner, which was held in Washington, DC, on February 11 to honor excellence in government service. The College’s nominee for the award, Rep. James Greenwood (R-PA), was among those honored for his leadership in promoting trauma system development, Medicare access, and medical liability reform. College representatives who attended the event included Executive Director Thomas R. Russell, MD, FACS, and Fellows LaSalle D. Leffall, Jr.; Mary Maniscalco-Theberge; LaMar S. McGinnis, Jr.; Kurt Newman; Anton N. Sidawy; and Hugh H. Trout III.

During the February 7, 2003, meeting of the Board of Regents, the College’s “Statement on Ensuring Correct Patient, Correct Site, and Correct Procedure Surgery” was reaffirmed, but the Regents emphasized the fact that this statement comprises guidelines, not standards of care. Members of the Board of Regents recognize that many hospitals and systems already have policies in place that appropriately ensure correct site surgery.

Physician and staff representatives of surgical specialty societies concerned about issues pertaining to office-based surgery met at the College’s headquarters on February 5 to develop a common set of principles they could support in state regulations. The meeting represented the first step in a larger effort that will be conducted jointly with the American Medical Association to develop a model state law governing office-based surgery, pursuant to a College-sponsored resolution that was adopted by its House of Delegates in December.

Hugh H. Trout III, MD, FACS, represented the College at a hearing held on February 10 by the Centers for Medicare & Medicaid Services’ Practicing Physicians Advisory Council (PPAC) on issues the agency needs to address as it prepares to draft regulations pertaining to the 2004 Medicare fee schedule. Dr. Trout’s testimony highlighted two issues: (1) flaws in the calculations used to derive the sustainable growth rate that determines, in part, the annual fee schedule updates; and (2) the need to adjust Medicare payments to account for rapidly escalating medical liability premium costs. Amilu Rothhammer, MD, FACS, the College’s Second Vice-President, serves on PPAC as the College’s representative.
The American College of Surgeons issued a press release February 14 applauding the House and Senate for passing legislation that halted the 4.4 percent Medicare physician payment cut that was scheduled to become effective on March 1. In the press release, Thomas R. Russell, MD, FACS, the College's Executive Director, said, “The College is grateful to each of the legislators who worked together to correct the errors in the [payment] formula.” He further noted that “credit must also be given to the Administration, which worked with the physician community over the past year to identify solutions to the problem and provide the leadership needed to get the job done.”

The Omnibus Appropriations bill, H.J. Res. 2, allows the Centers for Medicare & Medicaid Services to correct errors it made when calculating physician payments in 1998 and 1999. Due to the cumulative nature of the payment formula, these errors were producing a series of annual, significant payment cuts—5.4 percent in 2002 and an estimated 4.4 percent cut in 2003. President Bush signed the legislation into law on February 20.

In his second State of the Union address, President Bush identified a number of health care goals for the coming year. Listed prominently among those goals was “high-quality, affordable health [care] for all Americans.” Although the President did not clearly identify his plan for ensuring access to care for the uninsured, he asserted that a “nationalized health care system that dictates coverage and rations care” was not an option.

Recognizing that health care for the elderly is the “binding commitment of a caring society,” President Bush announced his intention of committing $400 billion over the next 10 years to reforming and strengthening Medicare. While details about the plan were still unavailable at press time, the Administration has indicated that approximately 95 percent of that money will be dedicated to developing a prescription drug benefit for seniors. The remaining funds are to be used to adjust the Medicare fee schedule payments to physicians (see previous article). However, other stakeholders will be competing for those remaining dollars.

Importantly, the President appealed for an end to frivolous lawsuits. Calling the constant threat of litigation a major reason for higher health care costs, President Bush asked Congress to work with him to pass national medical liability reforms.

Unfortunately, the budget neglected to allocate funds to further strengthen the nation’s trauma systems, even though the federal trauma system development program was deemed relevant to homeland security.

Finally, the budget earmarked $80 million for the Agency for Healthcare Research and Quality (AHRQ) to test and validate information technology that will aid in developing electronic medical records and other technology that may be used to ensure patient
Liability reform legislation reintroduced

A bipartisan group of legislators, led by Rep. James Greenwood (R-PA), recently introduced legislation to reform the medical liability system. H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act (HEALTH) of 2003, is modeled after California’s Medical Injury Compensation Reform Act (MICRA) and includes a $250,000 cap on noneconomic damages. The legislation also imposes a three-year statute of limitations, requires proportional damages among defendants, modifies the collateral source rule, allows for periodic payments of future damages, and limits attorney fees.

Last year, the House passed similar legislation, while the Senate voted against such a measure. Prompt action by the House on H.R. 5 is anticipated, while the Senate plans to conduct hearings before determining its next steps.

Changes proposed for state health insurance programs

The Administration’s budget provided a framework for changes in Medicaid and in the State Children’s Healthcare Improvement Program (SCHIP). Health and Human Services Secretary Tommy G. Thompson recently announced a plan to address outdated Medicaid rules and give states extra funding to improve state Medicaid and SCHIP programs. The plan essentially changes the program from an entitlement to a block grant program. The stated purpose is to allow governors more flexibility to design programs that fit their particular state’s needs for the poor and uninsured families. However, switching to a block grant program could leave these programs subject to new changes and limits in the future.

The proposal will:

- Provide an estimated $3.25 billion in extra federal funding for Medicaid in fiscal year 2004, with $12.7 billion in new funding over seven years.
- Preserve comprehensive benefits for “mandatory” groups, giving states expanded flexibility to tailor coverage for “non-mandatory” recipients and services.
- Encourage coverage and the creation of “medical homes” for whole families, rather than just the children in low-income families.
- Support increased use of home and community-based services for Americans with disabilities, including older Americans needing care that can help prevent premature use of nursing home care.

In addition to this plan, the President’s budget includes $2.4 billion over five years to extend Transitional Medicaid Assistance, which provides extended Medicaid coverage (12 months) for those transitioning from welfare to work. For more information, go to www.hhs.gov/news.
What price commitment?
Point/counterpoint
The late Alexander Walt, MD, FACS, referred to medicine as the “most noble profession.” I agree and believe two of the most important fundamental characteristics of medicine are our ethical heritage and personal commitment to the profession. I would like to briefly examine both of these foundations of our profession.

The first written promulgation of physician ethics is more than 3,500 years old. Various renditions were developed subsequently, but the similarities between them are remarkable. The first physician oath, taken by Hindu physicians, is as follows:

You must be chaste and abstemious, speak the truth, not eat meat; care for the good of all living beings; devote yourself to the healing of the sick even if your life be lost by your work; do the sick no harm; not, even in thought, seek another’s wife or goods; be simply clothed and drink no intoxicant; speak clearly, gently, truly, properly; consider time and place; always seek to grow in knowledge. Do not treat women except their men be present; never take a gift from a woman without her husband’s consent. When the physician enters a house accompanied by a man suitable to introduce him there, he must pay attention to all the rules of behavior in dress, deportment, and attitude. Once with his patient, he must in word and thought attend to nothing but his patient’s case and what concerns it. What happens in the house must not be mentioned outside, nor must he speak of possible death to his patient, if such speech is liable to injure him or anyone else. In face of gods and man, you can take upon yourself these vows; may all the gods aid you if you abide thereby; otherwise may all the gods and the sacra, before which we stand, be against you; and the pupil shall consent to this, saying, “So be it.”

Among the subsequent oaths, only one refers to physician reimbursement. This quote comes from the first known formal pledge of medical ethics among the Jews: “Do not harden your heart against the poor and the needy; rather have compassion upon them and heal them.”

According to the Oxford English Dictionary, commitment means, “To give to someone to take care of, keep, or deal with; to give in charge or trust, consign to.” In a sense, physicians have a dual commitment: one to our patients and another to our profession.

It is my perception that these two cornerstones, ethics and commitment, are being assaulted by external forces. Unfortunately, I worry that within the profession these values are eroding as well.

Medicine as business

In Time to Heal: American Medical Education from the Turn of the Century to the Managed Care Era, Ludmerer states that medicine has become a business. I have previously commented on this trend, but I will repeat a summary of why he be-
lieves medicine has become a business and how this development has led to our current health care crisis.

In the 1950s and 1960s, the National Institutes of Health expanded its research dollars, which in retrospect may have been detrimental in two different ways. First, this growth allowed medical school faculties, particularly in nonsurgical specialties, to expand and even double or triple without a concomitant commitment to teaching or supervised patient care. The second adverse effect is paradoxically a result of our success: knowledge derived from research has spawned expensive diagnostic and therapeutic modalities.

The second seminal change in American medicine after World War II was the passage of the 1963 Health Professions Educational Assistance Act, with additional bills in 1965, 1968, and 1971. This led to an increased number of medical schools and expansion of medical school class sizes. Lewis has postulated that the subsequent proliferation of physicians has paralleled and, indeed, caused the increased costs in medical care. Cooper has challenged this concept, arguing that we are now facing a physician shortage. Nonetheless, he does concur that the physician costs of medicine continue to rise despite an increase in the number of physicians.

The third force affecting increased costs was the passage in 1996 of Titles XVIII and XIX of the Social Security Act. The elderly and some of the indigent were now covered by health insurance, and academic health centers (AHCs) again increased faculty sizes.

Then in the late 1980s, the cost of medicine reached crisis proportions for the business community. It was argued that “there is more health care than steel in a Chevrolet.” The business community responded by embracing fierce price competition among insurers who then proposed externally “managed care” to physicians and hospitals. This solution was championed by the Clinton Administration at the 1993 Jackson Hole Conference. Ultimately this proposal failed, due in no small part to omitting from the planning process the very provider groups that would care for the patients. Nevertheless, managed care survived, albeit on life support, and was inflicted on an unsuspecting public and academic health community.

As a defense, AHCs adopted corporate strategies to cope with market forces, and began losing sight of their basic mission. As a result, we sacrificed our special place in society. Some of the strategies that have developed are depicted in Table 1, above. It is noteworthy that none of these strategies would improve patient care or enhance a scholarly environment. I reluctantly am forced to conclude that Ludmerer is right—medicine has become a business, and this change creates an ethical dilemma. It also makes me worry that I am no longer playing for the same team that I signed up to play for in medical school.

Business ethics

The evolution of ethics in business began in the Renaissance. Descartes postulated that observation was in doubt—the so-called methodical doubt. He proposed to reduce all concepts to their fundamental mechanistic terms, thus leading to “reductionism.” The economists of the day were not to be left out of this scientific scrutiny. John Locke said, “The great and chief end, therefore, of men’s uniting into commonwealths and putting themselves under government is the preservation of property.” In Locke’s view, the preservation of property was devoid of a set of ethics that pro-

| Table 1 |
| Strategies by AHCs to cope with health care reform |
| Reduction in residency size |
| Integrated delivery systems |
| Limitation of tenure |
| Aggressive marketing and advertising |
| Hospital “consortia” for GME |
| Increase patient volume |
| Increase market share |
| Seek new sources of income |
| Managed care initiatives |
| Redesign faculty practice plans |
| Increase primary care |
| One plan for the entire school |
| Hospitalists and intensivists |
| AHC consolidation |
tected the peasants from the landowners. Subsequently, Dudley North thought that it was best in business “to leave things alone to seek their own natural balance.” Ultimately, it was Adam Smith, in Wealth of Nations, who espoused a “natural law” in which self-interest itself served to protect each of the parties, including capitalist, producer, laborer, and buyer.9

In 1989, Lawrence Shames published The Hunger for More: Searching for Values in an Age of Greed.10 This book fundamentally and enthusiastically condemns the ethics of business. He states, “In terms of moral categories as old as the Bible and as central to Western Civilization as Aristotle, there is no such thing as business ethics, anymore than there is such a thing as sports ethics or leisure ethics or sex ethics. There’s only one ethics, and it applies to all aspects of life.” He then documents multiple examples of greed and flawed ethics within the business community. Recently, his position has been persuasively corroborated and updated on the Internet.11 Shames concludes, “Business ethics was rife with given. The sanctity of profit was, of course, a given. Not just the reality, but the legitimacy of human avarice as a motivator, was also a given. Inequality was a given, since Darwinian competitiveness was a given, and on the savannah of business, there would always be winners and losers, predator and prey. Even a certain amount of criminality was a given; no one expected universal virtue in a domain where success was defined solely by the rewards of success, where accomplishment was judged by counting.”

Although the book was written in 1989, it was prescient of our current corporate scandals. Shames further concluded, “Everything would not be all right, since the problem at its most fundamental, was not one of mere greed, but of an awful want of respect for the rules, for each other and for ourselves. Cheating in business was one expression, but not the substance, of that lack of regard. Wealth, where it was dubiously acquired, became a measure of our content, a way of thumbing our noses at a system that could make us prosperous but not exalted.”

I maintain that as medicine has progressed into a business, we are starting to experience a similar decay in our medical ethics. Can we avoid this turn of events? Is there an alternative?

### Table 2

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<th>Compensation: Academic surgeons</th>
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<tbody>
<tr>
<td>Average couple/two children</td>
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<tr>
<td>Invasive cardiologist</td>
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<tr>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>Orthopaedics—foot and ankle</td>
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<tr>
<td>Orthopaedics—spine</td>
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<tr>
<td>Orthopaedics—trauma</td>
</tr>
<tr>
<td>Neurosurgeon</td>
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<tr>
<td>General surgery</td>
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<tr>
<td>General surgery—trauma</td>
</tr>
<tr>
<td>Urology</td>
</tr>
</tbody>
</table>


### Table 3

<table>
<thead>
<tr>
<th>Compensation: Private practice after eight years</th>
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<tbody>
<tr>
<td>Interventional cardiologist</td>
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<tr>
<td>Gastroenterologist</td>
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<tr>
<td>Orthopaedics—foot and ankle</td>
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<tr>
<td>Orthopaedics—spine</td>
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<tr>
<td>Neurosurgery</td>
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<tr>
<td>Cardiac surgery</td>
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<td>General surgery</td>
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</tbody>
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**Medicine—public good**

 Permit me to put medicine into economic perspective and then examine the evolution of physicians’ income over the last century. From a microeconomic standpoint, I want to believe medicine is a public good. A service is defined as a public good if it has the attributes of nonexclusivity and noncompetitiveness.12 Nonexclusivity obligates access—individuals cannot be excluded from benefit. In the U.S., health care is implicitly rationed and access is unequal. A good is noncompetitive if consumption of additional units of the good involves zero social marginal costs of production.
Medicine has been compared to national defense and the fire and police departments, which are also public goods. Many economists argue that efficient provision of public goods ought to be accomplished free of charge. While access to emergency care and a disease-free society benefit everyone, medicine is at least partly rivalrous in consumption, and, thus, it is not a pure public good.

A corollary to medicine as a public good is whether physicians who handle emergencies should strike. Police officers, firefighters, and soldiers are prohibited from striking. Recently, surgeons went on strike in several states. Is this activity reflective of commitment to our patients?

In 1900, a physician’s annual income, at $750 and $1,500 a year, was slightly below the national workforce average. In 1928, it averaged $6,354, but fell in 1929 with the Great Depression to $3,758. In 1945, it was $8,000, and in 1969, it was $32,000. In contrast, in 1998, the average primary care physician made $139,244 and a general surgeon, on average, made $225,653. To put this in perspective, in 1900, physicians were considered to be in the lower middle class, whereas now physicians make four to 10 times the national income average, depending on their specialty. More recent examples for specialty surgeons’ and physicians’ income are shown in Tables 2 and 3, page 11.

