Training rural surgeons
In memoriam: James Daniel Hardy, MD, FACS, dies
Robert S. Rhodes, MD, FACS

Dr. Nahrwold receives Hubbard Award

Dr. Russell conducts grand rounds

Winners of residents trauma papers competition announced

Task force considers professionalism

NTDB™ data points: How national is the trauma data bank?
by Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

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Letters

Highlights of the ACSPA Board of Directors and the ACS Board of Regents meeting, February 7-8, 2003
Paul E. Collicott, MD, FACS

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From my perspective

On March 21, the College hosted a very important meeting in Washington, DC, on the quality measurement and patient safety movements. We convened the leaders of the surgical specialty societies along with representatives of the public and private bodies that are involved in the development of methods to measure and assess outcomes. Prominent coalitions and agencies represented at the meeting included the Institutes of Medicine, the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality, the National Quality Forum, and the Leapfrog Group.

The College had determined that we needed to bring these groups together to expand our common understanding of the issues involved in the quality movement, as well as the implications and magnitude of its effects on our health care system. For quite some time now, this topic has stirred a whirlwind of discussion. The ongoing discussion and debate about the quality improvement and patient safety agenda are now culminating in what should be real and visible activity in this area in the foreseeable future. Perhaps one could consider this a “tipping point,” where the reality of the situation is that progress will occur in a significant way, and, as surgeons, we need to be part of this process.

Sharing information

At the meeting, representatives of each of the agencies mentioned previously provided information about their activities related to quality improvement. They also discussed the role of surgery in their efforts to make the health care system more quality-centered.

Additionally, a number of the representatives of the specialty societies outlined their efforts to promote quality measures. For example, the Society of Thoracic Surgeons and the American Society of Plastic Surgeons both reported on their development of powerful outcomes measurement tools. Furthermore, a representative of the Department of Veterans Affairs provided information about the success of the National Surgical Quality Improvement Program, which uses a risk-adjusted quality measurement technique that the College believes could be applied in other settings to improve outcomes.

All of the groups clearly share the desire to improve the quality of care in this country and to decrease error rates. To achieve these objectives, however, there needs to be synergistic interaction among all the parties that have a vested interest in our health care system. We need to continually stimulate cooperation between the groups so that we can work together to meet our shared goals.

The message

Much of the discussion throughout the meeting reaffirmed some of the comments that I have made in this column previously regarding the quality movement: that the health care system of the future will be consumer-driven; that patients and payors are going to need strong evidence of which surgeons, institutions, and so on, have proven track records in managing specific types of cases; that surgeons, physicians, and hospitals will need to be accountable for the care they provide.

“If we are to regain and retain the trust of our patients, we must assume the mantle of leadership in the quality movement and truly be accountable for our performance and outcomes.”
Listening to the various perspectives presented by participants during the meeting, it became clear to me that we need to have common measures for comparing the outcomes of hospitals, physicians, and other providers. For example, we are likely to see a strong push toward the widespread application of report cards similar to those the CMS currently is using to rate nursing homes. In the near future, these report cards will be used to evaluate hospitals and eventually physicians and other providers.

This sort of evaluation process is likely to result in new expectations that surgeons should facilitate the data-gathering and analysis effort and that they should be accountable for their practice patterns. Clearly, organizations like the American College of Surgeons and the surgical specialty societies will need to provide our members with the technical skills and assistance they will require in order to develop and maintain useful record-keeping systems. In addition, activities such as computerized physician-order entry, referrals that are made based on the evidence of which hospital or provider has the best outcomes, and staffing intensive care units with intensivists will add significantly to the expense of operating hospitals and practices. It also will potentially lead to new workforce issues that will need to be addressed.

Once the data are generated, the information will need to be disseminated to the purchasers of care—health plans and patients. As we create a more consumer-driven system, patients and payors will need to be given information that will assist them in making appropriate choices based not only on cost, but on quality as well. I have had many conversations with the representatives of payors and private industry; it is apparent that they anticipate eventually linking quality indicators to payment for services and referrals to those centers that are perceived as ensuring better outcomes.

What we must do

Some surgeons might view these efforts negatively—as yet one more intrusion into our profession by outside groups. Others may perceive these trends as being necessary changes that will help us become more trusted partners in the delivery of care. The latter position is the one that I believe will allow us to work with other stakeholders while, at the same time, meeting our moral and ethical obligations as health care professionals.

To me, one of the clearest messages that emerged from our meeting is that the surgical and medical communities have, to a degree, been marginalized in our health care system. Thus, as a profession, we must become more proactive in terms of addressing concerns about patient safety and quality. We need to make a cooperative effort to determine, achieve consensus on, and communicate the steps that need to be taken to develop a better health care system. We need to drive the agenda and provide the indicators, measures, and outcomes data that will lead to improved patient care. If the medical profession fails to have this level of input, no doubt the government, business, and other public and private agents will again be the primary contractors in building the next generation of health care delivery.

If we are to regain and retain the trust of our patients, we must assume the mantle of leadership in the quality movement and truly be accountable for our performance and outcomes. We must evaluate our practices and be actively involved in this era of heightened accountability and more open reporting of outcomes. Systems to pursue these goals must be put into place in hospitals and in individual practices.

The challenge is clear. However, by working with our patients, I believe we can and will be leaders in the quality movement. As always, your comments and suggestions are appreciated.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
Thomas R. Russell, MD, FACS, ACS Executive Director, has been appointed to a special Clinician Advisory Group for the Leapfrog Group. Representing 130 private and public sector employer-purchasers with health insurance plans covering 30 million Americans, the Leapfrog Group has been a driving force in the effort to develop national health care quality and performance measures. The Clinical Advisory Group to which Dr. Russell has been appointed is charged with ensuring that national clinician leaders have input into the organization’s strategy and action plan.

Walter J. Kahn, MD, FACS, an ophthalmologist from Red Bank, NJ, has been named one of four recipients of the 2003 Pride in the Profession Award presented by the American Medical Association Foundation. Dr. Kahn was given the award for “providing patients with quality care beyond the call of duty.” The award is part of the AMA Foundation’s first annual Excellence in Medicine Awards program and was presented to Dr. Kahn because of his work with Project Orbis, a not-for-profit organization that works to alleviate blindness in underserved communities around the world. An article about Project Orbis and about Dr. Kahn’s work with the group was published in the February 2002 issue of the Bulletin of the American College of Surgeons and can be found online at http://www.facs.org/fellows_info/bulletin/feb02bullet.html.

ACS Executive Director Thomas Russell, MD, FACS, hosted an issue symposium on quality measurement and reporting for surgical specialty society leaders and College Advisory Council Chairs in Washington, DC, on March 21. The 65 surgeons and policy staff who attended the event learned about current and planned efforts to help patients and “consumers” identify and purchase high-quality health care services through presentations by and dialog with federal officials, private sector policy leaders, and their colleagues in the various specialties. Program participants included representatives from the Institute of Medicine, the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, and the Leapfrog Group. The College plans to continue the dialog on these issues in its own effort to reach consensus within the profession and provide meaningful advice to policymakers as programs to measure, report, and improve quality of care continue to evolve. For further information, contact Barbara Cebuhar at bcebuhar@facs.org.

The new annual edition of the College’s Publications and Services Catalog is now online. There are two ways to view and order titles from the 2003-2004 catalog. You can visit the online catalog at http://www.facs.org/commerce/2002/catsplash and browse through titles covering a wide range of surgical topics before placing your credit card order via a secured Web server. Or you can download and print a paper copy of the catalog—and its corresponding order form—and then fax (312/202-5001) or mail your order to the College’s customer service staff (American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211).
Total Medicare spending during calendar year 2002 was 8.3 percent higher than in 2001, according to the annual Medicare trustees' report released March 17. The spending increase was 6.2 percent for Medicare Part A and 11.3 percent for Part B. In remarks to a physician audience, Tom Scully, Administrator of the Centers for Medicare & Medicaid Services (CMS), said the increase in physician spending was approximately 7 percent. Other Part B components that accounted for large spending increases included outpatient hospital services (10%), durable medical equipment (20%), and hospice care (24%).