Adverse external forces

Paralleling the erosion in the perception of medicine as a public good has been a decrease in government support for academic health centers. Medical schools have responded to this problem in several ways. First, in many schools, tuition has increased (Figure 1, this page), which has increased student debt and may have frightened young physicians into a destructive focus on finances. Second, the hospital has become the revenue engine that supports the administration of the health center and the school of medicine. To enhance the revenue stream, hospital administrators have targeted surgeons, particularly specialty surgeons, to attract patient volume and dollars. Surgeons are encouraged to spend more time in the operating room at the expense of scholarly activity. Third, AHCs are recruiting niche surgeons to establish high-profile lucrative programs. To recruit these boutique practitioners, the academic reimbursement model has been abandoned,
and, in its place, we now have the “professional athlete model.” This has escalated some specialty surgeons’ annual income into the obscene stratosphere and confirms the cynic’s view that “annual income relates inversely to community service.”

Negative internal forces

Adverse forces are assaulting both ethics and commitment from within the profession. Permit me two examples: On-call pay and freestanding ambulatory surgery centers.

In the last century, it was common for the medical staff to provide call either in their specialty or for the emergency room. The so-called Pontiac Plan required all doctors to take their turn in the ER with few exceptions. This plan proved inadequate, and in the early 1960s, emergency medicine developed as a specialty. Since then, emergency care has been provided in most hospital emergency rooms by members of this specialty. In the late 1960s, trauma systems were developed, and as part of that program, the general surgeon in the level I and II hospitals often took call in-house or had to be immediately available. Blunt trauma became the predominant cause of injury, but only 12 percent of these cases required surgical intervention. The primary roles of general surgeons became resuscitation and critical care, which are not adequately reimbursed. This necessitated hospital administrators to subsidize the trauma service through annual support dollars (administrative stipends) or on-call pay, particularly when the surgeon was in-house. Simultaneously, it became necessary for anesthesia to stay in-house to care for trauma, emergency surgery, and obstetrics.

In the past three to four years, a different pattern has evolved, with specialty surgeons asking to be paid to take call at home. Although regional differences exist, the demand for this at-home call compensation varies

**Figure 4**

The number of freestanding ambulatory care centers has grown 31 percent since 1996

Source: SMG Marketing Group.

**Figure 5**

Where outpatient surgeries have gone

Source: SMG Marketing Group.
from $1,000 to $2,000 per night. The rationale for this on-call pay has been justified by one of the specialty surgery organizations. As far as I know, this policy constitutes a precedent in the relationship between medical staff physicians and hospital administration. The incremental costs on an annual basis to the health care budget of the U.S. are considerable. Assuming a minimum of 1,000 level I and II trauma centers, the annual cost of on-call orthopaedic and neurosurgery ($2,000 each/night) would be $1.46 billion. (See Figures 2 and 3, p. 12) But most general surgeons, neurosurgeons, and orthopaedic surgeons do not want to take trauma call. The reasons for this reluctance include poor reimbursement compared to elective operative cases, disruption of the next days' elective schedule or office practice, a perceived increase in malpractice liability, and impairment of lifestyle. Isn't this behavior also evidence of a lack of commitment?

The second example is freestanding ambulatory surgery centers. Paradoxically, these centers do reduce costs compared to hospitals and may provide better service/convenience to the patient. However, there is potential secondary gain for the surgeon in these centers. Since 1996, the number of these ambulatory surgery centers has increased from 2,314 to 3,383 (see Figures 4 and 5, p. 13). Half of these ambulatory surgery centers are owned by corporations, one-fourth are limited partnerships, and the remaining one-fourth are a combination of partnership and sole proprietorship. Since 1996, the volume of surgical cases in these centers has increased from 4.3 to 7 million per year. The incentives for surgeons to join these groups include a perceived increase in income (particularly for the surgeon owner or part-owner), no night call, no Emergency Medical Treatment and Active Labor Act (EMTALA) requirements, and an improved lifestyle. Many of these centers accept only patients with commercial insurance, excluding Medicare, Medicaid, and indigent patients.

This prerequisite has a double negative effect. It accentuates the double-access standard of care with a destructive rebound on the traditional general hospital. By skimming the payor cream off of the top of the insurance dollar container, it aggravates the ability of the acute care hospitals to cost shift for government-insured patients and the indigent. It may also impact negatively on the availability of general and specialty surgeons in trauma centers (see Figures 6 and 7, above.)

I believe these two examples of negative internal forces are uniquely troublesome. They parallel the ethical flaws that have recently flourished in our business community. Greed and a lack of commitment to our patients have contaminated the medical profession.
Clearly, not all businesspeople (CEOs and CFOs) are greedy or corrupt. Indeed, most are socially responsible and contributing citizens. Similarly, the majority of physicians serve their patients and their profession admirably and are not driven by greed. However, as in all walks of life, some physicians sully our profession. I believe that we must address these issues and find solutions, or we risk (and deserve) the scorn and condemnation of our patients and the public at large.

Let us assume (and I want to believe) that the economists are right: medicine is a public good. As such, we are the only example of a public good where professionals have the privilege of receiving fee-for-service payment. In contrast to physicians, police officers and firefighters work shifts. In many police departments, if there is a pay differential, it is very nominal. Many police departments also have a fairly rigorous on-call protocol under which any police officer may be called back for an emergency. Firefighters typically work 24 hours and are then off for 48 hours. I propose that the fee-for-service application to a “public good” is quite fragile and is a privilege.

It is an inescapable fact that medicine as currently provided must stand on its own financial feet; hence, it is a business. Disease and injury are inevitable and health care represents 16 percent of our gross domestic product. Physicians are a small part of the total labor/professional component of the health care industry. In a very real sense, we are a profession within a business. The nonphysician administrators of the health care business (insurance executives, hospital administrators, administrators within clinics, nursing homes, and rehabilitation facilities) may not appreciate the uniqueness of medicine’s relationship to our community and to the patients we serve. In fact, as shown in Table 1, their solutions to health care reform are predictable, approached from a business perspective, and their recommendations to bolster profit do not always take into account what is best for the patient. Nevertheless, within the medical profession, it is imperative that we adhere to the ethics of our profession and maintain our commitment to our patients.

Our colleagues within the business community are making a gratifying effort to reform “the world of problems caused by greedy corporate executives.” A “watchdog” organization called the Conference Board’s Commission on Public Trust and Private Enterprise has been created by concerned business leaders, including Mr. Warren Buffet. They want stricter rules on stock options and strong oversight by corporate boards over executive pay. This pay should be linked to long-term company performance. The group also recommends that companies charge stock options as an expense, whereas others recommend doing away with this “perk” altogether.

I assert that we need a similar group within our national organizations to provide oversight/recommendations on the ethics and business components of medicine. This oversight committee must recognize the unique requirements of an academic health center in teaching values and ethics to health professionals. Committee members should include individuals representing academic medicine and should be drawn from organizations such as the American Association of Medical Centers or the Institute of Medicine.

I further believe that professional organizations,
such as the American College of Surgeons, must address greed within the profession and identify lack of commitment. How much is a physician worth? In the past, many professional societies have refused to address this issue. When (not if) our country adopts a single-payer health care system, will professional organizations continue to ignore this issue? Will the professional societies become “unions for professionals?” Would it not be better for professional societies to establish rules or recommendations on night call in the hospital or at home? Should all surgeons participate in this call, or just the ones who work in large health centers?

Finally, I believe the College and other professional organizations must take a firm stand in academic health centers to protect that which is noble and right about medicine. There will be inevitable conflicts between the business of medicine and the values of medicine. How can one teach the ethics and values of medicine if one does not practice them? Under our current health care paradigm, 40 million Americans do not have equal, comfortable access to health care. The public expects doctors to provide charity care; if we do not, we have abandoned our principles and sacrificed our ethics to “business.” Our professional societies can and must serve as effective “watchdogs” for our profession.

References


Dr. Trunkey is professor of surgery, Oregon Health & Science University School of Medicine, Portland, OR.
Counterpoint: What price commitment?

by Charles D. Mabry, MD, FACS, Pine Bluff, AR

Let me begin by stating the obvious: Dr. Trunkey is a true icon of American surgery. He has contributed far more to the development of trauma delivery, trauma research, and to surgical education than most surgeons could ever imagine. Certainly, he already has done much more for surgery than I ever will. So, I approach writing this counterpoint to his article with great humility.

Dr. Trunkey has written a challenging piece, in which he claims American surgery and surgeons have undergone an erosion in terms of both our “ethical values” and our collective “personal commitment to the profession.” He outlines several economic theories that link, through hypothesized cause and effect, the increased government funding of American medicine in the last century with the increase in costs of today’s medicine. He then correctly points out that academic health centers (AHCs) have had to change significantly in response to the increased cost of medical care delivery and the resulting pressure of today’s market forces. Dr. Trunkey goes on to suggest that medicine in America is a specific economic item—“a public good,” quoting a host of economists who feel that “efficient provision of public goods ought to be accomplished free of charge.” He then compares work hours and pay of physicians with those of police officers and firefighters. Then, if my eyes don’t deceive me, he argues that some, if not all, surgeons’ salaries are too high in relationship to our worker comrades, he laments the creation of ambulatory surgery centers (ASCs), and he bemoans the concept of hospitals paying surgeons to take call. Finally, he asks for “our national organizations to provide oversight/recommendations on the ethics and business components of medicine” and asks the College to “address greed within the profession and identify lack of commitment.”

I don’t know if it’s me or my new glasses, but I don’t recognize a darn thing in Dr. Trunkey’s picture of American surgery. What he sees is certainly not what I see. I guess it has got to be these glasses.

My perspective

I have a completely different view of American surgery and of the individuals who comprise the majority of the surgical workforce. I also have an opposing viewpoint on the interplay of government funding, business, and medicine. It could be that actually Dr. Trunkey and I are seeing exactly the same things but from very different perspectives.

Unlike Dr. Trunkey, who has been in academics all of his career and who practices at an AHC, I am a general surgeon from a mid-sized town in mid-America. I have practiced at a 300-bed community hospital for the past 20 years and am fortunate to have good surgeons with whom I work and share call. I also am involved with the business side of medicine. First, I manage
my own solo surgical practice. Further, I spend one day a week as a practice management advisor to the chair of the department of surgery at the University of Arkansas for Medical Sciences. I know firsthand the challenges facing academic surgery and AHCs and work constantly to help our state’s academic surgeons respond to those concerns.

I also have had the distinct privilege for the past 10 years of serving with some of the brightest and hardest-working Fellows ever as a member of the General Surgery Coding & Reimbursement Committee of the College. In this role, I get to interact with many surgeons from across our country, both in academics and private practice, as well as those in other surgical specialties, as one of the College’s representatives to the AMA Relative Value Update Committee, which deals with coding and reimbursement issues. Finally, I helped develop and teach the College’s new Practice Management Course, which is presented four times yearly at sites throughout the country. This course is designed to help private practice and academic surgeons manage their practices more efficiently. During the course, we work with surgeons from small and large practices and hear the problems they face daily in their practices.

Now this “business” is all very well and fine, but, for the most part, I get up in the morning, put on my scrubs, operate, go to the office, take call, and treat patients like the rest of you. So, taking all of those experiences into account, I feel that I can speak with some credibility about what American surgery looks like and, more importantly, what type of ethics and personal commitment our Fellows exemplify. I truly can say that I do see things a lot differently than does Dr. Trunkey. Let me share with you what I have seen and how differently I interpret some of the “problems” of concern to Dr. Trunkey.

Commitment

Let’s take oaths for starters. The surgeons that I see all epitomize the Hippocratic Oath that they took by giving of themselves. The ones who I know and work with treat the sick with compassion. They routinely neglect themselves and their families to make sure that their patients receive appropriate care.

I, for one, make no apologies for surgeons receiving their current pay. I have checked my copy of the Oath of Hippocrates, and the others quoted by Dr. Trunkey, but none of them involves us taking the oath of poverty. Given the lifestyle and sacrifices that surgeons make, society instead should value them more, not less. In fact, speaking of oaths in America, the most common oaths that I hear sworn today (and downright cussing from some), are from surgeons who work 80-plus hours a week, and then have to turn around and write letters requesting reviews of denials for legitimate claims.

As for caring for the poor, no group of professionals is more generous or charitable than surgeons. Using general surgery in my state as just one example, the average Arkansas surgeon took care of 12 percent of their patients for free this past year. Not only was the surgeon’s labor provided for gratis, but surgeons also bore the cost of seeing those indigent patients in their offices and clinics, which meant that they paid for their office and nursing staff, supplies, and malpractice insurance in order to see and care for these patients. This generosity alone speaks much more eloquently than either Dr. Trunkey or I can to the high level of ethics and commitment exemplified today by American surgeons. Try getting that much charity out of some other professions.

Economics

Now let’s discuss economics and those economists who proffer opinions about the cost of medicine and workforce issues. Dr. Trunkey’s citations remind me of two wise quotations: the common aphorism, “Economics is the one science that makes astrology look respectable”; and George Bernard Shaw’s famous statement, “If all economists were laid end to end, they would not reach a conclusion.” In this instance, I would certainly disagree with the economists’ conclusions that the government-funded medical advances of the past few decades are bad. Personally, I am glad that our government funded research to discover new ways of treating illness. I am glad that we have produced more physicians and surgeons, particularly in light of the fact that as the Baby Boom generation (of which I am a member) ages and needs care, we hope-
fully will have enough physicians to go around. And, I am not sure who would oppose covering the elderly and indigent with health care insurance through the passage of Titles XVIII and XIX of the Social Security Act. That outlay is a perfectly marvelous use of our tax money. Now, there is little disagreement that some of the increased cost of medicine is due to improvements in medical care and innovation. But let's get real here: who among us doesn't want these improvements? I surely want those advances for my family, and I suspect that even these economists will want them when illness strikes close to home.

One great part of the increased cost of medicine is related to the expenditures and costs associated with complying with legislative mandates and malpractice prevention. Think about how our hospitals, anesthesia, and surgery have all had to change over the last few decades due to the worsening malpractice environment and the passage of burdensome laws, such as the Americans with Disabilities Act, the Emergency Medical Treatment and Active Labor Act (EMTALA), and the Health Insurance Portability and Accountability Act. Very little of the increased cost in medical care related to these changes has anything remotely to do with surgical fees or how surgeons care for their patients. Physician payment and the operations surgeons perform really don't affect the bottom line of America's health costs to any great extent. In the final analysis of rising medical costs, surgeons are really only bit players in a much larger drama.

Payment and workforce

Let's now go back to the topic of surgeon pay and the supply of surgeons. If the economists think that we have produced too many surgeons or that we are paying them too much, they need to come to the part of America I know. I just don't see what they are seeing. There is no disagreement that surgeons are now paid proportionately more than surgeons were at the turn of the last century. But, consider how much more knowledge surgeons now must master, the length of training they must endure, and the more difficult environment in which they now practice.

Many surgeons believe that we are running out of good, experienced surgeons and are doing so at an alarming rate. This situation is felt to be the result of a whole generation of surgeons retiring early or leaving medicine due to the combined pressures of increased malpractice claims and decreased reimbursement. And it appears that fewer medical students are choosing surgical careers, especially in those surgical disciplines that require long residencies and long hours of work after residency. Why? It is simple math. The Medical Group Managers Association* and the American Medical Association Socioeconomic Survey† indicate that the average private practice general surgeon works about 60 hours per week, 48 weeks per year. If you divide the average salary for a surgeon by the average weekly hours worked (assuming time-and-a-half for overtime), the average surgeon's pay per hour comes out to roughly $74.40 (see the table on this page). Offset that salary with the increasing risks posed by AIDS, hepatitis B, or malpractice. Throw in the calculus that in order to become a surgeon one has to spend at least five years after medical school earning nominal wages before he or she may begin to earn this princely sum of $74.40 per hour.