In their report, the trustees estimated that the Part A trust fund will remain solvent until 2026. Part B funding is ensured through its financing mechanism, in which contributions from general revenues and beneficiary premiums are both adjusted automatically each year to provide a guaranteed funding stream. The trustees’ report is available online at http://www.cms.hhs.gov/publications/trusteesreport/.

Early CMS reports are forecasting future cuts in the Medicare physician payment update, despite congressional action early this year that addressed egregious data errors in the formula used to calculate annual adjustments to fee schedule payments. According to a CMS letter sent on March 20 to Medicare Payment Advisory Commission (MedPAC) chair Glenn Hackbarth, preliminary estimates indicate the physician fee schedule update for 2004 will be a -4.2 percent. The letter goes on to state that physician updates will remain negative through 2007.

The projected cut illustrates the flaws inherent in Medicare’s physician payment update methodology itself, which takes into account such factors as the gross domestic product in determining how much total physician spending may increase before negative adjustments are made. A sluggish economy and an unexpected increase in volume appear to be driving next year’s cuts. For additional information, go to http://cms.hhs.gov/providers/sgr/sgr2004p.asp.

The House passed H.R. 663, the Patient Safety and Quality Improvement Act, on March 12 by a vote of 418-6. This legislation would ensure the voluntary, confidential reporting of medical errors to patient safety organizations. Introduced by House Energy and Commerce Health Subcommittee Chairman Michael Bilirakis (R-FL), the legislation will create a framework through which the nation’s health care system can more effectively advance patient safety initiatives and further promote the reporting and analysis of errors.

The issue moves to the Senate where S. 720, also known as the Patient Safety and Quality Improvement Act, has been referred to the Committee on Health, Education, Labor, and Pensions.
Legislators in both the House and Senate are circulating a sign-on letter to their colleagues expressing support for increased fiscal year 2004 funding for programs covered by Title XII of the Public Health Service Act, especially the Trauma Care Systems Planning and Development Act. The letters, championed by Sens. Pat Roberts (R-KS) and Jack Reed (D-RI) and Reps. James Greenwood (R-PA) and Luis Gutierrez (D-IL), urge legislators to support the trauma program, which provides federal grants to assist states in developing, implementing, and monitoring statewide trauma care systems.

The College is grateful that hundreds of surgeons have written letters to their senators and representatives urging them to support funding for trauma systems. To date, 43 senators and 98 representatives have signed these letters of support. Surgeons who want to encourage members of their congressional delegations to sign onto the Roberts/Reed or Greenwood/Gutierrez letters can do so through the College’s Legislative Action Center at http://capwiz.com/facs/home/.

The Department of Health and Human Services (HHS) has announced that it will allow states to immediately request up to 20 percent of the $1.4 billion in HHS bioterrorism preparedness funding that has been allocated for state use in fiscal year 2003 (http://www.hhs.gov/news/press/2003pres/20030320.html). HHS Secretary Thompson’s announcement comes at a critical time when states are battling extraordinary budget deficits while trying to enhance their disaster response capabilities.

States will be able to use this funding for a number of public health, hospital, or disaster preparedness efforts, including enhancing the trauma care and burn care components of their emergency medical services plan.

The ACS Committee on Trauma encourages surgeons to urge their governors to act through the Surgery State Legislative Action Center at http://capwiz.com/sslac/issues/alert/?alertid=1662331.
Proper coding for breast procedures is complicated because of the many ways the care for such cases can progress. For example, biopsies are sometimes performed on two or more lesions in the same session, or a visit to discuss the next steps in treatment may occur during the postoperative period of the biopsy. To receive reimbursement, it is necessary in both instances to indicate that these procedures are distinct.

This article describes in detail both diagnostic and procedural coding for breast biopsies, excision of benign breast lesions, lumpectomies, and mastectomies with special attention to reporting multiple procedures and the use of other modifiers. Although the focus of this article is on breast procedures, many of the same problems occur when billing for other cancer operations.

This article is written for both surgeons and staff who prepare claims and presents the normal International Classification of Diseases (ICD-9-CM) and Current Procedural Terminology (CPT) rules. Of course, if a payor has specified different rules, follow those rules for claims submitted to that insurer. Be sure to retain the rules so that you can demonstrate why you are not following the normal CPT or ICD-9-CM rules.

**Breast biopsies**

Code 19101 is used to report an open, incisional biopsy. The remaining breast biopsy codes are for minimally invasive procedures. Code 19100 is used to report a percutaneous core needle biopsy done without image guidance and code 19102 is used to report the same procedure but with imaging guidance. Code 19103, Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance, is for reporting biopsies performed with either the advanced breast biopsy instrument or Mammatome machines. It is appropriate to report image guidance with code 19103 if the surgeon performs the procedure.

**Localization clip or wire**

At times the surgeon may choose to do a biopsy and, at the same operative session, leave a metallic localization clip so that the site may be found later if it is necessary to remove more tissue. The placement of a clip is reported using add-on code 19295, Image guided placement, metallic localization clip, percutaneous, during breast biopsy. Report code 19295 for each lesion that is marked with a clip, and report the imaging guidance if the surgeon does the guidance. The additional work of placing the clip is negligible, but the code is intended to assist in recovering the expense of the clip if the surgeon incurs it. Therefore, code 19295 may not be paid if the procedure is performed in a facility where the institution bore the cost of the clip.

Another technique used for marking a lesion is the immediate preoperative placement of a localization wire, which is reported using code 19290, Preoperative placement of needle localization wire, breast. If additional wires are placed in other lesions, use add-on code 19291 for each lesion that is marked.

**Excision and mastectomy**

Code 19120, Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19140), open, male or female, one or more lesions, is used for the removal of a breast lesion that is usually palpable or identified by means other than “preoperative placement of a radiological marker.” It is done with an incision and involves the com-
plete gross removal of a lesion that may be benign or malignant, in males or females. Code 19120 is for the simple removal of a mass.

When a breast lesion or mass requires localization by the preoperative placement of a radiological marker, the excision of the first lesion or mass is coded as 19125, Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion. Each additional lesion localized by a different radiological marker is coded with the add-on code 19126. Obviously, radiological guidance is always used for these procedures and is reported by the surgeon if he or she does the guidance.

Code 19160, Mastectomy, partial, is used in the surgical treatment of a breast malignancy when conservative management is chosen. Documentation in the operative report should indicate that the mass or lesion is removed with attention to obtaining adequate margins of uninvolved breast tissue appropriate for the lesion. If an axillary dissection is performed in conjunction with the partial mastectomy, code 19162, Mastectomy, partial; with axillary lymphadenectomy, should be used.

The classic radical, Urban type radical, and modified radical mastectomy procedures are coded 19200, 19220, and 19240, respectively. Table 1 on this page provides the complete descriptors for the three codes. The most common procedure, code 19240, is differentiated from code 19200 in that the pectoralis major muscle is not removed. Code 19240 is used regardless of whether the pectoralis minor muscle is removed.