Who could resist such an attractive offer? It is

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no wonder that fewer people are choosing surgery. Even more astounding is how many of today’s talented and hardworking surgeons still remain at the helm, despite all the obstacles that are thrown their way. That is all the more reason why I couldn’t disagree more with Dr. Trunkey’s premise that American surgery suffers from eroding ethics and lack of commitment and that surgeons’ primary focus is on earning money. Quite the contrary: in what nonmedical profession would you find such work and devotion for such a low wage?

Business’s influence

Dr. Trunkey gives three examples of the bad influence that business has upon medicine: AHCs, call pay for surgical specialists, and the increasing number of ambulatory surgical centers. Once again, I see something completely different happening in each area.

AHCs have come under pressure to change in the past few years. The assumption from some in those AHCs is that this change is all for the bad. However, when viewed from outside these AHCs, the question being asked is simply this: how can society and government most wisely spend money to educate new doctors, create new knowledge, and provide highly specialized medical care? Do we need to re-examine how that money is currently being distributed and spent? If we do spend money for scholarly activity, should we ask AHCs to be more accountable for that capital investment? Money for education and health care is scarce, and progressively derived from a patchwork of many new sources other than the government, including the hospital. As a result, AHCs are being benchmarked against other educational and health care organizations. New experiments are being tried to educate students and care for patients more efficiently. This change does indeed induce academic discomfort and dyspepsia. But, many feel that these questions and changes are long overdue. We don’t know where all of the answers lie for academia; but we do know that the answers cannot be found by feverishly clutching onto yesteryear.

The real challenge for AHCs, I believe, will be to retain their hardworking and dedicated academic surgeons, and not drive them off by urging them to fund the remainder of the nonsurgical faculty. Even golden geese have limits on their ability to lay golden eggs. Medical schools will have to look inward and ensure that funds are being distributed fairly among the faculty to support teaching. Deans and presidents can no longer avoid right-sizing large, bloated faculty, or making each academic department stand on its own merits. Dr. Trunkey calls on the College to “take a firm stand in academic health centers on protecting what is noble and right....” However, who is to say what is noble? What looks noble and right to one person is clearly seen as oversized and inefficient to another. National organizations such as the College shouldn’t get involved in the business of keeping inefficient or duplicative schools afloat. The institutions themselves will have to do their own heavy lifting in this area. The College has enough other problems to worry about.

Most surgeons take their turn at call without pay. They do so with only a modicum of complaint and, therefore, support their local hospitals and communities for free. That is the way it has been in the past, and it has worked all very well and fine. However, the passage of EMTALA has changed the dynamics for those hospitals designated as receiving hospitals. The statute and the regulations provide that any participating hospital that: (1) has “specialized capabilities or facilities” such as burn units, shock-trauma units, or neonatal intensive care units; or that (2) is a “regional referral center” in a rural area may not refuse to accept a patient in transfer, if it has the capacity to treat the individual [42 USC 1395dd(g); CFR 489.24(e)]. The receiving hospital is obligated to accept the transfer in most cases, so long as it has the ability to treat the patient and its capabilities exceed those of the referring hospital. Thus, receiving hospitals must ensure that surgical specialists are available to supply those specialized services. Amazingly, EMTALA has even been interpreted by some to dictate the minimum amount of call that these specialists must take and to limit which procedures they can do while on call.

As the risk of being involved with malpractice suits has climbed, and the cost of malpractice insurance has risen logarithmically in response,
surgeons have begun to ask to be compensated for this governmentally mandated and structured call. This situation is far different than the one that existed years ago when the Pontiac Plan or even the guidelines for trauma centers were first instituted.

This current phenomenon is simply the result of the law of supply and demand. Think about it this way: if surgeon reimbursement were adequate for such procedures, if the malpractice risk were reduced, and if there were an oversupply of these surgical specialists (as some of the economists have theorized), we would have them all begging to take call, for free. However, due to the continued drop in reimbursement for surgical services over the years, coupled with the sharp rise in malpractice costs, it is no wonder that hospitals (and through them, the federal government) are being asked to offset the increased work and risk associated with such call. In fact, I anticipate that this trend will not only continue but increase if the mismatch in surgeon reimbursement and malpractice risk/insurance is not corrected. Dr. Trunkey questions the surgeon’s commitment in this instance. I counter that we should question the commitment of our government to fairly pay our surgeons for the labor that it legislatively imposes upon them. We simply are not asking the correct question in this instance.

ASCs are obviously another point of concern for Dr. Trunkey. There is no doubt that somewhere out there some ASC is running amuck and abusing the system. However, I believe that this situation is the exception, rather than the rule. Where I practice, ASCs have been a good development for both the patient, hospital, and surgeon. Their establishment has been a true win-win-win situation. Dr. Trunkey even says, “...these centers do reduce the costs compared to hospitals and may provide better service/convenience to the patient.” Who could argue with results such as that?

Now, Dr. Trunkey refers to this outcome as a paradox. I would think of it not as a paradox but as a perfectly logical result. This difference may all be in the perspective of the viewer. In our community, for example, the ASC is jointly owned and operated by the hospital and surgeons. The surgeons have helped reduce the costs of operating the center, hospital management has also learned a few new things about how to manage an operating room, and as a result, the patients have benefitted from reduced costs at the ASC.

Yes, the surgeons have gotten some income from their investment in the ASC, but the hospital also is happy because it is part of a successful venture and its income has increased. The story gets better: the lessons learned have extended over into the hospital. Our hospital operating room has adopted some of the cost-savings measures developed for the ASC, our surgeons are now much more willing to change their habits to provide more efficient care and save the hospital money, and overall operating costs have declined with better patient care as a result. We are not an isolated example, but very typical of this movement toward ambulatory surgery centers. Bottom line: if a hospital or institution is not joint venturing with their surgeons, then both parties may be the losers, as they both have much to learn and gain from such cooperative ventures. It follows that if hospitals and surgeons cannot cooperate and work as a team, then the ultimate loser will be the patient.
Public good
Finally, let’s discuss the economic theory that medicine is a “public good.” There is no question that medicine is good for the public and that countless lives have been saved by modern medical miracles. However, equating and comparing the complex training, skills, and judgment required of a surgeon with those of firefighters and police officers is simply ludicrous. I’m not going to bother arguing that point. But, don’t forget that surgeons have to run offices—pay for their supplies, malpractice insurance, and staff. Unlike the police and fire departments, a surgeon depends upon income from patient care, as opposed to taxes, to keep their office open and running. I have never known of a fire or police department to declare bankruptcy, but I have known of surgical practices that routinely skim on the cusp of it. The patients treated by a surgeon depend upon that person being a good businessperson. If the surgical practice is not run efficiently, then there is no money to keep the practice afloat, and it closes. Ultimately, then, the patient suffers from the mismanagement of a surgical practice. If anyone believes that medicine fits the economic theory of a “public good,” here’s a suggestion: the next time you see an economist develop appendicitis, dial 9-1-1 and ask for surgical help from the nearest local law enforcement officer.

Role of organization
Finally, I don’t disagree with Dr. Trunkey’s view, that “our professional societies can and must serve as effective ‘watchdogs’ for our profession.” But, the American surgery that I see is a profession composed of dedicated women and men, who give of themselves faithfully and selflessly. While I’m sure we all need watchdogs, what we need more desperately is help and support to continue our work as surgeons. The College can serve surgery and surgeons best by being an advocate for both the patient and the surgeon. Our profession must cope with formidable challenges and face the prospect of declining payment and rising costs. Good medicine involves good business. Good medicine and good business involve not only accepting and embracing change but, most importantly, guiding change for the better.

What do I see? I see that the American College of Surgeons is doing and can do much more for our surgeons. If we manage our health care resources prudently, pay surgeons fairly, and educate surgeons in how to navigate these sea changes, surgery should sail safely on into the next century.

Most clearly, I see that ethics and commitment is surgery’s strong suit, not our weak point. I just see things differently than Dr. Trunkey. What he sees is certainly not what I see. As I say…it has to be the glasses.

Dr. Mabry is a general surgeon in private practice in Pine Bluff, AR, and a Regent of the College.
I would like to make some general comments in response to Dr. Mabry’s counterpoint piece and to offer clarification of some of the points I raised previously.

Clarifications

I had considered beginning my article with the statement that the American health care delivery system is broken; however, I thought it was too obvious. The high cost of health care and drugs is getting worse. More than 40 million Americans are without health insurance. Malpractice costs are out of control. Access to care is unequal. These issues are clearly important, but they were not part of my central message. I would like to reiterate my two major concerns: I believe there is an erosion of our medical ethics/values and a lack of commitment on the part of some physicians.

I said, “Clearly, not all businesspeople (CEOs and CFOs) are greedy or corrupt. Indeed, most are socially responsible and contributing citizens. Similarly, the majority of physicians serve their patients and the profession admirably and are not driven by greed.” I never intended a blanket indictment against the medical profession.

Dr. Mabry states in his closing remarks, “I just see things differently than Dr. Trunkey.” I think that is true. I would hope Dr. Mabry and other surgeons who find my views controversial would recognize a number of physicians besides myself are concerned about the two central issues that I’ve articulated. If we fail to address these concerns, the associated problems will grow bigger and the crisis will widen.

I also would like to clarify the central thesis made by Ludmerer. Nobody would seriously challenge that government funding of research, building new hospitals, and funding new health care for the aged and the poor are misguided or pointless. What Ludmerer stated, and I agree with, is that these programs had unintended consequences that contributed to increased costs in health care delivery. Please don’t shoot the messenger.

I also presented the argument that some economists consider medicine a public good. Clearly, there are differences between a physician and a firefighter, police officer, or soldier with regard to the amount of time and money each spends on education in preparation for their profession. How much is this worth to society? Does a physician have more value to society than a soldier? Maybe. But what is it worth? I personally do not believe general surgeons are paid excessively. That was not my point. My point was that if we don’t address concerns about annual incomes being too high, we risk the condemnation of society when they determine it is excessive.

Other issues

Dr. Mabry raises several issues in his counterpoint that I had not addressed and, yet, are important. For example, without question we need tort reform. Malpractice litigation does contribute to the high cost of medicine and is out of control. I cannot fix the ethics/values of the legal profession, but I do want to address these issues within the medical profession. If President Bush succeeds in capping medicolegal claims, it would be a boon to the profession and society. We in the medical profession must then make sure that these reductions in malpractice costs are passed on to our patients.

Dr. Mabry also raised the issue of decreased reimbursement. Payment is a concern, and I appreciate his work and effort to correct this.
I would like to clarify another issue Dr. Mabry raises. He claims, “The majority of surgeons in America take their turn at call without pay.” I do not believe this is true. Bishop and Associates have examined the extent of those specialty surgeons who now want the hospital to pay them to be on call at home. This represents a fairly dramatic change from 10 years ago. I illustrated my concern through two graphs, but there is more information from the source.* The American College of Surgeons (ACS) could use these data to confirm my concern or they could work with the American Hospital Association to see whether physicians are willing to take call. I believe that most hospital administrators feel that they are being extorted. I wish to clarify further that those surgeons and anesthesiologists who stay in-house to be on call richly deserve some type of compensation.

Dr. Mabry also says my editorial “lambastes the creation of ambulatory surgery centers and bemoans the concept of hospitals paying surgeons to take emergency call.” I think this accusation is unfair on both counts. As already noted, I support the concept of some type of compensation if the call is taken in-house, but I do not support it if the surgeon is at home.

I do not believe that any of my comments “lambast” ambulatory surgery centers (ASCs). My concern is whether ASCs also have unintended consequences. The studies by Schumacher suggest that hospital administrators are having difficulty covering the emergency room with certain specialties. I believe that further study either by Schumacher or by the College would support the argument that surgical specialists are often absent from the emergency room. Is this a cause and effect because of the ASCs? The shortage of specialists in the ER will obviously require more study, and it is undoubtedly caused by many factors.

Ethics and business

I would challenge Dr. Mabry to categorically state that there are no problems with ethics, values, or commitment in surgery. I had not intended to give specific examples, but I think it would be worthwhile to give at least one: the Lupron scandal.† TAP Pharmaceutical is a joint venture between Takeda Pharmaceuticals of Japan and Abbott Laboratories, which has marketed Lupron in the U.S. Lupron is a drug designed for control of prostate cancer. TAP provided free samples to physicians/urologists knowing that a charge would be submitted to Medicare. TAP also provided 2 percent management fees to high-volume urology practices. In addition, unrestricted $25,000 “research grants” were given to urologists for education. TAP also paid for lavish entertainment and trips. After a four-year investigation, Takeda Pharmaceutical Industries has struck a settlement deal with the U.S. Justice Department for $875 million. At least six employees now are charged with conspiracy and kickbacks to physicians and surgeons. Four urologists have pleaded guilty to statutory penalties; however, they may receive probation in return for having cooperated with the government investigation. Two other urologists have already been granted probation in return for forfeiting more than $1 million in profit and agreeing to provide free care to indigent patients. Although I could cite multiple other examples, it wouldn’t serve a useful purpose to belabor my concern. Hopefully, I can convince Dr. Mabry that there may be a role for the ACS to serve as a watchdog.

Dr. Mabry states in his closing remarks, “Good medicine involves good business.” I could not agree more. That is why I have recommended that physicians/surgeons be appointed to organizations such as the University Hospital Consortium and the Association of Academic Health Centers to ensure that our values and ethics are not infringed upon by some of the business strategies in academic health centers and large community health centers. In many ways, the College is the ideal professional society to represent surgeons and patients. Working through the American Association of Medical Colleges, the ACS could defend our ethics and values in the academic health centers that have initiated business plans that are problematic or contrary to our professional values. I would like to reiterate that it is impossible to teach ethics when one does not practice them.


I appreciate Dr. Trunkey reviewing and responding to my counterpoint article. It is a bit challenging to decide which of his commentaries to address in this final part of the debate because his opinions are much more focused, reasoned, and tempered in his response than in his original article. Rather than the broad brush used in his main article, he now paints a slightly different picture with a smaller brush and finer strokes.

However, Dr. Trunkey consistently holds to his two primary concerns: the erosion of ethics/values and the lack of commitment on the part of physicians. I am pleased that he clarifies his concerns on these two issues by further noting that these vices afflict only a minority of physicians. In his response, Dr. Trunkey also brings out several areas to which he feels that the American College of Surgeons (ACS) should be investing more time and effort.

Rather than bore the reader with my thoughts on what we each think we said, I would prefer to devote this commentary to the essence of what I think the ACS should and should not do to address some of the important issues that we each have identified.

The ACS has many challenges to face over the next several decades, and resources are limited and precious. The College obviously cannot right each wrong. Therefore, to best represent patients and the Fellows who care for them, it is essential that the College pick and choose wisely which problems it will tackle. I hold that the College should put its primary emphasis on the issues that most adversely affect the majority of patients and surgeons, and not on issues that may involve a few bad apples. What, therefore, is the College doing about these issues, and, more importantly, should it be doing more?

**Ethical Surgery**

The ethics of surgery happens to be one of the most important and favored issue of the College.* The Board of Regents established the Regents' Committee on Ethics many years ago to address ethical issues that Fellows encounter. The College hosts an annual lecture and devotes ample editorial space to discussing and educating Fellows about ethical questions they may face. The Ethics Colloquium at the 2002 Clinical Congress covered the timely topic of “The Ethics of Entrepreneurialism in Surgery” and included a thorough discussion of some of the deplorable exploits Dr. Trunkey mentions.

The Fellows of the College, through various committees, have spent much time, deliberation, and discussion in arriving at important conclusions about past and current ethical issues. These are summarized for the Fellows and published in the Bulletin, in the form of the various statements of the College and College guidelines. Important recent College directives of this type have been: “Guidelines for Collaboration of Industry and Surgical Organizations in Support of Research and Continuing Education,” “Statement Regarding Clinical Trials,” and “Statement on Ethics in Patient Referrals to Ancillary Services.”†

Dr. Trunkey hopes to convince us that the ACS should “serve as a watchdog.” I don’t necessar-

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ily disagree with him, and this concept certainly sounds good in theory, but what does he mean? What else does he want the College to do? We can teach morality, but I don’t think we can mandate morality. For example, any or all of the statements mentioned previously, if taken to heart by the infamous “Lupron surgeons,” would have averted this ethical public debacle. However, there will always be a few in any group, organization, or profession who don’t want to follow the rules of society or ethical guidelines of organizations. It is for this reason that we have prosecutors and prisons. And in the case of the Lupron surgeons it is good that these punitive systems are in place, because those individuals richly deserve some time behind bars.

In his closing line, Dr. Trunkey says, “It is impossible to teach ethics when one does not practice ethics.” I am not sure to whom he is referring. If there is any doubt about the commitment or the involvement of the ACS on ethical issues, I encourage the reader to browse through the following section of the ACS Web site (http://www.facs.org/about/committees/ethics/index.html) and decide individually. It is a very impressive display in both breadth as well as depth of the high ethical standards Fellows of the College are expected to uphold. As for the Fellows, the ones who I know and have come in contact with could easily qualify as Professors in Ethics, if “ethical practice” were the criteria for teaching this particular course. In my opinion, there is no finer group of women and men out there in this regard.

The critical question, however, is whether the ACS should do more than it currently is doing on ethical issues. To me, the answer is no. We can only do so much, and the thought of our College becoming some type of “watchdog” is where I draw the line. What would we watch, and whom would we choose to bite? And whom would we appoint to determine how to handle all those shades of gray that will inevitably be out there? We are an educational organization, not an arm of law enforcement. New ethical dilemmas will constantly crop up, and rest assured that the College and the Fellows stand ready to discuss and deliberate the proper solutions to those predicaments—as we have done all along.

Lack of commitment

Dr. Trunkey uses as a prime example of lack of commitment by surgeons the practice of hospitals paying surgeons to take call. Here is a typical example of how this “problem” evolves in a community. Hospitals A, B, and C are located in the big city of Megalopolis and have on staff surgeons in all of the various surgical specialties and subspecialties. Surgeons in Megalopolis primarily operate at hospitals A and B and, to a lesser extent, in hospital C. Remember that EMTALA now requires every hospital to have a surgeon on call for unassigned patients, if it elects to offer that particular surgical service to the public. Therefore, in Megalopolis the surgeons are torn between taking call at all three hospitals or dropping one or two hospitals from their practice to meet all the demands of unassigned call, group call, and so on. As a result, hospital C finds itself without any orthopaedists, neurosurgeons, and/or general surgeons. Hospital C wants to increase its market share and census by also offering these specialty services at its facility. Purely as a business strategy, hospital C then approaches and agrees to pay surgeons to take call, so that it can offer these services to the public. Make no mistake, the aim of hospitals A, B, and C is to make money, and to do that they all have to offer certain services that have EMTALA-mandated call-coverage requirements. The surgeons taking obligatory call are just caught in the crossfire between the federal government and the hospitals.

To summarize here: a hospital pays a surgeon to perform a service that may or may not involve actual patient contact. The surgeons’ revenue is supplemented by hospital revenue. Is this arrangement proper, moral, and just? In this instance, what is the appropriate role of the College? Should the College insert itself between the financial arrangement of the surgeon and hospital by issuing some sort of national edict? Wait, don’t answer yet. First consider this similar but more common and timeworn situation that involves academic surgery and the relationship between hospital(s) and academia. Many institutions have complex revenue-sharing relationships, in which funds from physicians are diverted to other academic depart-
ments, physician revenue is supplemented, or physician costs are offset by the hospital. There are many instances of “directorships” in which a surgeon’s income is supplemented by the hospital for the surgeon performing some administrative duty. Nurses or other personnel are often hired by the hospital but work for the surgeon, and, as a result, the surgeon (or surgical department) gains financially. This type of hospital supplement to an academic surgical department is very common, and may even occur at Dr. Trunkey’s institution. Let’s again summarize here: Hospital pays a surgeon to perform a service that may or may not involve actual patient contact. Revenue of surgeon is supplemented by hospital revenue. Is this proper, moral, and just? What’s the real difference between the two scenarios? In neither instance do I find the surgeon nor the hospital morally bankrupt. I find no lack of commitment on anyone’s part. From my viewpoint, there is no harm, no foul.

The bottom line of this discussion: financial arrangements are made thousands of times per day between surgeons and hospitals. They are made for sound business reasons and persist in today’s environment because they serve a purpose. I have trouble distinguishing between these two scenarios. They both involve payments for services rendered. However, in either instance there are critical questions that we should be asking: has the good of the patient been compromised by this financial arrangement? If so, then most assuredly, the ACS needs to be front and center in the debate, arguing for good patient care. If not, then I believe there are many, many more urgent and pressing issues that the College should be devoting time and effort to solving.

Conclusion

It is critical that the College be involved in issues that affect patients and surgeons. But, it should prioritize and devote its time to those problems that are both common and, as importantly, that it can reasonably be expected to do something about. The College is doing many things for today’s surgeon to ensure that our patients have good surgical care now and in the future. I do agree with Dr. Trunkey that the College needs to expand its data collection and analysis of these various practice parameters, such as numbers of surgeons taking call, lack of call coverage for surgical subspecialties, and so on. Those data are essential to helping the College become more responsive to new problems as they develop and to gauge important trends in such areas as physician supply, training, and research. The challenges facing today’s surgeon are great. Development of new educational programs, publication of surgical and ethical standards, increased involvement in socioeconomic affairs, and assistance in improving reimbursement for surgeons are all important parts of that effort now being led by ACS Executive Director Thomas R. Russell, MD, FACS, and the Regents, Governors, and Officers of the College.

From my viewpoint, the ethics and commitment of American surgery and the Fellows, while not perfect, stands heads and shoulders above all other professions. They are our pride, not our shame.
The quality imperative

New tools and expanded responsibilities for surgeons

by
LaMar S. McGinnis, Jr., MD, FACS, Atlanta, GA, and Barbara Cebuhar, Division of Advocacy and Health Policy

It’s difficult for many of us in practice to comprehend the speed and intensity of the health care quality measurement and public reporting movements. The combined pressures of increased expenditures, soaring medical liability premiums, and patients’ perceived threats of harm have created an overarching imperative to improve quality, control costs, and help patients become better health care “consumers.” Payors and consumer activists are insisting that physicians and other providers become more accountable for the quality of medical care they deliver.

In response to these demands, policymakers are seeking ways to show that access to high-quality, affordable care is possible. This year they hope to make it easier for consumers to access public quality reports for nursing homes and home health care. These reports allow patients to compare performance measures of facilities and make educated decisions about where to seek care. However, the challenge lies in defining what works over time and when there are fewer financial resources and higher patient expectations.

A surgical tradition

The College has been at the forefront of the quality improvement movement since 1913, when it was founded to set patient care standards and uphold the enduring ethical principle of “first do no harm.” Ernest A. Codman, MD, FACS, though shunned in his day for his insistence on tracking outcomes, proved that surgery could measure and police itself. Surgeons were the first clinicians to talk directly to patients about cancer treatment options in a consumer publication, such as Ladies’ Home Journal. In 1915, the College hosted forums throughout the U.S. to talk about early detection and to identify cancer treatments that helped increase survival rates. Then in the late 1920s surgeons once again became patient advocates, insisting that hospitals and surgical suites meet acceptable standards of care. This effort set the foundation for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Since the early 1940s Fellows have developed systems to improve our ability to monitor and identify effective treatments for cancer. Then in the late 1960s, as it became clear that early intervention for trauma patients within “the golden hour” meant a higher survival rate, the
College worked to certify and train members of state networks. Ever since, the College has been committed to tracking what worked best for care and survival of the trauma patient. Fueled with the data, the College has helped develop responsive, statewide networks to secure the best quality of trauma care for our patients at every step of the emergency response process. Our vision for the future includes further analysis and expansion of two benchmarking tools—the National Cancer Data Base and the National Trauma Data Bank™—so that patients and clinicians can identify areas for improvement, as well as set best practices.

**Drivers of the movement**

In the last decade, a convergence of factors has driven health care policy. In 1999, the Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, challenged the entire American health system to develop a better way to protect lives. Subsequent reports from the IOM and purchasers have caused a ripple effect, increasing the cry for a more transparent quality improvement and public reporting system. The continued drumbeat about “risks” that exist within the system, coupled with increased consumer expectations about good outcomes, has stunned medicine and may have undermined the confidence that our patients have in our judgment. What caused this shift in the patient care landscape, and what is the College doing about it?

At the end of the last decade it became increasingly clear to policymakers that previous attempts at reform had failed. Managed care was unable, over time, to both control costs and assure quality. The statewide health plan implemented in Oregon suggested that health care services and funding could and should be prioritized, but that system, too, failed to control costs.

These and other health care reform efforts of the early 1990s were frustrated by the inability to retrieve useful outcomes data from health care information technology systems designed to account for claims. Effective use of resources, we found, depended on a more well-informed and engaged patient, as well as the ability to stay current with fast-paced innovation, develop thoughtful treatment plans, effectively manage a practice, and so on.

**New expectations**

Today, payors are asking the medical professions to be more forthcoming with data, measuring their performance and ultimately being held accountable for the quality of care provided to their beneficiaries. Accountability means something different to each stakeholder. Many physicians have been surprised by the tacit challenge to their commitment to providing the highest quality care. It has become increasingly clear that few policymakers and consumers understand the rigorous requirements for board certification or membership in many professional organizations. Fewer still understand the rigor required and the ongoing education efforts provided by Fellowship in the College, or the scrutiny peers offer on our caseload and experiences during surgical services reviews and in morbidity and mortality conferences.

Instead, purchasers are reacting to the steady climb in health care costs. Once again, they are looking at ways to “buy better.” Their position: set standards for care, remove wasted efforts and cost from the system, direct patients to the known high-quality providers, and apply volume-based purchasing theories. The expected result: better quality for patients and lower costs for purchasers. While some of these principles have worked well to improve efficiencies on the assembly line, patient care doesn’t always lend itself to following specific standards. Patients’ needs, conditions, and circumstances are too varied.

The idea of measuring and reporting quality makes good sense. But defining and implementing the “ideal” quality principles have become increasingly difficult. Medical standards and practice have become more sophisticated in less time. The half-life or turnover of medical information and technology has compressed to four years. More patients survive longer, and in the end require more expensive care. The complexity of care, the proliferation of lifesaving technology, and the scarcity of our resources come together in what seems to be a “value” collision course. Yet, purchasers have not been forthcoming in offering to pay for the additional data collection and analysis. Hospitals burdened with providing more than 30 performance measures want surgery to define three or four comprehensive (and timeless) measures of quality to track over time. It becomes even more
important for all the stakeholders to sit down and determine what will provide the highest value for our society and, ultimately, what it is worth to each of us.

**Culling the pearls**

To achieve some consensus on what constitutes quality, the country's largest purchaser of health care services, the Centers for Medicare & Medicaid Services (CMS) is encouraging an informed discussion among all the stakeholders—consumers, payors, health service researchers, physicians, and other providers.

The National Quality Forum (NQF), a private sector offshoot of the national health care reform efforts, was established to encourage that discussion of the overarching quality standards in health care with all perspectives at the table. NQF's mission is to develop consensus on what medical insiders understand to be quality care and to translate that information to the public. The difficulty has been in defining quality and determining what sort of comparative information is useful to patients as they select providers of elective care. Perhaps one of the fundamental sticking points in this quality discussion has been the process of collecting meaningful data, without burdening the health system any further. To some activists, bad data are better than no data. Based on our 90-year history of assuring quality, the College is of the contrary opinion that only decisions based on sound data are in the best interests of the patient.

Many clinicians, however, have been frustrated by the pressing urgency to report data that aren't reliable. It is not that they are unwilling to come forward with that information, but their training and commitment, aimed at ensuring that patients have accurate and meaningful data, means a dedication to fully validating any procedures that will affect their patient. So, while each of us knows there is a relationship between quality, safety, and cost, it has been difficult to retool the delivery system and get the data that will help us uncover wasted resources and to identify obstacles to providing the most effective therapies and systems.

It doesn't have to be such a conundrum. Surgery has never lost sight of our fundamental responsibility to be the patient's quality care advocate. In addition to ongoing work in cancer and trauma, last year the College received a $5.2 million grant from the Agency for Healthcare Research and Quality (AHRQ) to further validate the Department of Veterans Affairs (VA) National Surgical Quality Improvement Program (NSQIP) in 14 private sector hospitals.

NSQIP is an exciting, risk-adjusted, surgical outcomes "registry" and benchmarking effort that is credited with improving mortality rates by 27 percent and the morbidity of cases by 47 percent in 122 VA hospitals. This system has been at work in the VA since 1996 and provides pre-, peri-, and postoperative observations of all surgical patients and conditions for up to 30 days after a procedure. Shukri Khuri, MD, FACS, and the many surgeons who designed the system realized that it needed to provide risk- and complexity-adjusted outcomes that could be compared to national averages. Speciality trained registered nurses, biostatisticians, and surgeons collect and analyze the data, which are entered into a Web-based collection and benchmarking system. The resulting sets are risk-adjusted and compared with information in a database of more than 900,000 patients.

Once the information is processed, the surgeon and the surgical service are able to compare their observed versus actual outcomes experience (o/e) with the national average and comparable hospitals. Additional research on the NSQIP system suggests that the national database offers us the information necessary to identify outliers. It also suggests that when volume without risk adjustment is used as an indicator of quality of care, in 60 percent of the cases the patient could have been sent to a lower performing facility. In addition, comparison with national data sets serves to highlight costly practices and may be used to predict the likelihood of difficulties for particular patient profiles and procedures.

The challenge for the College and the VA was to show that the system worked with a non-static population. The three initial test sites—Virginia, Kentucky, and Emory University in Atlanta, GA, showed that the system worked with populations not represented in the VA. As part of the grant, the College has engaged 11 additional private sector centers in Michigan, Missouri (St. Louis University and Washington Universities), Utah, Florida, California (University of California, San Francisco), Maryland, New York (Columbia and Cornell Universities) and Massachusetts (Massa-
chusetts General Hospital) to put NSQIP to the test. After one year, the investigators are pleased with the tests of the program’s risk adjustment, data collection, and benchmarking capabilities in hospitals that serve a broader population than typically reflected in the VA systems. While preliminary results will be reported this spring, principal investigator Dr. Khuri and the site investigators believe that this model could provide a data collection system for the entire surgical profession. This kind of system has the prospect of serving, in very much the same way as the tumor registry program that the Commission on Cancer of the College coordinates with the American Cancer Society, as a comparative quality-improvement database. The investigators, while concentrating on providing meaningful data to surgeons, understand the need to explore how the public might use the information to assess the strengths of a surgical service. National leaders in the health care measurement and public reporting arenas, as well as large health plans, are very interested in NSQIP, and we are currently pursuing opportunities to validate it further.