**Table 1. Complete descriptor for mastectomy codes**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Complete descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>19200</td>
<td>Mastectomy, radical, including pectoral muscles, axillary lymph nodes</td>
</tr>
<tr>
<td>19220</td>
<td>Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)</td>
</tr>
<tr>
<td>19240</td>
<td>Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle</td>
</tr>
</tbody>
</table>

**Sentinel lymph node biopsy**

Sentinel lymph node biopsy is coded using the injection code 38792, Injection procedure; for identification of sentinel node, to report the work of injecting radiotracer or blue dye, and the appropriate lymph node excision code. The node excision codes, 38500 or 38525, are used as appropriate for the axilla. The full descriptor for code 38500 is Biopsy or excision of lymph node(s); open, superficial, and the full descriptor for code 38525 is Biopsy or excision of lymph node(s); open, deep axillary node(s). If the lymph node being excised is a cervical lymph node, code 38510, Biopsy or excision of lymph node(s); open, deep cervical node(s), is used. If it is an internal mammary lymph node, code 38530, Biopsy or excision of lymph node(s); open, internal mammary node(s), is appropriate.

**Reconstructive surgery**

Sometimes reconstruction takes place in the same operative session as the mastectomy. Either one surgeon or two—a general or breast surgeon and a reconstructive surgeon—may be involved. When two surgeons operate, the general or breast surgeon reports the mastectomy and the reconstructive surgeon reports the appropriate reconstructive procedure. Each surgeon writes separate operative notes for his or her portion of the surgery.

**Global period services**

Often services are provided during the global surgery period but are unrelated to previous surgery. The most obvious example is an office visit to explore treatment options during the postoperative period of a positive breast biopsy. In this instance, report the appropriate office visit, established patient, with a modifier indicating an unrelated evaluation and management (E/M) service by the same physician during a postoperative period (modifier –24).
Treatment after biopsy

Sometimes a breast tumor is excised during the global period of the biopsy, or a re-excision may be done during the global period of the initial tumor excision. If either situation occurs, report the initial procedure as usual, and report the second procedure with a modifier to indicate a staged or related procedure by the same physician during the postoperative procedure (modifier –58). The full text for this modifier says it should be used if the second procedure was: “(a) planned prospectively at the time of the original procedure (staged); (b) more extensive than the original procedure; or (c) for therapy following a diagnostic surgical procedure.”

In the case of surgical treatment following a biopsy, the operative note should state, as part of the indications and findings, that the latter procedure is for therapy following a diagnostic surgical procedure. Documentation for a “re-excision” and the use of the –58 modifier should: (a) include reference in the indications and findings of the first procedure that, if final margins are unsatisfactory, a subsequent procedure is planned; or (b) include a discussion in the indications and findings of the second procedure that surgery more extensive than the original procedure is indicated by the final or permanent pathological findings.

Imaging guidance

We have, in several instances, simply said that if the surgeon performs imaging guidance, it is appropriate to report the imaging guidance code along with the code for the breast surgery. The various breast procedures and associated imaging guidance codes (with their full descriptors) are shown in Table 2 (p. 11). The imaging guidance codes are structured quite differently, with some specific to breast procedures and others used for a wider range of procedures. Code 76095 is reported once for each lesion located. Codes 76096 and 76942 are reported twice if two or more lesions are located bilaterally. Codes 76360 and 76393 are only reported once regardless of how many lesions are located.

The College spends considerable time and effort helping surgeons become fully trained and credentialed to perform ultrasound procedures. To ensure that surgeons who use ultrasound are qualified and that the ultrasound facilities and equipment they use are appropriate for the medical application and meet and maintain quality standards, a voluntary verification process has been made available to Fellows.

Nevertheless, the College has received reports from Fellows around the country that they are routinely denied payment for ultrasound-guided breast examinations and biopsies. We recently wrote to a large number of insurers who have denied claims, asking them about their policies for reimbursing ultrasound procedures. So far, the overwhelming majority of replies have been positive. We will be following up with those who have not responded and with a handful of insurers whose responses were unsatisfactory.

Multiple procedures

To properly and completely report what the surgeon did, many claims will contain multiple procedures performed at a single setting. It is important to select the correct modifier and to understand the way CPT expects payors to set fees. A multiple procedure may or may not be reported with a multiple procedure modifier (modifier –51). When it is reported as a multiple procedure, the code is reduced in price by the insurance company. On the other hand, an add-on procedure code can never be reported without an associated base procedure. Therefore, the procedure is priced at its “true value,” is not reduced, and is not reported with a modifier. The following rules may help in selecting the correct modifier(s):

- Report separately each incision made or each lesion biopsied percutaneously. Do not report separately when more than one biopsy is performed through a single incision.
- Report only the definitive procedure when, in a single setting, a biopsy is taken, followed immediately by a frozen section, and then the full tumor is removed.
- Use a multiple-procedure modifier (modifier –51) when there are multiple lesions that are not bilateral. Individual Medicare carriers, and perhaps some private payors, may prefer the modifier for the right side of the body (modifier –RT) or left side of the body (modifier –LT).
- For Medicare, report the codes in the order of descending relative values and attach the
<table>
<thead>
<tr>
<th>Breast procedures</th>
<th>Imaging procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy of breast; percutaneous, needle core, using imaging guidance</td>
<td>Stereotactic localization guidance for breast biopsy or needle placement (e.g., for wire localization or for injection), each lesion, radiological supervision and interpretation</td>
</tr>
<tr>
<td>Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance</td>
<td>Mammographic guidance for needle placement, breast (e.g., for wire localization or for injection), each lesion, radiological supervision and interpretation</td>
</tr>
<tr>
<td>Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion</td>
<td>Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation</td>
</tr>
<tr>
<td>Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker</td>
<td>Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation</td>
</tr>
<tr>
<td>Preoperative placement of needle localization wire, breast</td>
<td>Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation</td>
</tr>
<tr>
<td>Preoperative placement of needle localization wire, breast; each additional lesion</td>
<td>Stereotactic localization guidance for breast biopsy or needle placement (e.g., for wire localization or for injection), each lesion, radiological supervision and interpretation</td>
</tr>
<tr>
<td>+ Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker</td>
<td>Mammographic guidance for needle placement, breast (e.g., for wire localization or for injection), each lesion, radiological supervision and interpretation</td>
</tr>
</tbody>
</table>

All specific references to CPT terminology and phraseology are: CPT only © 2002 American Medical Association. All rights reserved.
multiple procedure modifier to all but the first code. (If your carrier prefers modifiers –RT and –LT, you probably must attach a modifier to the first code also.)

- Place add-on codes immediately following the base code identified in CPT. Do not attach a modifier to the add-on code, and do not reduce the fee. Add-on codes are identified in CPT by a plus sign (+) to the left of the procedure code with a note indicating which is the base code.

- Use the bilateral modifier (modifier –50) when the same procedure is performed on each breast. Remember to increase your fee above what it normally is for a unilateral procedure.

- Remember the Correct Coding Initiative (CCI) for Medicare and similar payor programs. The most common edit in breast surgery is for a biopsy of one lesion and an excision of another lesion on the same day. Use the distinct procedural service modifier (modifier –59). If the payor requires it, use the multiple procedure modifier (modifier –51) also.

**Diagnostic coding**

When reporting a diagnosis on a claim for a breast biopsy, report what is known at the time the claim is prepared, using ICD-9-CM code. If the claim is prepared before the pathology report has arrived, the only way to bill is to supply a nondefinitive diagnosis such as code 611.72, Lump or mass in breast. On the other hand, if the pathological report is complete, the diagnosis from the report for the biopsy may be used. If an additional procedure is needed (for example, re-excision to obtain satisfactory margins, mastectomy), use the definitive diagnosis from the first pathological report. Some cases involve two different diagnoses and it is important to associate the correct diagnosis and procedure codes.

The index to diseases in ICD-9-CM has a very large table containing codes for each anatomic site for each of six neoplasms: primary malignant, secondary malignant, cancer in situ, benign, uncertain behavior, and unspecified nature. There are also codes in the V10 series for personal history of malignant neoplasm. The V10 series should not be reported as a primary diagnosis. Rather, the full four- or five-digit ICD-9-CM code should be reported.