A long-term situation
In the meantime, it is essential that surgeons understand that the public reporting movement will not go away. Purchasers are demanding greater transparency of what is meaningful and why in health care. They want to understand the data that medical insiders consider when evaluating care. The College’s Division of Research and Optimal patient care is committed to developing promising improvement systems and expanding the use of current College data sets.

To set a well-informed course for the measurement and reporting of quality surgical care, the College will be hosting a meeting of the leadership of the Surgical Specialty Societies in March. The group will hear from all the stakeholders involved in this national effort and hopes to develop principles that will guide surgery’s efforts in the legislative and regulatory arenas. While no bills are pending in Congress, the College’s Health Policy Steering Committee’s workgroup on quality and patient safety is mindful of the intense pressure to develop report cards, as well as workable and meaningful standards that the public may use to evaluate and purchase health care. CMS has been charged with finding meaningful standards that can be implemented within the calendar year. AHRQ will be releasing the National Quality Healthcare Report this fall. The subcommittee will continue to assess, monitor, and advocate on behalf of surgeons in this arena. In the months to come, we hope to continue our role by convening several work groups to address the issue of what information is meaningful for surgeons to report and for their patients to use in evaluating quality of surgical care.

Despite the upheaval in health care, the College is prepared to maintain its historical role as the patient’s quality advocate. We look forward to the results of the NSQIP trials in these health systems. We also hope that in the months ahead, more surgeons will help legislators and regulators understand what it will take to bridge that gap between what we know is clinically valuable and what our patients want to know about the quality of the care they receive.

For more information about the College’s continuing efforts to measure quality of patient care and application of standards, please go to http://www.facs.org/oebs/otherendeavors.html. For more information about the College’s work translating quality measurement to policymakers, contact lamar.mcginnis@cancer.org or bcebuhar@facs.org. If you would like to learn more about NSQIP and other quality of care initiatives, contact the Division of Research and Optimal Patient Care or Karen Richards in the Office of Evidence-Based Surgery, krichard@facs.org.

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In his Presidential Address that was published in the December 2002 issue of the Bulletin, ACS President Richard R. Sabo, MD, FACS, described the dilemma faced by surgeons who want to provide the latest technology for their patients and yet find the “transition from old to new ideas” difficult for a number of reasons, including issues of education and training.* He further points out that the College, through its Committee on Emerging Surgical Technology and Education (CESTE), is helping surgeons by analyzing the implications of new surgical technology and providing guidelines on how to incorporate these technologies into practice.

We at the Food and Drug Administration (FDA) share the College’s concern that new technologies be incorporated safely and effectively into clinical practice. One concern, of course, is that new surgical devices be safe and effective before they are marketed. Under the law, the FDA is charged with assuring that this is the case. Although the FDA does not itself test or examine new devices, we review and evaluate the data submitted by manufacturers who wish to market a new device, working with them to develop preclinical and clinical study protocols that support their applications.

The level of data required depends on what is already known about the technology and the level of risk associated with using it. For well-known medical devices that evolve into newer models with only minor changes, bench testing may be all that is necessary. For cutting-edge technologies, we expect that the manufacturer-sponsored clinical trials include controlled studies with multiple investigators at several institutions.

Our goal is to be sure that the manufacturer’s medical claims for the device are supported by good clinical evidence. We must consider such factors as the proposed indications for use and the intended patient population, as well as the learning curve that new users undergo—that is, we assess the degree to which a new device is usable by a practicing surgeon. While performing this premarket review function, we work to ensure a level playing field among competing manufacturers, and in the process accumulate an extensive database on the results of medical device testing.

But even the most stringent program of premarket testing cannot eliminate the possibility of unforeseen adverse events. Some of these are so rare that they would not be detected during clinical investigations. Others may occur when the device is used by a wider variety of clinicians than in the study, on a broader patient population, or in different settings. This means that our job does


Surgical technology:
A perspective from the FDA

by Binita S. Ashar, MD, FACS,
and Daniel G. Schultz, MD, FACS,
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not end when we clear or approve a new medical product for clinical use. In fact, we have a nationwide post-market surveillance program through which we monitor adverse events, analyze their causes, and take action to remedy the situation. This may include sending safety alerts to clinicians, requiring manufacturers to make labeling changes, and, if necessary, requiring the recall of the device.

It is obvious that we in the FDA share with the College and its members the same ultimate goal—the successful introduction of safe and effective medical devices into clinical practice. We both want to see the seamless transfer of medical technology from the laboratory to the patient’s bedside. We can best accomplish this by working in partnership.

How can the practicing surgeon help in this process and at the same time contribute to improving public health? First and foremost, he or she can report adverse events to us. We cannot effectively monitor the safety of devices already in use without good information from practicing surgeons. Reporting can be done easily through our Web site at www.fda.gov/cdrh/mdr.html.

Second, those surgeons who are involved in designing and conducting clinical trials of new devices should recognize that they have a special public health responsibility to provide complete and reliable clinical data. Without good data, we cannot make evidence-based decisions about the quality of newly marketed products.

Third, surgeons should consider applying their knowledge and expertise in our new product review process by serving as consultants or members on our various advisory panels. These panels consist of experts in various clinical specialties who help the FDA evaluate the results of preclinical and clinical trials sponsored by a device manufacturer, and make recommendations to the agency on whether the product should be approved.

Finally, some College members may want to consider going a step further and working for us on either a part-time or a full-time basis. Those individuals who might be interested in either panel membership or possible employment can explore the subject further at www.fda.gov/cdrh/ode, or contact us directly at 301/594-2022.

We appreciate the proactive role that CESTE has taken in the American College of Surgeons and look forward to working with the committee in helping ensure that medical devices are safe and effective. We hope this editorial has motivated practicing surgeons to play an active role in this partnership.

This article represents the professional opinion of the authors and is not an official document, guidance, or policy of the U.S. government, the Department of Health and Human Services, or the FDA, nor should any official endorsement be inferred.

Editors note: The College’s Division of Advocacy and Health Policy maintains a list of Fellows with device expertise and interest in serving as FDA advisory panel consultants and members. Those individuals who would like to be included should contact Adrienne Roberts in the College’s Washington Office, at 202/337-2701, or via e-mail at aroberts@facs.org.

Dr. Ashar is medical officer, Office of Device Evaluation, U.S. FDA/Center for Devices and Radiological Health, Rockville, MD.

Dr. Schultz is director, Office of Device Evaluation, U.S. FDA/Center for Devices and Radiological Health, Rockville, MD.
Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the Bulletin to keep Fellows abreast of any changes in the procedures of the various boards. The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the Bulletin contains the reports of the American Board of Neurological Surgery, the American Board of Orthopaedic Surgery, the American Board of Otolaryngology, the American Board of Plastic Surgery, and the American Board of Thoracic Surgery.

The April issue of the Bulletin will feature the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Ophthalmology, the American Board of Surgery, and the American Board of Urology.
Resident numbers/neurosurgical match

There are 95 accredited neurosurgical training programs in the U.S. In January 2002, 287 individuals registered with the Central Application Service of the Neurosurgical Matching Program and 221 submitted rank lists. Two hundred were ranked and 134 were matched. Over the past five years the number of individuals registering for the neurosurgical match and submitting rank lists has declined by 27 percent and 14 percent, respectively. Currently, there are 752 residents training in U.S. neurosurgical programs; 136 graduated in June 2002.

Primary examination

The American Board of Neurological Surgery (ABNS) administers a written examination annually to neurosurgical trainees and those neurosurgeons who are re-entering the certification process. The multiple-choice examination covers the breadth of neurosurgery’s clinical and basic science curriculum. The examination may be taken for practice and self-assessment but must be taken for credit and passed in order to sit for the initial certifying oral examination. For residents entering training after June 30, 1998, it has been a joint requirement of the ABNS and the Accreditation Council for Graduate Medical Education (ACGME) training requirements for neurosurgery that the written examination be passed in order to successfully complete the residency program. Many U.S. neurosurgical programs now require passing the examination for credit in order to progress to chief resident.

In March 2002, the primary examination was administered to 489 examinees. Two hundred twenty-four took the examination for credit and 265 for self-assessment. The failure rate for certification candidates was 28 percent.

Oral examination

The initial certifying oral examination is administered by the ABNS each spring and fall to those qualified neurosurgical practitioners who have applied for certification and met the requirements of graduation from an accredited training program, demonstrated good professional standing as assessed by mentors and peers, and shown satisfactory practice performance over a minimum of one year’s consecutive cases.

In November 2001, 73 individuals sat for the oral examination, with a 16 percent failure rate. In May 2002, 75 individuals were examined, with 16 percent failing.

Candidate performance on the oral examination is scored numerically by a total of six examiners but pass/fail is determined by computer program so as to maximize objectivity and fairness in the process. The use of standardized questions for a portion of the examination is being explored.

Residents entering Canadian training programs after July 16, 1997, have been ruled ineligible for ABNS certification. This action has become a major issue to our Canadian colleagues and has had a negative impact on numbers of applicants to Canadian training programs. This policy was reviewed and reaffirmed by the board at its last meeting.

Maintenance of certification (MOC)

The ABNS issued its first time-limited certificates in May 1999 and is in the process of developing its MOC program to meet the American Board of Medical Specialties requirements. Evidence of professional standing will continue to require unrestricted licensure and some manner of evaluation by peers. Cognitive expertise will be assessed with a secure multiple-choice examination that covers basic as well as practice-specific specialty knowledge. It is planned that such an examination will be in place by 2006 and will be administered at national testing centers.

Methodologies for demonstration of involvement in lifelong learning and self-assessment are under consideration, as are those for practice performance. Some preliminary experience has been gained through voluntary participation of neurosurgeons in outcomes analysis of key cases (lumbar disk surgery) sponsored by the American Association of Neurological Surgeons. It is envi-
sioned that such an outcomes database for selected cases could be a powerful tool for self-assessment of practice.

Developing standards and the assessment of diplomates against those standards, as well as cost-effective, meaningful methodologies for assessment of each of the six competencies, will be major hurdles for the ABNS. We would welcome information regarding the methods and experiences of other surgical specialties in this regard and believe that the American College of Surgeons might provide a valuable forum for the surgical specialties in development of our MOC programs.

Revocation of certificates

The ABNS has amended its bylaws to provide the board with more discretion in revocation of certificates. At its meeting in May 2002, due process hearings were held and certificates of three diplomates revoked.

Resident duty hour

The ABNS, our program directors’ Society of Neurological Surgeons, and our Residency Review Committee for Neurological Surgery, while committed to the welfare of our residents and safe delivery of care to our patients, have major concerns regarding the new ACGME-sponsored restriction on resident duty hours. There is particular concern that the lack of flexibility will adversely impact resident opportunities and expectations for continuity of care, overall operative experience through training, and the development of essential neurosurgical discipline and professionalism. We appreciate the ACS leadership for bringing together the opinions of its surgical specialty boards and societies to develop a strong statement of concern to the ACGME.

ABNS directors/officers

At its 2002 spring meeting, Dennis Spencer, MD, FACS, and Charles Hodge, MD, completed their six years of contribution and leadership to the ABNS. Newly elected directors are H. Huntington Batjer, MD, FACS, and Kim J. Burchiel, MD, FACS. New officers of the board are David Piepgras, MD, FACS, chair, and R. Michael Scott, MD, vice-chair. Arthur Day, MD, FACS, and Ralph Dacey, MD, FACS, remain as treasurer and secretary, respectively.

The American Board of Orthopaedic Surgery

by Gordon M. Aamoth, MD, Chapel Hill, NC

The mission of the American Board of Orthopaedic Surgery (ABOS) is to assure the American public that certified orthopaedic surgeons are truly qualified and competent physicians. The agenda for the ABOS this past year included re-evaluating our certification process, reassessing and re-engineering the maintenance of certification concept, discussing the certification/recertification of nonsurgical and/or retired orthopaedic surgeons, the eligibility for certification of foreign-educated orthopaedic surgeons, and developing a practice performance and outcomes measurement process.

Directors-elect

The term of service for a director of the board is 10 years, and both Michael A. Simon, MD, FACS, Chicago, IL, and Donald C. Ferlic, MD, FACS, of Denver, CO, completed their tenure this past year. They served with extraordinary dedication and commitment to the board and they will be missed. Joining the board as directors-elect are Randall E. Marcus, MD, FACS, of Cleveland, OH, who has for many years served on the Question Writing Task Force, and James Weinstein, MD, of Hanover, NH, who brings expertise in outcomes and practice performance evaluation.

Exams

The board’s primary certification process involves a two-part examination. The Part I written examination is administered upon completion of residency education. There were 805 candidates who sat for the 2002 exam, of which 79.1
percent passed. The reference group of first-time takers—that is, candidates who received their residency education in the U.S. or Canada—had a pass rate of 88.8 percent.

The Part II examination is a practice-based oral examination. In order to qualify, applicants must be in the operative practice of orthopaedic surgery for 22 months, and have a full and unrestricted state license to practice medicine, as well as undergo a stringent peer review. This past year, 725 candidates took the Part II examination, with a pass rate of 86 percent. It is the opinion of the board that the practice-based oral examination is the most valid method to assess practice performance.

Maintenance of certification

Maintenance of certification remained the board’s primary focus this year. We are working diligently with the American Academy of Orthopaedic Surgeons and, under the direction of James V. Luck, MD, of Los Angeles, CA, a joint task force has been created to explore methodologies that will ensure the MOC process is reliable, clinically valid, and economically feasible. The ABOS is deeply committed to this initiative.

In closing, the board would like to thank the more than 250 orthopaedic surgeons who have provided invaluable assistance to the board during the past year. They have generously volunteered their time without compensation by participating as members of the Question Writing Task Force, the Field Test Task Force, the Recertification Question Writing Task Force, and as oral examiners. Without these dedicated volunteers, the mission of the ABOS could not be realized.

American Board of Otolaryngology

by Gerald B. Healy, M.D., FACS, Boston, MA

Qualifying/certifying examinations

It was necessary to postpone the written exam scheduled for late September 2001. Rather than select a new, arbitrary date, the written exam was rescheduled for April 26 in Chicago, IL, immediately preceding the oral exam that was already scheduled for April 27-28, 2002. Since it was not possible to score and psychometrically analyze written exam results so quickly, all candidates were given the opportunity to take the oral exam. After analysis, those candidates who did not meet the qualifying score on the written exam did not have their oral exam scores processed. Candidate response to this plan was positive.

Thus, 298 candidates took the written examination. The oral examination was conducted for 320 candidates by approximately 115 individuals, including American Board of Otolaryngology (ABO) directors, senior examiners, and guest examiners. Three hundred and ten passed and were certified. These individuals received the first 10-year, time-limited certificates issued by the ABO.

Otolaryngology training exam

The otolaryngology training exam (previously, the annual otolaryngology exam) was conducted on March 3, 2002, in more than 100 locations, including one overseas. This is the fifth year that the exam has been prepared and conducted by the ABO. More than 1,100 residents and practitioners participated in the exam.

Elections

David E. Schuller, MD, FACS, was elected in April 2002 to serve a two-year term as president. Harold C. Pillsbury III, MD, FACS, was elected for a two-year term as president-elect, and Gerald B. Healy, MD, FACS, was reelected to a third term as executive vice-president. H. Bryan Neel III, MD, FACS, continues to serve as treasurer.

Herbert C. Jones, MD, and Charles J. Krause,
MD, FACS, completed their terms of service and were elevated to senior counselor at the conclusion of the 2002 annual meeting in April, after many years of dedicated service to the ABO. The board accepted with regret the resignation of A. Julianna Gulya, MD, FACS, and James N. Thompson, MD, FACS; they were also elevated to senior counselor status. The board approved a reduction in its size, by attrition. Thus, no new directors were elected.

Senior examiners
Senior examiners serve as the core group of experienced oral examiners, along with ABO directors. Senior examiners are elected to a five-year term, and are eligible for reelection to one additional term after a hiatus of three years. To be elected as a senior examiner, an individual must have served as an ABO examiner at least twice. He or she must be prominent in the specialty, especially in the areas of patient care and medical education, and must demonstrate an interest and ability in the creation of educational and test materials. William W. Shockley, MD, FACS, completed his term of service after the 2002 annual meeting.

American Board of Medical Specialties
The American Board of Medical Specialties (ABMS) is the umbrella organization of the 24 recognized certifying organizations in the U.S. Representatives to the ABMS Assembly this year are David E. Schuller, MD, FACS; Harold C. Pillsbury III, MD, FACS; and Gerald B. Healy, MD, FACS. Alternate representatives are Jack L. Gluckman, MD, FACS; Dean M. Toriumi, MD, FACS; and Gayle E. Woodson, MD, FACS.

2002-2003 examinations
The 2002 written examination will be conducted on Monday, September 30, in three cities: Chicago, IL, Boston, MA, and San Francisco, CA. The subsequent oral examination will be conducted at the Westin O’Hare Hotel in Chicago on April 26-27, 2003. The next otolaryngology training exam is currently scheduled for Saturday, March 1, 2003.

American Board of Plastic Surgery
by John J. Coleman III, MD, FACS, Indianapolis, IN

Examinations
Oral examination. A total of 236 candidates sat for the oral examination September 6-8, 2001. One hundred eighty-two candidates passed and 54 failed, with a failure rate of 22.8 percent. In September 2000, 279 candidates took the oral examination. Two hundred twenty-seven candidates passed in 2000 and 52 failed, with a failure rate of 18.6 percent. The 2001 failure rate was 4 percent higher than the previous year but was compatible with the range of 17 percent to 25 percent for the last four years.

The board anticipated 236 candidates for the 2002 oral examination. As of September 8, 2001, the American Board of Plastic Surgery (ABPS) had certified 6,037 plastic surgeons.

Written or qualifying examination. The written or qualifying examination was held September 5, 2001, for 241 candidates. Results of the 2001 written examination were distributed on November 27, 2001. Of the total of 241 candidates, 190 passed the written examination with a failure rate of 21.2 percent. In 2000, 186 of 243 candidates passed the written examination, with a failure rate of 23.1 percent, which was consistent with prior years. The 2002 examination was to be the first computer-based test (CBT) format and was scheduled for October 18, 2002, at test centers across the country. Approximately 260 candidates were expected to sit for this written examination CBT.

Subspecialty certification in surgery of the hand (formerly, certificate of added qualifications in surgery of the hand). ABPS administered the 2001 subspecialty certification in surgery of the hand.
examination to 42 ABPS diplomates, 23 of whom were recertifying. Fifteen of 19 diplomates passed the hand surgery examination. The failure rate was 4.2 percent. A total of 23 diplomates sat for the 2001 hand surgery recertification examination; 21 passed and the failure rate was 8.7 percent. The 2002 certification examination in surgery of the hand was administered in Chicago, IL, on August 26, 2002, and in computer test centers around the country through September 21, 2002. The board expects 47 candidates, 30 of whom are recertifying. Results were to be announced in mid-October.

**Recertification**

The first recertification examination will be offered April 25, 2003. The first time-dated certificates will expire in 2005. The cognitive examination will be offered as a CBT format in four modules: Comprehensive Plastic Surgery; Cosmetic/Breast Surgery; Craniomaxillofacial Surgery; and Hand Surgery. A subspecialty certificate in surgery of the hand will be accepted in lieu of the hand surgery module cognitive examination component of the recertification program. A number of changes, reflecting the recommendations of the American Board of Medical Specialties' Task Force on Competency, have been made in the recertification process. The four key components of professionalism, knowledge, lifelong learning, and performance in practice, are incorporated into the recertification program. Diplomates are collecting an operative log for six months.

**General surgery training years**

ABPS continues to evaluate methods of assessing the preparation and knowledge of core surgery principals in the PGY I, II, and III years. The board held a retreat in November 2001 to review this issue and has charged an ad hoc committee with continuing to review the evaluation of prerequisite training years for plastic surgery.

**Revocation of certification**

The American Medical Association periodically reports sanctions to diplomates’ licenses and ABPS contacts the state medical licensing board in question for original documents. Plastic surgeons with revoked state medical licenses are referred to the Ethics Committee for revocation of certification. To date, the board has revoked certification for 20 diplomates.

**American Board of Medical Specialties**

Surgical dermatology. ABPS joined the other surgical specialty boards to object to the proposed training in surgical dermatology at the Accreditation Council for Graduate Medical Education.

**Subspecialty issues**

The American Board of Plastic Surgery, Inc., continues to be committed to the engagement, development, and recognition of subspecialty interests for the purpose of advancing the core of the entire specialty. The board’s four advisory councils have been working since May 2000, contributing to the work of the recertification process. The advisory councils reflect the four identified subspecialty modules for the recertification program: comprehensive plastic surgery; cosmetic plastic surgery; craniomaxillofacial surgery; and hand surgery. The members include board directors and nominees from plastic surgery subspecialty organizations. The board is also going to utilize subspecialty expertise to develop journal review questions for self-learning for the *Plastic and Reconstructive Surgery* journal. These items will add to the items in the public domain that diplomates can access as they prepare for recertification.

**In appreciation**


**New officers/directors**

The new directors elected to the ABPS are Bernard S. Alpert, MD, FACS; Rod Lentz, MD; and James M. Stuzin, MD, FACS. ABPS officers for 2002-2003 are John J. Coleman III, MD, FACS, Indianapolis, IN, chair; Bruce L. Cunningham, MD, FACS, Minneapolis, MN, chair-elect; Lawrence L. Ketch, MD, FACS, Boulder, CO, vice-chair; and Carolyn L. Kerrigan, MD, Lebanon, NH, secretary-treasurer.
Recertification policies

New. The deadline for submitting maintenance of certification applications has been changed. Applications are now due on May 10 instead of May 1 each year. The change will now allow diplomates to include continuing medical education (CME) hours earned in April-May of each year from medical meetings, like the annual meeting of the American Association for Thoracic Surgery.

At the fall board meeting held October 20, 2001, the directors approved a change in the CME requirements for the recertification process to allow CME credit for the Thoracic Surgery Foundation for Research and Education-supported course at Harvard entitled Skills for the New World of Health Care.

Several years ago, the American Board of Thoracic Surgery (ABTS) announced changes in the recertification policies beginning in 2001. In response to an initiative by the American Board of Medical Specialties, the board will rename the recertification process to better reflect its effort to develop standards and methods to evaluate physician specialists following their initial certification. Accordingly, the American Board of Thoracic Surgery, along with the other medical certifying boards, has begun the transition toward using the term “maintenance of certification” rather than “recertification.”

A valid ABTS certificate is an absolute requirement for entering the recertification process. The only pathway for renewal of a lapsed certificate will be to take and pass the Part I (written) and the Part II (oral) certifying examinations. The CME requirement is 70 Category I credits in either cardiothoracic surgery or general surgery earned during the two years prior to applying for recertification. Not all Category I credits will be allowed; for instance, SESATS and SESAP are the only self-instructional material acceptable for CME credit. The Physicians Recognition Award for recertifying in general surgery will not be accepted in fulfillment of the CME requirement. Other specific CME requirements will be published in the Recertification Booklet of Information.

The ABTS will no longer publish the names of individuals who have not recertified. Listing diplomates with invalid certificates in directories published by the American Board of Medical Specialties has proven to be confusing to credentialing groups of various hospitals, managed care providers, and patients seeking care. In addition, none of the other 24 member boards of the American Board of Medical Specialties publishes the names of individuals holding invalid certificates.

All diplomates should be aware of the changes in the requirements in anticipation of renewing their own certificates. The board feels that maintenance of certification is important to the public and to each physician’s professional career. All diplomates need to be up-to-date with regard to the requirements for recertification so that they are prepared when the time comes to recertify.

Background

Time-limited certificates were first issued in 1976. Diplomates certified after 1975 must be recertified within 10 years of the date of the original certification in order to maintain their certification. Diplomates with time-limited certificates may apply within three years of the expiration of their 10-year certificate.

Diplomates of the Board of Thoracic Surgery and the ABTS who were certified prior to 1976 do not require recertification and are considered to hold unlimited certificates.

The board emphasizes the importance of recertification in communications to diplomates whose certificates are due to expire and informs them that an expired certificate is no longer valid. The board office is experiencing an increasing number of inquiries with regard to the status of diplomates of the board. The inquiries are coming from various agencies, such as hospital administrations, credential committees, HMOs, insurance companies, other third-party payors, governmental agencies, and those in the medicolegal profession.
The annual mandatory certification maintenance fee of $100 is required of all active diplomates age 65 and under. Beginning in 2001, the fee is cumulative. This fee helps defray administrative expenses related to maintaining and utilizing the diplomate information on the board’s computer system. The board will not respond to inquiries about the diplomate’s certification status until the fee is paid each year.

Examinations
A total of 178 individuals took the Part I (written) examination that was held November 18, 2001, in Chicago, IL. The pass rate for this examination was 87 percent. The 2001 written exam was the ninth criterion-referenced examination administered by the board. The philosophy of criterion-referenced testing is based on the concept that candidates should be measured against a standard of knowledge predetermined by the board rather than against each other, as is the case in a norm-referenced examination.

The board conducted its sixth criterion-referenced oral examination June 7-8, 2002, in Chicago. With this type of examination, the board applies statistical methods to equate the examination. The purpose of statistically equating is to place alternative forms of the examination on a scale such that all candidates are compared to a single standard. Equating is accomplished through a statistical process that weights each facet of an examination form. The basic premise of this analysis is that all candidates have a comparable opportunity to pass because all candidates are measured against the same criterion standard. In 2002, 171 candidates took the oral exam, of which 162 (95%) passed and eight (5%) failed.

The Examination Consultant Committee, established in 1989, continues to be a vital component in the development of the written examination. The committee meets in September each year to review questions written by the consultants. At its meeting in 2001, 95 questions were retained for future use in the written examination and the in-training examination.

New pathways/requirements certification
On October 20, 2001, the ABTS approved the following resolutions regarding thoracic surgery certification. The exact timing of implementation for some of the resolutions has yet to be determined.

1. Certification by the American Board of Surgery (ABS) is optional rather than mandatory for residents who begin their thoracic surgery training in July 2003 and after.

2. One pathway to ABTS certification will consist of successful completion of a full general surgery residency in an Accreditation Council for Graduate Medical Education (ACGME)-approved program (five years), with or without ABS certification, followed by successful completion of a two-or three-year ACGME-approved thoracic surgery residency. Individuals entering thoracic surgery residency

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In 2001, 257 diplomates recertified, of which 142 were for the first time and 115 were for the second time. Two hundred and four diplomates used the SESATS computer version and 53 diplomates used the paper and pencil version.
residencies in July 2003 or after will be eligible under this pathway.

3. A second pathway to ABTS certification will be a categorical-integrated six-year thoracic surgery residency, to be developed by the Thoracic Surgery Directors Association. Residents in these programs will be under the direction of the Thoracic Surgery Program Directors. Before this pathway is implemented, the residency review committee for thoracic surgery (RRC-TS) must first approve the standards and requirements for such programs. Individuals will match for such programs directly from medical school or at some later time. It is estimated that the first such programs would begin to accept residents in 2004 at the earliest.

4. A third pathway to ABTS certification will be through successful completion of an ACGME-approved three-year thoracic surgery residency after a minimum of three years in an ACGME-approved general surgery residency, so long as certain prerequisite criteria are met during the general surgery training. These prerequisites include:

- General surgery: 12 months
  - including 6 months abdominal surgery and 6 months pediatric, oncology, and head and neck surgery

- Critical care: 2 months
- Transplantation and immunology: 2 months
- Trauma: 2 months
- Cardiothoracic surgery: 3 months
- Vascular surgery: 3 months
- Total: 24 months

It is estimated that such programs would begin to accept residents in 2005 at the earliest.

5. Any individual currently in the ABTS certification process (that is, in a thoracic surgery residency or who has already finished a thoracic surgery residency) will be guided by the requirements in force at the time of his or her residency.

6. The ABTS supports the following recommendations of the Joint Council for Thoracic Surgery Education (JCTSE):

- The JCTSE strongly encourages the RRC-TS as part of the special requirements for thoracic surgery residencies to require documentation of faculty participation in medical school curriculum.
- The JCTSE strongly encourages the ABS and Association of Program Directors in Surgery (APDS) to develop a shorter curriculum in “surgery”—to include ABS certification—which, if and when approved, would permit an alternate pathway to ABTS certification.
- The JCTSE strongly encourages the ABS and APDS to participate in the development of a surgical preparatory core curriculum as a standard entry to ACGME boarded surgical specialties.

Interested parties should take particular note that the categorical-integrated program and the 3/3 program mentioned above have yet to be fully developed and will require approval action by the RRC-TS before they become available. The ABTS is committed to working closely with the ABS and other organizations in general surgery toward the development of combined 4/3 programs leading to the possibility of certification by both the ABS and the ABTS.

Applications

New. All residents who begin their training in 2001 must file their application and operative cases logs electronically through CTSNet. The board will allow residents who began their training in 2000 to file their cases through CTSNet (electronically) or by submitting a paper version. However, the summary sheet must be filed with the application, and the only way to obtain the summary sheet with the new operative case requirements is by printing it from the www.abts.org site.

The timeframe between the deadline for submission of an application to enter the certification process (August 1) and the subsequent approval process has been condensed to just a few weeks now that the schedule for the examination has been changed to November. Therefore, it is extremely important for all candidates to submit a complete and accurate application as the original submission. There will be no time for corrections or additions. The board urges the program directors to help their residents in the application process by carefully reviewing the application before signing off on it and by informing their residents about the importance of an accurate and complete application.
The board, as of its meeting in October 1999, will no longer allow residents to submit applications on August 1 pending certification by the American Board of Surgery in September. It is not administratively possible to continue to allow this extension since the time frame has been compressed by three months. Thus, the American Board of Thoracic Surgery will no longer accept incomplete applications and the August 1 deadline for submission of the application is firm for all residents.

**Booklet of Information**

Published annually, the Booklet of Information contains information about how the operative index case requirements should be recorded and tracked and now has two components: surgical volume or intensity and index case distribution. All residents must perform an annual average of 125 major operative cases each year with a minimal number of 100 in any one year.

At the 2002 spring board meeting, the board approved changes to the index of operative cases required for all candidates effective July 1, 2002. Specifically, the changes affect the minimal number of cases required in congenital cardiac, adult cardiac, and pacemaker implantation/close EP. For more information about the new operative case index requirements, see the board’s Booklet of Information or visit the board’s Web site at www.abts.org.

**In-training examination**

A total of 340 individuals took the in-training examination that was administered online on April 13 and 20, 2002. Due to computer problems experienced with the delivery of the online examination, the board offered the exam on April 27 to those residents affected by the technical difficulties.

The in-training examination consists of 80 general thoracic and 80 cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination. Score reports and comparative results were posted on the Internet for all test takers. Due to the technical problems experienced, the board encourages program directors and residents to continue to use the in-training examination as an educational and self-evaluation tool.