**Conclusion**

As we said earlier, coding for breast disease is complex because of the many ways care can progress. However, by following the rules for the diagnostic and procedural coding systems, it is possible to report all of the care provided, whether it involves multiple procedures done on the same day, care within the global period of another procedure, or any number of other seemingly perplexing scenarios. That allows us to give care when it is needed—something we all want to do.

Nonetheless, payment will not necessarily be made for all of the care surgeons render. Far too many payors either do not accept or do not recognize modifiers at this time, crippling their ability to accurately learn what happened during an episode of care. Although the Health Insurance Portability and Accountability Act (HIPAA) has imposed significant burdens on surgeons, perhaps it will encourage payors to accept modifiers.

By October 16, most payors must be compliant with the electronic transaction and code set provisions of HIPAA. (Small payors—those with fewer than 50 employees—have an additional year to become compliant.) The code set standard adopted for CPT says insurers must accept modifiers, although it goes on to say they do not have to make payment adjustments because of the presence of modifiers. Nevertheless, that is an important first step. The groundwork has been laid for local surgeons to explain to individual payors why they should recognize modifiers and make a payment differential for them.
Training the rural surgeon: A proposal

by

John G. Hunter, MD, FACS, and Karen E. Deveney, MD, FACS,
Portland, OR
Consider this scenario: After completing a general surgery residency in a large urban medical center, you have decided to practice general surgery in a rural setting, seeking a simpler life and a protected environment for raising a family. You have pored through hundreds of “surgeon wanted” ads and settled on the lure of the wide-open spaces of the western U.S. In the shadow of snow-capped mountains, with wheat fields stretching to the horizon, you think you have found a home in one of the last unspoiled portions of America’s frontier. The town is inhabited by 500 cattle ranchers and wheat farmers, one family practitioner, and not one surgeon for 150 miles.

After a month in this community—seeing cuts, bruises, lumps, and minor trauma—your evenings are eerily quiet. Finally the first night call comes in. A planned home delivery appears to be a breach, and the baby is stuck. The seasoned family practitioner is nowhere to be found, so it’s your turn. When you arrive at the ranch, instead of being escorted into the house, the concerned rancher takes you to the barn. Much to your surprise, your first patient is a 700-pound heifer struggling to give birth to a calf. The legs are hanging out of the birth canal and progress is nil. Somewhat comforted that a human life is not at stake, you breathe a sigh of relief. Then the pertinent question hits you: “Where in my surgical residency should I have learned how to deliver a breach heifer?”

Such was the first experience of a young surgeon when he “hung up his shingle” in a small town in Wyoming not so many years ago. Over the years, he learned on the job. He learned many procedures and acquired skills not taught in surgical residency: how to deliver breach infants (humans, too); how to drain peritonsillar abscesses; how to pin a hip fracture; how to perform carpal tunnel release; and a host of other skills.

Training in general surgery formerly provided the training necessary to perform many of these procedures. Now, however, training in many frequently performed surgical procedures falls exclusively to otolaryngologists, urologists, orthopedists, and obstetrician/gynecologists, but these subspecialists are far too few to serve the emergency needs of small communities throughout the U.S.

Over the past 10 years, a small segment of the surgical literature has addressed the need for rural general surgeons. Questionnaires sent from sites throughout the country have demonstrated the desirability of special training opportunities for rural general surgeons. Each survey has identified a corpus of information and procedural skills that are readily obtainable but have never been packaged together for the resident interested in pursuing a career in rural surgery. The data from these questionnaires also demonstrate the importance of the general surgeon not only to the health of his/her community, but also to the economic viability of the rural hospital. One study showed one in seven rural hospitals closing in the last decade. Other studies from the State of Washington have demonstrated the tremendous economic importance of surgical procedures to keep rural hospitals off life support. State governments, in Oregon and elsewhere, have created the designation of critical access hospitals to provide state funding to isolated rural hospitals where a surgical base cannot be maintained.

Oregon’s situation

Oregon is the ninth largest state in the union and one of the most scenic, from the dramatic Oregon coast, to the glaciers of Mt. Hood, to the windsurfing and fruit growing of Hood River, to booming areas of central and southern Oregon, where retirees and others flock to enjoy Oregon’s green mountains and salmon fishing without having to put up with Portland’s rain. Beyond these tourist havens, one is left with a sparsely populated agricultural state to the east and a struggling seacoast economy to the west. In many of these communities, general surgeons are in short supply, and, despite the pristine beauty, it is difficult to attract surgeons to such underpopulated environments (see photo, p. 15).

In making a commitment to these communities, physicians face two major hurdles. First, small towns frequently lack the range and quality of schools, shopping, and cultural opportunities that physicians and their families desire. Second, many general surgeons leave their residency feeling untrained to negotiate the variety...
of problems that the rural general surgeon encounters. Success in a rural setting requires that both obstacles be conquered. It has been demonstrated previously that individuals raised in small towns are most likely to enjoy returning to that environment. This reality is particularly true of the physician’s spouse, who must be willing to forego the offerings of the city in favor of small-town life.

Special training program

To address the problem of inadequate training for rural practice in our general surgical residencies, we have developed a rural surgery training track at Oregon Health & Science University. Our program in rural surgery has the core philosophy that rural surgeons need a broad variety of skills and disciplines not traditionally taught in general surgery. They should be able to perform the basic, common procedures performed by obstetricians/gynecologists, otolaryngologists, orthopaedists, and urologists. Because general surgeons serve as the primary gastrointestinal endoscopists in most small communities, this skill must also be included in that training. A needs assessment survey performed by Dr. Deveney at our institution several years ago demonstrated the corpus of procedures performed by rural surgeons in Oregon (see table, p. 16). From the outset, we identified that the major challenge was to offer complete training in the wide range of procedures performed by rural surgeons during their career and to provide that training in one year. Clearly, this goal could not be accomplished in a very small community where “common” procedures may be
performed infrequently. Instead, we looked for a moderate-size rural community (15,000-30,000), where specialists were available to provide high-quality training, but the individual would begin to get the feel of small-town life, become an integral part of the community, and not suffer competition from specialty trainees. In Oregon, we define a rural community as one with a population of less than 30,000 and located more than 50 miles from a community of more than 50,000 people.

Grants Pass, OR, was chosen as the first site for our rural residency training program for several reasons. It is the right size (population 23,000) and is in the right location (250 miles from Portland and 50 miles from Medford). Further, it has a strong core group of general surgeons, a supportive hospital administration, and a faculty in the surgical subspecialties who are anxious to participate.

While one might argue that suburban community hospitals could offer identical training, the latter experience does not offer the external environment so critical to understanding the nature of practice in a small community. A legitimate criticism of this curriculum is that a community of 30,000 is not truly rural, and the trainee won’t get a real sense of what it means to live in a town of less than 2,000 residents, a long way from anywhere. To address this issue, we intend that the final two months of the one-year experience will be spent in a very rural location, one with a well-seasoned older general surgeon—ideally someone anticipating retirement. This way our trainee will have an opportunity to get to know the town, and the town will get to know the trainee before a commitment is made. Alternatively, this two-month rotation could take place in the practice of a well-established, well-respected, small-town surgeon who has no intention of retiring. In this case, the experience would not involve courtship with a particular community, but with the culture and reality of rural practice to which the individual might eventually return.

Currently, the rural residency program occurs in place of our laboratory year, traditionally done in the fourth year of residency in Oregon, and does not count toward the five years of general surgery training. If the general surgical residency is restructured to allow earlier specialization, we see rural surgery as one of the

Dr. Hunter is chairman, department of surgery, Oregon Health & Science University, Portland.
available options for advanced training. This program might follow three to four years of general surgery training, allowing an individual to sit for the general surgery boards and obtain an additional certificate for rural surgery training.