**Ad hoc committee to study computer-based testing**

David B. Campbell, MD, FACS, who chairs this new committee, is exploring possible applications of computer-based testing for the board’s examinations. The board began using the Internet for the administration of the in-training examination in April 2000 and continues to offer the examination online each year.

**Internet address**

The board is a participant on the CTSNet. The board’s Internet address is www.abts.org. Information related to the board’s certification pathways, recertification requirements, examinations, and history are posted on this site.

**Public education brochure**

The public education brochure, Your Surgeon Is Certified by the American Board of Thoracic Surgery, continues to be available for purchase through the board office.

**New board members**

William A. Gay, Jr., MD, has assumed the position of secretary/treasurer of the American Board of Thoracic Surgery, replacing Richard J. Cleveland, MD, FACS. Dr. Gay will serve for seven years.

At the 2001 fall board meeting, Peter C. Pairolero, MD, FACS, assumed the position of chair, replacing Fred A. Crawford, Jr., MD, FACS. Timothy J. Gardner, MD, FACS, was elected vice-chair. Gordon N. Olinger, MD, FACS, succeeds Richard P. Anderson, MD, FACS, as the examination chair. Douglas J. Mathisen, MD, FACS, was asked to stay on the board for another two years in order fulfill his obligations on the residency review committee for thoracic surgery as the board’s representative. David E. Hutchison, MD, FACS, retired as ad hoc director.

Three new directors were elected: Larry R. Kaiser, MD, FACS, William C. Nugent, MD, FACS, and Timothy Flynn, MD, the representative to the board from the American Board of Surgery.
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program, professor, depart-
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Beth Israel Deaconess Medical Center
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Professor and chairman, department of surgery,
University of Colorado
Denver, CO

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Otolaryngologist-in-chief, Children’s Hospital
Boston, MA

Charles D. Mabry
General surgery
Private practice
Pine Bluff, AR

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Plastic surgery  
Professor of surgery, Division of plastic surgery, University of California  
San Francisco, CA

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Orthopaedic surgery  
Wayland, MA

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Colon and rectal surgery  
Professor of surgery and health policy, management and evaluation, University of Toronto, and head, division of general surgery, Mt. Sinai Hospital  
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General surgery  
Attending surgeon, Baylor University Medical Center  
Dallas, TX

Ronald E. Rosenthal  
Orthopaedic surgery  
Wayland, MA

Maurice J. Webb  
Gynecology (oncology)  
Gynecologic oncologist, Mayo Clinic  
Rochester, MN
In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

P ractices must be in compliance with the privacy provisions in the Health Insurance Portability and Accountability Act (HIPAA) by April 14, 2003. For the last year, this column has outlined the HIPAA requirements and has offered examples and resources for surgical practices to use when designing products and processes that will help ensure the confidentiality of patient information. We hope that this information has been helpful to surgeons and their staffs in creating materials necessary to meet the privacy regulations.

In addition to the April 14 deadline, surgeons should keep in mind some other dates pertinent to HIPAA compliance. For example, last October the Centers for Medicare & Medicaid Services (CMS) allowed covered entities to file for an extension, which would give a practice an additional year to comply with HIPAA transaction and code-set standards. Additionally, the deadline for starting the testing phase of the electronic claims transactions between physicians' offices and the health plans or claims clearinghouse is April 16, 2003.

If a practice submits electronic claims directly to a payer, testing means ensuring that the practice's software is capable of sending and receiving electronic transactions in the standard HIPAA format. If a clearinghouse submits the practice's claims, it's important to make certain the clearinghouse is testing its software with all of the health care plans the practice accepts. If a practice has not heard from its software vendors, the clearinghouse, or the accepted health care plans, the practice should call and verify when those businesses intend to begin testing.

If a software vendor provides unsatisfactory answers to a practice's HIPAA questions, it might be a good idea to visit the payors' Web sites to see if they have posted vendor lists. Medicare carriers maintain these lists. In some cases, payor Web sites also offer monthly updates from vendors, clearinghouses, and billing services that have passed HIPAA-compliant testing for the various transaction sets.

Each practice should ask each payor if it has developed a HIPAA companion document or guide that specifies coding and transaction requirements. One example might be to ask payors for billing instructions regarding coding for services that were previously billed using local codes. As a result of HIPAA requirements, local codes will be eliminated by December 31, 2003. This information also may be accessed through many payors' Web sites.

A practice also may want to investigate whether an Internet-based claims system would best suit its needs for a HIPAA-compliant product. Online claims systems such as WebMDEnvoy (http://www.webmdenvoy.com) and MedUnite (http://www.medunite.com) offer "real-time" Internet-based services for HIPAA transactions. Both of these systems provide lists of payors that accept claims filed through their systems.

The road to HIPAA compliance is long and calls for great attention to detail. But once all the components are in place, a practice will be able to more easily verify patient eligibility for specific health plans, coordinate payment of benefits covered by supplemental insurers, submit claims for payment, track the process of reimbursement, and receive electronic payment for services.

Keeping current

What’s new in ACS Surgery: Principles and Practice

by Erin Michael Kelly, New York, NY

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

Keeping current in 2003 with ACS Surgery: Principles and Practice

ACS Surgery 2003 is now available. Save $30 and receive a free three-month trial to www.acssurgery.com (a $50 value) by ordering your copy today. For only $199 (regularly $229) you can be among the elite group of surgeons that subscribes to the only continually updated surgery textbook, ACS Surgery. Updated monthly online and annually in print, the ACS Surgery 2003 volume features 40 percent new and updated information to provide you with the most contemporary views on best practice and technique. Minimize complications, lower expenditures, and increase patient satisfaction with this unique reference. Call 1-800/545-0554 today to reserve your copy, and be sure to request offer number S32S8G1C.

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V. Operative Management

4. Ultrasonography: Surgical applications. Grace S. Rozycki, MD, FACS. In her newly updated chapter, Dr. Rozycki covers the clinical applications of ultrasonography, the general considerations for diagnostic ultrasound examinations, and the techniques for selected surgical applications of ultrasonography.

Of particular interest to trauma surgeons is an ultrasonographic test referred to as FAST—Focused Assessment for the Sonographic examination of the Trauma patient. FAST is a rapid diagnostic test for the evaluation of patients with potential truncal injuries. Its development is rooted in several historic, fundamental studies that demonstrated the high sensitivity of ultrasonography in detecting small degrees of ascites, splenic injury, and hemoperitoneum in the hepatorenal space and the pelvis. FAST determines the presence or absence of blood in the pericardial sac and three dependent abdominal regions: Morison’s pouch, the splenorenal recess, and the pelvis.

In her chapter, Dr. Rozycki also provides the following general technical tips that should prove useful in a wide range of ultrasonographic applications:

- The ultrasound machine should be inspected according to the guidelines of the institution’s department of biomedical engineering to ensure that it is functioning properly.
- The patient’s orientation on the monitor or screen relative to the position of the transducer should be checked by applying gel to the transducer’s footprint (that is, the part of the transducer that is in contact with the patient’s skin) and then rubbing the footprint with a finger near the indicator line of the transducer. Motion on the left side of the screen indicates that the transducer is properly oriented.
- Liberal amounts of gel should be applied to the area being examined. The gel acts as an acoustic coupler, helping to transmit the ultrasound.
waves and reduce their reflection. If too little gel has been applied, the waves will not be transmitted properly, and a dark area will appear on the ultrasound image.

- The transducer should be manipulated with small movements (not wide sweeps), and gentle pressure should be applied initially. This second point is especially important in imaging the breast or the thyroid; the tissues are superficial, and too much pressure can easily compress them and distort the ultrasound image.

- The gain and time-gain compensation settings should be rechecked for each new examination. For example, after completing a breast examination, the sonographer should begin an examination of the carotid vessels only after confirming that these settings are correct.

- Normal tissue should be examined ultrasonographically before the sonographer turns to the area of interest. For example, if the goal is to assess an abscess or deep vein thrombosis in one extremity, the first step should be to inspect the other extremity to see what the corresponding normal tissue looks like. This process helps to sensitize the examiner to subtle pathologic changes in the abnormal tissue.

- The patient should be asked to take a deep breath so that the motion of the diaphragm and the organs can be observed. If the motion of these structures is impaired, inflammation or an abscess may be present.

- If the left upper quadrant is difficult to examine (as is sometimes the case in the FAST), a nasogastric tube should be inserted to decompress the stomach and minimize the presence of air so that it does not interfere with the transmission of the ultrasound waves.

- Although B-mode ultrasound is usually sufficient to identify blood vessels, it sometimes cannot distinguish between the artery and the vein because of pulsations transmitted from the artery. In such cases, using the Doppler mode, compressing the vessel (veins compress very easily), or having the patient perform the Valsalva maneuver may help differentiate arterial from venous anatomy. In addition, the vena cava is more readily identified as the patient completes inspiration.

- A full bladder is needed for pelvic ultrasound examinations; it acts as an acoustic window, facilitating visualization of the pelvic structures. It should not, however, be so full that it is overdistended. If the bladder is not full enough, the urinary catheter can be clamped to allow it to fill; if it is too full, the catheter can be unclamped to allow it to drain. In this way, hematomas in the pelvis can be more easily detected.

Subscribers may view the full text of “Ultrasoundography: Surgical applications” at www.acssurgery.com.

VI. Special perioperative problems

11. Nosocomial infection. E. Patchen Dellinger, MD, FACS. Dr. Dellinger reviews nosocomial infections in the respiratory system, including those related to operative site or injury or those associated with intravascular devices, as well as urinary tract infections, enteric infections, and transfusion-associated infections.

Among the intravascular devices discussed are central venous and pulmonary artery catheters and multiple-lumen lines. In his chapter, Dr. Dellinger makes the following recommendations for changing central venous and pulmonary artery catheters:

- Signs of inflammation, skin irritation, or purulence at the insertion site should prompt immediate removal of the catheter. Any new catheter should be inserted in a different site. In a patient with systemic signs of infection (such as fever, leukocytosis, or malaise), culture of the insertion site, of the catheter, or of both is indicated to identify potential pathogens and to direct therapy. In a patient without systemic signs of infection, culture is unnecessary.

- If a patient with a catheter experiences systemic signs and symptoms of infection without a readily apparent source, the catheter should be removed even in the absence of inflammation at the insertion site. In this setting, however, approximately 75 percent of catheters are not infected, and a new catheter can be inserted at the same site over a guide wire placed through the first catheter. However, a catheter exchange places the new catheter in the old subcutaneous tunnel, which would be the most likely origin of catheter infection. The first catheter should be cultured.
Medicare’s Correct Coding Initiative
by the Division of Advocacy and Health Policy

In the September 2002 issue of the Bulletin, this column began a look at regulatory factors that may affect reimbursement for surgical services. That article cited Medicare’s Correct Coding Initiative (CCI) edits as a factor that causes certain procedures to be incorporated, or bundled, into other procedures reported on the same claim and a decrease in anticipated reimbursement. This month, we take a closer look at the CCI edits, which were originally implemented in 1996 by the Health Care Financing Administration, now the Centers for Medicare & Medicaid Services (CMS).

The CCI edits are developed based on coding conventions defined in the American Medical Association’s Current Procedural Terminology (CPT), current standards of medical and surgical coding practice, input from specialty societies, and data analysis of current coding practice.

Two types

There are two separate types of CCI edits. The first is comprehensive/component codes. In this series, the comprehensive code represents greater work, effort, and time as compared to the other code reported. The comprehensive code is paid and the component code, or the code with the lesser work value, is denied. For example, CPT code 43320, Esophagogastrostomy (cardioplasty), with or without vagotomy and pyloroplasty, transabdominal or transthoracic approach, is recognized as the comprehensive code of which code 36000, Introduction of needle or intracatheter, vein, is a component code.

The second set of code combinations is composed of mutually exclusive codes. These are code combinations for procedures that would not or could not be reasonably performed at the same encounter by the same physician on the same patient. For example, CPT code 49200, Excision or destruction of omental, omentum, peritoneal tumor or cysts or endometriomas, is recognized as mutually exclusive of code 47380, Ablation, open, of one or more liver tumor(s). When codes are defined as mutually exclusive, generally the procedure with the lower work relative value unit is the payable service. In the case of the previous example, a surgeon would be reimbursed for code 49200.

More information

CCI does allow for the use of specific CPT and Healthcare Common Procedure Coding System (HCPCS) modifiers that may be used to override...
Division of Education

Committee explores residency education issues

The Division of Education of the American College of Surgeons convened a special Ad Hoc Committee on the Environment of Residency Education to discuss and propose solutions to a number of critical issues that have impacted residency education in the recent past and will continue to do so in the foreseeable future. The aim of the College was to assemble preeminent national leaders from the field of surgical education to address a range of issues, including the impact of the restriction on resident work hours, need to attract and retain the best residents in surgery residency programs, and indebtedness of surgery residents and resident salaries.

The committee (see photo) met at the College's headquarters in Chicago, IL, December 16-17, 2002, and was chaired by Edward R. Laws, MD, FACS. During the meeting, the key issues were reviewed in presentations delivered by David C. Leach, MD; Marc K. Wallack, MD, FACS; Andrew L. Warshaw, MD, FACS; and Frank R. Lewis, Jr., MD, FACS. Small groups then addressed these topics in further detail and proposed concrete solutions. The groups were led by Lazar J. Greenfield, MD, FACS; Patricia J. Numann, MD, FACS; and Timothy C. Flynn, MD, FACS.

Membership of this committee includes representatives from various surgical specialties as well as two residents. The productive discussions resulted in a large number of significant recommendations, which will serve as the foundation for further steps to ensure optimum learning experiences for residents from across the surgical specialties.

For further information on the activities of the Ad Hoc Committee on the Environment of Residency Education, please contact Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, ACS, 633 N. Saint Clair St., Chicago, IL 60611-3211, tel. 312/202-5405, or via e-mail at asachdeva@facs.org.
ACS announces new membership category for medical students

A new category of membership in the American College of Surgeons has been created for medical students and was officially approved by the Board of Regents at their February 7-8, 2003, meeting. Students in medical schools accredited by the Liaison Committee on Medical Education in the U.S. and in accredited Canadian medical schools are eligible to apply for Medical Student Membership.

Benefits offered medical students who are granted affiliation with the College through this category of membership include: free attendance at the annual Clinical Congress; discounts on selected Lippincott Williams & Wilkins textbooks; health, life, auto, disability, and loan payment insurance policies; online access to the Journal of the American College of Surgeons; an MBNA credit card; discounts on personal data assistants and computer software; use of the ACS travel agency; access to the “Members Only” side of the ACS Web site; representation on selected committees of the College; and an official membership card. A one-time application fee of $20 is required, but there will be no annual dues during the duration of medical school education. Details on the application process and an application form are available online at http://www.facs.org/dept/fellowship/documents.html#application, or by contacting ikulyk@facs.org.

ACS/STS Health Policy Scholarship awarded

The first American College of Surgeons/Society of Thoracic Surgeons (ACS/STS) Health Policy Scholarship was granted to James S. Allan, MD, FACS, who is assistant professor of surgery at Harvard Medical School, Boston, MA.

This new award, jointly sponsored by the College and the Society, enables the recipient to attend the course “Skills for the New World of Health Care,” offered at Harvard University April 26 to May 4, 2003.

The Health Policy Scholar will serve as a pro tem member of the health policy committees of the College and the Society for a one-year period upon the conclusion of the course.

2003 Oweida Scholar named

Peter S. Hedberg, MD, FACS, Durant, OK, was selected to receive the 2003 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons.