Future possibilities

It is possible that a rural surgery specialty society or specialty interest group within the ACS will emerge to become the mouthpiece for the rural surgeon of the future. Such groups are already present in South Africa and Australia. For such a special program to be successful, its graduates must feel they possess skills and an identity that sets them apart from their peers who are not so broadly trained and who practice in larger communities.

Despite broad-based training, rural surgeons doubtless will occasionally find themselves desiring the consultation of a specialist. To augment this “connectedness” of our rural training program to the University Medical Center we have developed the capacity, and are modeling the economics, of “on demand” two-way video teleconferencing. Currently, systems using two ISDN lines are adequate to accurately convey surgical details to the consulting surgeon. With or without video conferencing, we hope to improve the quality of rural surgery by providing quality general surgical training in a wide variety of common surgical procedures that might be performed with confidence and competence by a surgeon in a small community.

For a firsthand account of the experiences of the first resident to go through this program, see the article by Garrett R. Vangelisti, MD, on page 18.

References


Dr. Deveney is vice-chair, surgical education, Oregon Health & Science University, Portland.
I have now completed the first six months of what may prove to be the best year of my residency experience. I am a fourth-year general surgery resident at the Oregon Health & Science University (OHSU), Portland. As the first general surgery resident to matriculate into the university’s rural surgery training program (RSTP), I have had the privilege of participating in the development of its curriculum and of catching a glimpse of the realities associated with a rural surgical practice. The purpose of this program is described in the article on page 13 by John G. Hunter, MD, FACS.

Program design

Traditionally, clinical rotations in general surgery have included obstetrics/gynecology, otorhinolaryngology, orthopaedics, urology, endoscopy, and general surgery. These rotations in the RSTP differ significantly from what first- or second-year residents experience in most general surgery training programs. In the university or community-based “junior” subspecialty rotations, general surgery residents rarely serve as the operating surgeon. The procedures performed are usually involved in the management of complex cases that have been referred by smaller hospitals, and the objective of these rotations is to provide exposure, not to promote competence.

The objective of the “senior” rotations in surgical specialties as part of the RSTP is to attain competence in the management of the type of cases that might be encountered in a rural practice far from a referral hospital. Essentially, it is designed to train the resident in surgical primary care. One of the unique challenges facing such a broadly trained surgeon is determining which cases they must do (emergencies), which cases they should do (common elective procedures), and which cases should be referred (rare procedures in complex patients). For example, patients with acute testicular torsion, active labor with fetal distress, or a peritonsillar abscess all represent surgical emergencies that should be treated without delay.

Carpal tunnel syndrome, however, represents a clinical problem that is not a surgical emergency yet may have serious consequences if neglected. A
A general surgeon with adequate training and experience in performing this operation may manage such a patient in a rural setting, thereby sparing the patient the inconvenience of traveling long distances to a higher acuity facility. A general surgeon equipped with the knowledge and technical skills to manage basic surgical problems in the subspecialties is of great value to the rural communities. If my first six months of the rural surgery training program is any measure, I feel confident that I will be able to manage many of the basic surgical problems of obstetric, gynecologic, orthopaedic, urologic, and otolaryngologic surgery.

Broad experience

During my obstetrics/gynecology rotation I learned about the management of ovarian masses, ectopic pregnancies, tubo-ovarian abscesses, pelvic inflammatory disease, and much more. My operative log grew thicker as I performed hysterectomies, emergent and elective cesarean sections, laparoscopic tubal ligations and oophorectomies, and dilation and curettage for diagnostic and therapeutic purposes. The orthopaedic rotation provided the opportunity to perform closed reductions of many types of fractures, the evaluation and management of patients with median and ulnar nerve compression syndromes, flexor and extensor tendon repairs of the hand, and the reduction of joint dislocations.

While on the otolaryngology service, I learned how to perform the incision and drainage of peritonsillar, submandibular, and deep neck abscesses. I gained experience in the basics of facial plastics, which proves useful during the excision of facial skin tumors or traumatic facial lacerations.

The urology experience exposed me to the evaluation and management of nephrolithiasis, bladder and prostate cancer, and, of course, the difficult Foley catheterization. The operative log continued to grow with the addition of orchietomies, vasectomies, and the surgical reduction of testicular torsion. Many of these opportunities are not available to general surgery residents at OHSU due to the presence of the many individuals training in the respective specialties.

I must emphasize that I have not simply been “programmed” in the technical aspects of these problems. For example, the technical skill of pinning a hip fracture is necessary but insufficient to care for patients with hip injuries. Some hip fractures require a hemiarthroplasty or dynamic hip screw rather than pinning.

The success of the RSTP and those individuals who complete it will not be measured by the size of the operative log alone. A thorough understanding of the pathophysiology of the disease process is of equal importance. This can only be achieved...
through supervised evaluation of patients in the outpatient clinic, pre- and postoperatively, and in the emergency department setting.

Rural life

In addition to the broad surgical training, I experienced a glimpse of life in a rural community. Despite a population of 23,000, everybody knows everybody in Grants Pass, OR. A trip to the supermarket is incomplete without hearing, “Hello Dr. Vangelisti,” from a patient, colleague, or both. A night on call can range from a simple page about an antiemetic or the emergency room physician calling you at home to discuss the two patients in the ER with stab wounds to the abdomen.

The Phantom of the Opera does not come to town much, and I have noticed the absence of a Starbucks on every street corner. However there is certainly much to enjoy. The world’s largest Chinook salmon ever caught with a fly rod was pulled from the Rogue River this year, and the steelhead aren’t too shabby either. This is one of three rivers within minutes of town, thus the name “Three Rivers Community Hospital.” Despite the many hours dedicated to reducing fractures, delivering babies, and pinning hips, I have found time to go fishing, hiking, and enjoy the scenic white water of the Rogue River with my wife and son.

Conclusion

So, whether my career leads me down the highways of academics or the back roads of rural Oregon, I believe this may prove to be the best year of my residency training. As the first resident at OHSU to embark on such an endeavor, there are occasions when a fellow resident asks with skepticism about the relevance of such broad training. “Garrett, will you ever pin a hip, perform a cesarean section, or drain a deep neck abscess? Is this training truly relevant?” My answer usually draws from an experience I had in the past week.

A 29-year-old female presented to our level III trauma center/ER two days after a hard fall on water skis. The blast to her left side took her breath away and then some. She stayed at home on the couch and treated her pain with aspirin and Vicodin. On arrival to the ER her abdomen was distended and diffusely painful. Her initial hematocrit was 22, and her systolic blood pressure was 80 with a pulse of 130. The nurse anesthetist and OR tech were called in from home and the patient was taken directly to the OR.

“Well did you take out the smashed spleen?” asked a fellow OHSU resident. No. David Oehling, MD, FACS, a general surgeon, and I removed the suspicious right ovarian cyst that had hemorrhaged over 1,000 cc into her abdomen. There was no need to call the gynecology service. This experience, like many others, demonstrates the value of the RSTP.

At many of the postgraduate general surgery training programs, I could probably log a handful of laparoscopic adrenalectomies, assist on several coronary artery bypass surgeries, and perform more laparoscopic cholecystectomies than I could count. It is very likely that many of the chief residents in general surgery will graduate this year without ever performing an oophorectomy.

It is for these reasons, and many more, that my year in the RSTP may be the most valuable portion of my general surgical training. I thank all of the people who have had the vision and enthusiasm to develop such a program, and I appreciate the opportunity to participate in its inception.

Dr. Vangelisti is a fourth-year surgical resident at the Oregon Health & Science University, Portland.
The 15th anniversary of National Trauma Awareness Month will be observed throughout the month of May. This education and awareness effort was initiated by Congress in 1988 to heighten national attention to trauma and efforts to reduce the consequences of severe injuries.

This anniversary year offers the College a chance to acknowledge the accomplishments of state trauma care systems and to highlight the need for more funding to ensure that all states are ready to respond to natural or man-made catastrophes.

by Adrienne Roberts,
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Background

The Trauma Care Systems Planning and Development Act of 1990 created Title XII of the Public Health Service Act to develop and foster coordinated trauma systems that give patients access to the most appropriate trauma care. Administered through the Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA), over the past 10 years, the program has distributed almost $25 million in funds to all 50 states and five U.S. territories. However, even with this influx of federal money, the nation’s trauma network remains incomplete. In fact, only one-fourth of the population lives in areas served by a trauma care system.¹

The original legislation was developed in response to a 1986 General Accounting Office report (GAO/HRD-86-132), which indicated that severely injured individuals in the majority of both urban and rural areas sampled in the U.S. did not have the benefit of a trauma system, despite considerable evidence that these systems improve survival rates and reduce disability. Nationally, unintentional injury is the leading cause of death for individuals ages one to 34, the second leading cause for individuals ages 35 to 44, and the third leading cause for people 45 to 54 years old. Studies of conventional trauma care show that up to 35 percent of trauma patient deaths could have been prevented if optimal acute care had been available.²

A subsequent report in 1999 by the Institute of Medicine (IOM), Reducing the Burden of Injury, called on Congress to “support a greater national commitment to, and support of, trauma care systems at the federal, state, and local levels.”³

These networks are responsible for saving thousands of lives by ensuring that severely injured patients receive the care they need within the “golden hour” of care. Current medical practices prove that treatment delivered within that crucial first hour following severe injury is likely to mean the difference between temporary and permanent disability and, perhaps, between life and death. Also key to an effective and efficient trauma system is a comprehensive information system to provide a foundation for evidence-based practice, performance improvement, and research. In 1994, the College established the National Trauma Data Bank™ (NTDB™) as a repository of injury information for use by trauma program directors, hospital administrators, health planners, and government agencies.³ This year, the NTDB doubled its size to more than 400,000 cases; it can be accessed on the College’s Web site at http://www.facs.org/dep/trauma/ntdb.html.

In addition to the lives lost, the financial impact of trauma is staggering. In 2000 alone, motor vehicle crashes cost Americans $230.6 billion—the equivalent of $820 for every citizen and 2.3 percent of the U.S. gross domestic product. The lifetime economic cost to society for each fatality is more than $977,000, with more than 80 percent of this amount directly related to lost workplace and household productivity.⁴ Clearly, severe injury poses a significant public health problem for the nation that is costly, potentially preventable, and requires immediate action. Although the College has succeeded in establishing a federal focus for these trauma system grants, many state and federal policymakers still do not fully grasp the role that these programs play in ensuring coordinated responses to natural disasters or acts of unconventional terrorism.

When injuries occur in rural areas, the dangers are even greater. The remoteness of some areas of the country can severely complicate the process of providing timely, high-quality care. Coupled with a more hazardous working and living environment, rural seclusion slows access to treatment, often leading to injury, disability, or death. It is for this reason that 10 percent of all funds appropriated to the trauma care systems program are directed to HRSA’s Office of Rural Health Policy and are specifically designated for addressing rural trauma-EMS issues.

Trauma and terrorism

The urgency of severe injury as a public health problem and the critical need to address it are even more evident today. Despite all national and local efforts, the latest findings indicate that almost half the states still lack a comprehensive trauma care system. With the events of September 11, 2001, still fresh in our minds, and the concerns about a potential backlash due to the war in Iraq, our nation has renewed its focus on enhancing disaster preparedness. Hence, it is critical that the federal government increase its commitment to strengthening the Title XII programs that promote trauma
care system planning and development. Trauma systems are a key component of homeland security. Indeed, they are the solution to conventional weapons terrorism, which is by far the most frequent mode of terrorist attack in the U.S. and around the world.

In addition, states have an opportunity to further strengthen their trauma system by tapping other funding streams, including $500 million that has been allocated to HRSA for implementing bioterrorism preparedness programs (trauma system support is one of 10 allowed uses for these funds), and $1 billion has been earmarked for the Centers for Disease Control and Prevention (CDC) to use for disaster preparedness. The College believes it is essential that state and federal policymakers focus on developing and supporting trauma systems that are as capable of responding to injuries caused by unconventional acts of terrorism as they are at reducing death and disability caused by other mechanisms.

Commitment to trauma systems
The National Highway Traffic Safety Administration and HRSA convened a stakeholders group in 1998 to craft a vision for the trauma care systems of the future. Representatives of the College and its Committee on Trauma, as well as the American Trauma Society, the National Association of Emergency Medical Services Physicians, the National Association of State Emergency Medical Services Directors, American College of Emergency Physicians, American Pediatric Surgical Association, and other organizations, met again this spring. They reviewed an update to the “Model Trauma Systems Planning and Evaluation” plan. This document provides a primer on a public health approach to statewide trauma system development and on the tools that can be used to evaluate and select improvements that best serve the trauma care needs of local communities. HRSA is also in the process of developing a strategic plan to identify national priorities for trauma care, as well as to provide guidance to increase efficiency, improve outcomes, and allow for continuous quality improvement. Ultimately, it is anticipated that this continued investment will help build strong yet flexible trauma systems that are prepared to respond to the needs of individual communities.

Current advocacy efforts
The College continues to press Congress to increase trauma funding in fiscal year (FY) 2004 so that trauma networks will be fully prepared to respond to any emergency. We are also working with the Senate and House authorizing committees—the Senate Health, Education, Labor, and Pensions (HELP) Committee and the House Energy and Commerce Committee—to introduce and pass legislation reauthorizing and enhancing HRSA’s trauma care program through fiscal year (FY) 2008.

The Trauma Care Systems Planning and Development Act of 2003, S. 239, was introduced by Senate Majority Leader Bill Frist, MD, FACS (R-TN), and Sen. Edward Kennedy (D-MA) in January 2003. It was recently approved by the Senate HELP Committee and is intended to improve the collection, analysis, and use of trauma patient data. In recognition of the growing pressure on state budgets, the bill further proposes to reduce the amount of matching funds that states must provide to participate in the program. It also authorizes funds for an IOM study to examine the state of trauma care and trauma research and calls on the National Institutes of Health to establish a comprehensive program of basic and clinical trauma-related research. The bill would reauthorize Title XII of the Public Health Service Act for another five years and double the funding available for trauma system development in FY 2004 from $6 million to $12 million. A companion House bill is expected to be introduced later this spring.

Action needed
Federal and state policymakers need to recognize the importance of building and supporting trauma systems that can respond to both conventional injuries and to acts of unconventional terrorism. Surgeons are urged to visit the College’s Legislative Action Center at http://capwiz.com/facs/home to encourage their legislators to support the trauma care systems legislation. We also need help asking state policymakers to allocate funds to participate in this national effort. Surgeons should visit http://capwiz.com/facs/sllac/issues to ask their governors and state officials to take full advantage of the federal programs available to help build and nurture these vital systems of care.

continued on page 48
Radiation treatment rooms 2B, “ARK,” and 3B, “LIBERTY,” at the Kaiser-Permanente Medical Center in Hollywood, CA, had become all too familiar sights to me while recently receiving treatment for localized recurrent cancer of the prostate. I had undergone radical excision four years earlier, but the prostate specific antigen (PSA) blood test had risen from an initial zero postoperatively to 0.81 IU. A transrectal biopsy of the prostatic bed had shown the same cancer cells (Gleason 3) as in the original tumor. So, my oncologists, Brace Hintz, MD, and Jon Kaswick, MD, and I decided that a course of radiation with 6,400 rads over 32 visits was indicated.