The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylvania. The $5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees. The purpose of the Oweida Scholarship is to help young surgeons practicing in rural communities attend the Clinical Congress and benefit from the educational experiences it provides. The Oweida Scholarship is awarded each year by the Executive Committee of the Board of Governors.
Reporting medical device problems: How surgeons can assist the FDA

by Janie Fuller, DDS, MPH, Rockville, MD

The U.S. Food and Drug Administration (FDA), an agency of the U.S. Public Health Service within the Department of Health and Human Services, routinely performs surveillance to monitor for problems associated with the products it regulates. The FDA gathers medical device surveillance data primarily through reports submitted by manufacturers, user facilities,* and health care professionals. From time to time, the FDA's device surveillance indicates a need to devote special attention to a specific device-related problem. Currently, the FDA is studying injuries associated with the use of trocars in laparoscopic surgical procedures.

As regular users of trocars and other medical devices, surgeons are in a unique position to assist with the FDA's device surveillance. The FDA receives reports from both mandatory (required by law to report) and voluntary sources. Those physicians employed by user facilities (which are required by law to report to the FDA) should familiarize themselves with and follow the procedures established by their user facility for submitting mandatory reports. Those who work in facilities that are not required to report can still assist the FDA by reporting device problems through the voluntary MedWatch program. By promptly submitting detailed information about the device problems they experience, surgeons can help the FDA and the device manufacturers ensure that devices are safer and more effective.

Those individuals who report device problems to the FDA can remain anonymous; however, the FDA encourages reporters to identify themselves so that it can contact them if it needs additional information. The FDA protects the identity of those persons who report.

History of mandatory device reporting

The FDA's first device reporting requirements were included in the 1976 amendments to the Food Drug and Cosmetic Act, which gave the FDA the authority to regulate medical devices. The first mandatory reporting requirements were limited to device manufacturers and became effective in 1984. In 1990, the Safe Medical Devices Act† extended reporting requirements to user facilities. Mandatory device reporting requirements are found in 21 Code of Federal Regulations Part 803. The FDA requires device user facilities to report deaths and serious injuries associated with their devices. Manufacturers also are required to submit reports on device malfunctions. Reports are to be submitted when there is information to suggest a device malfunctioned or caused or contributed to a death or serious injury. A device malfunction is defined as failure to perform as intended, or failure to meet design specifications when the failure is likely to cause or contribute to serious injury or death.‡

How health care professionals can report

Reporting is quick and simple, and can be done by telephone, fax, mail, or online, as follows:

*User facilities include hospitals, ambulatory surgical facilities, nursing homes, and outpatient treatment and diagnostic facilities that are not an employee-health or school-based clinic or the office of a physician, dentist, nurse practitioner, chiropractor, or optometrist.

Call 1-800/FDA-0178 to fax report.
Call 1-800/FDA-1088 to report by phone or for more information.
Via the MedWatch Web site at www.fda.gov/medwatch.
By mail to MedWatch, FDA, HF-2, 5600 Fishers Lane, Rockville, MD 20852-9787.

FDA shares device surveillance information

The FDA communicates the results of its postmarket surveillance efforts through articles in peer-reviewed clinical journals, through its own User Facility Bulletin, and on its device safety Web site: www.fda.gov/cdrh/safety.html. The information on the Web site includes safety alerts, public health advisories and notifications, “Dear Health Professional” letters, and so on. For example, this Web site includes the notices: “Reducing Radiation Risk from Computed Tomography for Pediatric and Small Adult Patients” and “Problems with Endovascular Grafts for the Treatment of Abdominal Aortic Aneurysm (AAA).”

Persons interested in receiving safety alerts, public health advisories, and other FDA safety notices by e-mail when they are released may subscribe to the DEV-ALERT mailing list through a link on the FDA device safety Web site or by logging onto http://list.nih.gov/cgi-bin/wa?SUBED1=dev-alert&A=1. Additionally, medical device adverse event reports are available through a searchable database on the Web site at http://www.fda.gov/cdrh/maude.html. The MAUDE database includes voluntary reports since June, 1993, user facility reports since 1991, and manufacturer reports since August, 1996, and is updated quarterly.

The FDA has just launched a new means to communicate device safety information, the Patient Safety News, available at http://www.fda.gov/cdrh/psn/. This is a televised series for health care personnel, carried on satellite broadcast networks across the country. Each edition features information on new medical devices, FDA safety notifications and product recalls, and on ways to protect patients when using medical devices. This site contains the text for each broadcast, plus links for more information on each story. It also has instructions for purchasing videotapes of previous broadcasts and sending comments to the FDA about broadcasts.

Dr. Fuller is Regulatory Review Officer, Office of Surveillance and Biometrics, U.S. FDA/Center for Devices and Radiological Health, Rockville, MD.

2003 ACS Japan Traveling Fellow selected

Reid B. Adams, MD, FACS, associate professor of surgery, University of Virginia Health Science Center, Charlottesville, has been selected as the 2003 ACS Japan Traveling Fellow.

As the Japan Traveling Fellow, Dr. Reid will participate in the annual meeting of the Japan Surgical Society in Sapporo, Japan, June 4-6, 2003. He will attend the Japan Chapter meeting during that event and will then travel to several surgical centers in Japan.


Dr. Adams
An ad for Blue Cross/Blue Shield in the September 4, 2002, issue of the Wall Street Journal highlighted the brilliant career of Helen Octavia Dickens, MD, FACS, first African-American woman to be admitted to the American College of Surgeons. Dr. Dickens died in 2001 at the age of 92.

Born in 1909 in Dayton, OH, of a homemaker mother and a father who had been born into slavery, she was eight years old when her father died, and her mother was earning only $24 per week when she graduated from high school. Her determined spirit drove her to get accepted and excel at Crane Junior College in Chicago, IL, where she took premedical courses. She graduated from the University of Illinois College of Medicine in 1934, one of five women in a class of 137 students.

She undertook a residency in obstetrics at Provident Hospital in Chicago from 1933-1935, and began a private practice in Philadelphia, PA, under arduous conditions, returning to Provident and then to Harlem Hospital in New York City. She was certified by the American Board of Obstetrics and Gynecology in 1948, and appointed director of the department of obstetrics and gynecology at Mercy Douglass Hospital in Philadelphia, where she served in that capacity until 1967. In 1950, she became a Fellow of the College, and for this achievement was honored by the governor as a Distinguished Daughter of Pennsylvania.

She became associated with the University of Pennsylvania School of Medicine from 1964 when it acquired the Women’s Hospital in Philadelphia, where she had worked since 1951. Her longstanding association with the University of Pennsylvania School of Medicine resulted in her ultimately being named professor emeritus in 1985. In 1998, the Helen O. Dickens Center for Women’s Health at the Hospital of the University of Pennsylvania was named in her honor.

Dr. Dickens’ special research interests included cancer education and treatment of pregnant teenagers; she conducted research in therapeutic interventions that might improve behaviors and established a teen clinic. She was very widely published, received numerous awards, and had a long list of “firsts.” She developed the Office of Minority Affairs at the University of Pennsylvania School of Medicine to provide academic counseling to minority students. The work of the office has resulted in a 98.5 percent minority student retention rate.

The collected papers of Dr. Dickens are currently held by the University of Pennsylvania Archives and Records Center. For further information, please contact Susan Rishworth, College Archivist, at 312/202-5270, or via e-mail at srishworth@facs.org.
The College has updated the Members Only section to allow you to set your own user ID and password to access its many features. To make that change, go to the College’s home page at http://www.facs.org and click on the “Members Only” link at the top of the page.

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

While you are in the “Members Only” area, please check to be sure that your mailing address, telephone numbers, and e-mail address are both current and accurate. Be assured that the College does not provide your e-mail address to outside entities. E-mail addresses are used only for College communications.
2003 Trauma Video Session: Call for videotapes

Authors of videos on subjects related to trauma (for example, “How-I-do it,” operative techniques of interesting or challenging problems in trauma resuscitation or management) who wish to present their video during the 2003 Clinical Congress in Chicago, IL, Wednesday, October 22, 1:00–3:00 pm, are encouraged to submit:

1. Preliminary information on the appropriate form, which is available from Gay Lynn Dykman, Committee on Video-Based Education, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, tel. 312/202-5262. This form is also accessible on the College’s Web site at www.facs.org/clincon2003/traumavideo.html.

2. A 50-word abstract for each video.

3. The video itself (1/2” super-VHS or CD/DVD formats).

Submit before April 4, 2003, to Rao R. Ivatury, MD, FACS, Department of Surgery, West Hospital, 15 East, P.O. Box 980454, 1200 E. Broad St., Richmond, VA 23298-0454. For further information, call 804/828-7748.

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additional lumina are needed later should be resisted. One study showed that 53 percent of all triple-lumen lines observed had only one lumen in use, indicating that multiple-lumen lines are often used unnecessarily. Subscribers may view the full text of “Nosocomial infection” at www.acssurgery.com.

Dr. Dellinger also discusses multiple-lumen lines. Catheters with two or three internal lumina have become widely available and are often sold in kits that include equipment for guide-wire insertion. These catheters are more convenient when a patient requires multiple lines for monitoring and for delivery of intravenous medications and parenteral nutrition. However, these multiple-lumen lines may be associated with a higher incidence of catheter-associated septicemia than are single-lumen catheters; the data are inconclusive. In one small study, the insertion of two single-lumen catheters did not result in a lower complication rate than did one double-lumen catheter. A catheter with multiple infusion ports is likely to be manipulated more often than a single-lumen catheter, but it is unclear whether the extra manipulation results in a higher infection rate. In situations in which one lumen would suffice, the temptation to insert a multiple-lumen line in case semiquantitatively. If the culture is negative (that is, < 15 colonies), the second catheter can be left in place. If the culture is positive (that is, >15 colonies), the second catheter should be removed immediately, and any new catheter should be placed at a different site.

Dr. Dellinger also discusses multiple-lumen lines. Catheters with two or three internal lumina have become widely available and are often sold in kits that include equipment for guide-wire insertion. These catheters are more convenient when a patient requires multiple lines for monitoring and for delivery of intravenous medications and parenteral nutrition. However, these multiple-lumen lines may be associated with a higher incidence of catheter-associated septicemia than are single-lumen catheters; the data are inconclusive. In one small study, the insertion of two single-lumen catheters did not result in a lower complication rate than did one double-lumen catheter. A catheter with multiple infusion ports is likely to be manipulated more often than a single-lumen catheter, but it is unclear whether the extra manipulation results in a higher infection rate. In situations in which one lumen would suffice, the temptation to insert a multiple-lumen line in case
At Spring Meeting

Programs to consider current state of vascular surgery

Two programs featured at this year’s Spring Meeting, in New York, NY, will consider the current state of vascular surgery. The postgraduate course, Vascular Surgery 2003, will be held Monday, April 14, 2003, from 8:00 am to 4:30 pm.

Robert W. Hobson II, MD, FACS, will serve as moderator for the postgraduate course.

The objective of this six-hour course is for the participant to understand key concepts in vascular surgery. Topics to be addressed include Carotid Endarterectomy and Stenting, High-Risk Carotid Plaque and Its Implications for Management, Optimal Management for Restenosis after Endarterectomy, Indications for Aortic Endograft versus Open Abdominal Aortic Aneurysm (AAA) Repair, Clinical Follow-Up after AAA Repair, and the Management of Endoleaks.

The second general session program, Endovascular Surgery for General Surgeons: Current State of Practice, will take place Tuesday, April 15, from 8:00 to 11:30 am.

The moderator for this program will be Gregorio A. Sicard, MD, FACS.

This program will feature presentations on Lower Extremity Peripheral Interventions and Results, Role for Growth Factors in Lower Extremity Vascular Disease, What’s New in Vena Caval Filters, Current Status of Endoluminal Repair of Abdominal Aortic Aneurysms, Endoluminal Repair of Thoracic Aortic Aneurysms, Techniques for Carotid Artery Stenting, Implications for Clinical Trials, and Is There a Role for Cerebral Protection in Carotid Angioplasty and Stenting?

To learn more about the Spring Meeting and to register for these and other programs, visit the College’s Web site at www.facs.org.

Coding workshops

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

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

The Eastern States Committees on Trauma will present Trauma and Critical Care 2003: Point/Counterpoint XXII, June 2-4, in Atlantic City, NJ. The Tropicana Casino and Resort will be the site of the program, which will bring together internationally recognized authorities to address difficult and controversial trauma and critical care issues. The course will take a broad look at some of the current issues in contemporary trauma care.

Course topics include: Nonoperative Management of Torso Trauma—Where Is the Pendulum?; Changing Concepts in the Diagnosis and Treatment of Blunt Aortic Injury; A Quantum Jump in Trauma Experience—Tales from Latin America; Challenging Cases in Blunt Trauma; Physician Extenders in Trauma Care; The Injured Child: What’s New, What’s Not; Recreational Injuries; How I Do It—Technical Pointers in Managing Major Penetrating Trauma; Challenging Cases in Penetrating Trauma; and Critical Issues in Critical Care.

The scientific program committee consists of Kimball I. Maull, MD, FACS, Co-Chair; Charles C. Wolfarth, MD, FACS, Co-Chair; L.D. Britt, MD, MPH, FACS; David V. Feliciano, MD, FACS; Lenworth M. Jacobs, Jr., MD, MPH, FACS; and Michael Rhodes, MD, FACS.

Complete course information can be viewed online at: http://www.traumapointcounterpoint.com. For further information, contact the Trauma Office at 312/202-5342.

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certain edits. For surgical practices, the most commonly used CPT modifier is -59, Distinct procedural service. Modifier -59 allows physicians to indicate that two codes, which would be subject to a code edit, were actually provided as distinct procedures to the same patient on the same day.

CMS has designated the National Technical Information Service (NTIS) as the sole official distributor of the CCI edits. Surgeons may purchase a subscription for the CCI National Correct Coding Policy Manual for Part B Medicare Carriers in either paper or electronic form by contacting NTIS either by phone, at 1-800/363-2068 or 703/605-6060, or at the NTIS Web site at http://www.ntis.gov/products/families/cdi. A practice may purchase single chapters (such as, “Chapter VI, Surgery: Digestive System, CPT Codes 40000-49999”) that are applicable to the practice. Whether the subscription is for the complete manual or single chapters, subscribers will receive an introduction to the Correct Coding Initiative, general correct coding policies, policy narratives that will help you understand the edits, and a state-by-state listing of Medicare Part B Carriers.

Many commercial vendors sell electronic versions of the CCI edits. Two types of programs are available as computer software: a reference guide similar to the CCI manual that tells what the edits are; and more sophisticated practice management programs that aid in the preparation of claims. A practice certainly may opt to use a commercial software package that incorporates the CCI edits. If this is the case, staff should make sure that the software is updated on a quarterly basis (January, April, July, October) to avoid the unnecessary resubmission of claims.

Some health care insurers other than Medicare do use so-called “black box” edits. Those edits are proprietary to those payors and are not available for review by outside parties.

For more details about the CCI edits, see the CMS Web page at http://cms.hhs.gov/medlearn/ncci.asp.

This column helps answer questions from Fellows and their staffs and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site. If you would like to see specific topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or e-mail HealthPolicyAdvocacy@facs.org.
THE QUALITY IMPERATIVE, from page 31

References


Next month in JACS

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

Original Scientific Articles:
• Predicting Outcomes of Hepatic Transplantation
• Vapreotide and Complications after Pancreatectomy
• Outcomes for Breast Conservation Therapy

Education:
CME and ABS Examination Performance

Palliative Care:
Symposium: Medical Futility and Withdrawal of Care