Déjà vu
This was not the first time I had found myself in the radiation therapy patient’s position. In 1971, I had been diagnosed with nodular sclerosing Hodgkin’s disease—the form with a better prognosis. Treatment was a bit different then. I underwent a course of 4,000 rads with the archaic Cobalt 60 machine to the thoracic area with the Mantle technique devised by Stanley Kaplan, MD, of Stanford (CA) University. I also was given a four-month course of chemotherapy invented by Vincent DaVito, MD, called MOPP. The combined modalities succeeded in making the mediastinal masses disappear and never return.

It is a unique opportunity for someone in the medical profession to be put in the place of the patient—to experience a series of malignancies and to view the treatment process from the other side.
Awareness building

Often as I sat in the waiting room to undergo my recent course of radiation therapy, I would strike up a conversation with someone, and we would share our feelings. Rather than reveal that I was a physician, I preferred to be another hopeful patient undergoing radiotherapy. It wasn’t difficult to guess which patients had the most serious conditions. A woman with a kerchief covering her bald head was obviously afflicted with a brain tumor. Anyone wearing a gown was getting torso treatment, while fully dressed men such as myself were getting prostate radiation. For those of us in the latter group, the schedule was so efficient and the process so routine, we merely entered the treatment area and dropped our pants and shorts for the five-minute procedure.

Lying on my back atop the mechanized table, I had time to notice a lot about my surroundings. The room was well-ventilated and air-conditioned, the lighting subdued, and the walls decorated with colorful pastoral scenes. The ceiling was covered in simulated pine panels, and a closed-circuit video camera was recording the process. The focus of my attention was on the huge Varian Megavoltage Linear Accelerator that had a large U-shaped gantry, and the patient on the mobile platform was raised into the open end of the U.

After being positioned on the table with beams centered on previously placed India ink tattoos on both hips and the suprapubic area, a bungee cord was placed around my feet so I wouldn’t move them. The Varian arm then rotated to the overhead position; a musical buzzer intoned simultaneously with a flashing red light during the 10-second exposure. The arm then rotated to the posterior position, and the second exposure was delivered. Then it rotated to the left lateral port, and finally, the right lateral port for 10 seconds each. During the brief and painless treatment, it was easy for the mind to wander and to speculate about how the beam of high-energy radiation was affecting those nasty cancer cells inside my body.

Dr. Hintz tells me it will take about six months after the radiation has ceased to determine whether it succeeded in ablating the recurrent focus of cancer. With a strong faith in a benevolent God, I trust that I once again will be cured.

Respect and humility

So, twice in my lifetime as a surgeon I have experienced what cancer treatment is like for our patients. The uncertainty, the waiting, the fear, and the pain all became much more acute and real as I lived through each phase. I believe that surviving each ordeal has made me more sensitive to the people who turn to me for their care. It is my firm belief that until one goes through this sort of ordeal, it is impossible to understand what it is like to be in a patient’s shoes. Hopefully, this understanding makes someone a better physician.

To those individuals who looked after me in my time of need, I owe my deepest gratitude and respect for their diligence, kindness, and expertise. Indeed, as I reflect on my experiences as a patient, I have attained a new respect and appreciation for all the professionals who contribute to patient care. As the “captain of the ship,” a surgeon often takes a great deal for granted, but the successful voyage is dependent on all the members of the crew doing their best. Without the expertise of my colleagues in medical oncology and radiotherapy, I wouldn’t be here to write this story.

I was fortunate to have the strength and serenity to leave the management of my care to these experts. The adage that says, “The lawyer who handles his own case has a fool for a client,” comes to mind. The surgeon who thinks he can determine the best course of treatment for himself has a fool for a patient. The lesson of humility has again been learned.
In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

The U.S. Department of Health and Human Services (HHS) published two final rules in the February 20 Federal Register that address standards required by the Health Information Portability and Accountability Act (HIPAA). The first rule contains revisions to the transaction and code set standards; the second establishes the long-awaited HIPAA security standards. This article summarizes the provisions that are pertinent to surgeons and their staffs.

Transaction/code set standards

HHS expects all parties to comply with the October 16 deadline for the transaction and code set standards. The following changes were made to the transaction and code set standards:

- HHS has retracted its designation of the National Drug Codes (NDC) as the recognized code set for reporting drugs and biologics for all covered entities but retail pharmacies. This reversal means that physicians will continue to use the Healthcare Common Procedure Coding System (HCPCS) codes to report drugs.
- The rule revision refines certain components of standard health care claims submitted by physicians and institutions. Covered entities are expected to test their systems using the data elements contained in the modified standard. Surgeons should check with vendors and payors with whom they exchange electronic data to determine when those businesses will begin testing with the modified health care claim standards.

Security standards

The HIPAA security standards become effective April 21, and practices must be in compliance with those rules by April 21, 2005. For the past year, this column has offered surgeons guidance in their efforts to comply with the HIPAA privacy standards. The publication of the security standard serves as a natural transition to looking at how practices secure the electronic information governed by the privacy standards.

The privacy standard has given patients the right to know how their physicians use and disclose patient information. The security standards also require practices to implement safeguards to ensure that patient information cannot be accessed by anyone who does not have the right to receive it.

The implementation processes a practice has used to become compliant with the HIPAA privacy standard will be useful in understanding the government’s expectations under the security standard. As surgeons have worked to ensure the privacy and confidentiality of patient information, their practices have already looked at some of the essential elements of security.

At this juncture, each practice should have assessed whether the physical location of computer terminals and fax machines adequately ensure that no unauthorized individuals have access to confidential information. A privacy officer should have set up access protocols for staff members (such as passwords, automated level-

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Around the corner

May


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Keeping current

What’s new in ACS Surgery: Principles and Practice

by Erin Michael Kelly, New York, NY

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

Keeping current in 2003 with ACS Surgery: Principles and Practice

ACS Surgery 2003 is now available. Receive a free three-month trial to www.acssurgery.com (a $50 value) by ordering your copy today. For only $199 you can be among the elite group of surgeons that subscribe to the 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 S35S1G3C.

V. Operative management

15. Intestinal anastomosis. Julian Britton, MS, FRCS. In his newly revised chapter, Dr. Britton addresses certain fundamental technical issues in the performance of an intestinal anastomosis and summarizes what is known about how these issues relate to the reliability of the various anastomotic techniques in current use. He also outlines operative approaches to performing three common intestinal anastomoses in somewhat greater detail.

One technical issue addressed in the chapter is the choice of stapler. Transverse anastomosis (TA) and gastrointestinal anastomosis (GIA) staplers are available with a variety of inserts containing different types of staples. These inserts vary with respect to the width and height (or depth) of the closed staple, as well as the distance between the staples in the rows. They are designed for use in specific tissues, and it is important to choose the correct stapler insert for a given application. In particular, inserts designed for closing blood vessels should not be used on the bowel, and vice versa. With TA and end-to-end anastomosis (EEA) staplers, it is possible to vary the depth of the closed staples by altering the distance between the staples and the anvil as the instrument is closed. The safe range of closure is usually indicated by a colored or shaded area on the shaft of the instrument. Thus, if full closure would cause excessive crushing of the intervening tissues, the stapler need not be closed to its maximum extent.

A 1987 comparison of anastomotic techniques that used blood flow to the divided tissues as a measure of outcome found that the best blood flow to the healing site was provided by stapled anastomoses in which the staple height was adjusted to the thickness of the bowel wall. The next best blood flow was provided by double-layer stapled and sutured anastomoses, followed by double-layer sutured anastomoses and tightly stapled anastomoses, in that order.
One of the procedures that Dr. Britton reviews is the single-layer sutured extramucosal side-to-side enterenterostomy. A side-to-side anastomosis may be performed when no resection is done, as a bypass procedure (such as a gastro-enterostomy); after a small bowel resection; when there is a discrepancy in the diameter of the two ends to be anastomosed (such as an ileocolic anastomosis after a right hemicolectomy); or when the anatomy is such that the most tension-free position for the anastomosis is with the two bowel segments parallel (as in a Finney strictureplasty).

Two stay sutures of 3-0 polyglycolic acid are placed approximately 8 cm apart on the inner aspect of the antimesenteric border. A 5 cm enterotomy is made on each loop with an electrocautery or a blade on the inner aspect of the antimesenteric border. If electrocautery is used, care must be taken not to injure the mucosa of the posterior wall during this maneuver; placement of a hemostat into the enterotomy to lift the anterior wall usually prevents this problem. Hemostasis of the cut edges is ensured, and the remaining enteric contents are gently suctioned out. A swab soaked in povidone-iodine may be used at this point to cleanse the lumen of the bowel in the perianastomotic region.

A full-length seromuscular and submucosal stitch of 4-0 polyglycolic acid is placed and tied on the inside approximately 5 to 10 mm from the far end of the enterotomies. The stitch is not passed through the mucosa; to do so would add no strength to the anastomosis and would hinder epithelialization by rendering the tissue ischemic. A hemostat is placed on the short end of the tied suture, and the assistant applies continuous gentle tension to the long end of the suture. An over-and-over stitch is started in the direction of the surgeon; small bites are taken, and proper inversion of the suture line is ensured with each pass through tissue. When the proximal ends of the enterotomies are reached, this so-called baseball stitch is continued almost completely around to the anterior wall of the anastomosis. A single Connell stitch may be used to invert this anterior layer.

Another full-length seromuscular and submucosal suture of 4-0 polyglycolic acid is then inserted and tied at the same location in the posterior wall as the first. If the two sutures are placed close enough together, the short ends need not be tied together and may simply be cut off. The remainder of the posterior wall is sewn away from the surgeon in the same manner as the portion already sewn, and the corners are approximated with the baseball stitch. The anterior wall is then completed with this second suture, either with the Connell stitch or with an over-and-over stitch with the assistant inverting the edges before applying tension to the previous stitch.

When the defect is completely closed, the two sutures are tied across the anastomotic line. The stay sutures are removed, and the anastomosis is carefully inspected. Often, there is no mesenteric defect to close in a side-to-side anastomosis, but if there is one, it should be approximated at this point with continuous or interrupted absorbable sutures, with care taken not to injure the vascular supply to the anastomosis.

Subscribers may view the full text of “Intestinal anastomosis” at www.acssurgery.com.

V. Operative management

30. Surface reconstruction procedures. Joseph J. Disa, MD, FACS; Himansu R. Shah, MD; and Gordon Kaplan, MD. In their new chapter, Drs. Disa, Shah, and Kaplan provide general recommendations on local flap procedures. In addition, they describe several different types of local flaps that are useful for the purposes of the general surgeon, and summarize key technical points specific to each.

As the authors point out, it is essential to cause as little tissue trauma as possible when raising a flap in all forms of plastic surgery. Using skin hooks rather than forceps is helpful in this regard. The flap is marked and incised, and elevation is begun, first with a scalpel and then, at the base of the flap, with a blunt scissors to keep from disrupting the blood supply. The electrocautery should be used judiciously in the elevation of skin flaps. Although cautization causes less bleeding, skin flaps often rely on the subdermal plexus for perfusion, and this plexus can be damaged by electrocautery dissection. Close attention to atraumatic technique throughout the procedure will result in less edema in the flap and, therefore, less circulatory compromise.
Hemostasis is essential; in small flap procedures, bipolar coagulation controls bleeding with minimal damage to the flap's blood supply. Two-layer closure is recommended, with absorbable suture material in the deeper layer to decrease the tension and fine nylon for skin closure.

One of the local flaps that the authors describe is the rhomboid flap (Limberg flap), which is a transposition flap that is designed in a specific geometric fashion. The initial defect is converted to a rhomboid, with care taken to plan the flap in an area with minimal skin tension. The rhomboid must be an equilateral parallelogram with angles of 60° and 120°; this design allows the surgeon to excise less tissue than would be needed for an elliptical flap. One face of the rhomboid constitutes the first side of the flap (YZ), which should be aligned along the line of maximum extensibility. The short diagonal of the rhomboid is then extended outward for a distance equal to its own length. This extension should be oriented along relaxed skin tension lines, perpendicular to the line of maximum extensibility; it constitutes the second side of the flap (XY). Next, a line parallel to YZ is drawn from X to outline the third side of the flap. Correct orientation of the rhomboid is vital for providing flap repair with minimal tension, particularly with respect to the line of maximum extensibility: it is along this base line that maximum tension results when the donor defect is closed. Once the flap has been correctly designed and elevated, it is transposed into the defect. Closure is done in two layers.

Rhomboid flaps work best on flat surfaces, such as the upper cheek and the temporal region. Extra attention to flap design is necessary when an attempt is made to close a defect over a convex surface with a rhomboid flap; improper flap design leads to excessive tension and potential flap necrosis.

Subscribers may view the full text of “Surface reconstruction procedures” at www.acssurgery.com.

Looking ahead

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

- “Patient safety in surgical care: A systems approach,” by Robert S. Rhodes, MD, FACS.
- “Gastroduodenal procedures,” by E. Ramsay Camp, MD, and Steven N. Hochwald, MD.
- “Nutritional support,” by Rolando H. Rolandelli, MD, FACS; Dipin Gupta, MD; and Douglas W. Wilmore, MD, FACS.

Mr. Kelly is editor, What’s New in ACS Surgery: Principles and Practice, WebMD Reference, New York, NY.
James Daniel Hardy, MD, FACS, died in Madison, MS, on February 19, 2003, following a short illness. A Fellow of the College since 1951, Dr. Hardy served as ACS President from 1980-1981.

Dr. Hardy was born with his twin brother, Julian Patterson, in Birmingham, AL, on May 14, 1918. They grew up, along with a younger brother and four stepchildren, in Newala—a rural town 35 miles outside Birmingham. During high school, he formed a dance orchestra in which he played the trombone. He also played right guard on the football team.

He attended the University of Alabama, where he majored in chemistry with minors in biology and German. Upon graduation, he received an offer to join the German department but, instead, chose to go to medical school at the University of Pennsylvania, where he was president of Alpha Omega Alpha. Although he began his residency in internal medicine at Penn, his military service with the 81st Field Hospital during World War II turned his interests to surgery. Thus, after the war he returned to Penn to complete his training in general and thoracic surgery. There he was heavily influenced by Isidor Ravdin, MD, FACS; Jonathan Rhoads, MD, FACS; and Julian Johnson, MD, FACS. His research interests at this time included wound healing and circulatory physiology. He also received a masters of medical science in physiological chemistry from Penn for his work on heavy water and the management of body fluids.

In 1951, Dr. Hardy moved to Memphis, TN, as assistant professor of surgery and director of surgical research at the University of Tennessee College of Medicine. He quickly achieved national recognition and was soon promoted to associate professor.

In 1955, at age 37, he moved to Jackson, MS, to become the first chair of the department of surgery at the newly opened four-year School of Medicine of the University of Mississippi. In the ensuing 32 years in that position, he trained over 150 surgeons and significantly enhanced the quality of surgical care throughout the state. He also built a world-renowned department. Early faculty members included Curtis Artz, MD, FACS, and Watts Webb, MD, FACS, both of whom made their own outstanding contributions to surgical science and went on to chair departments.

Dr. Hardy was a prolific surgical scholar. He coauthored or edited more than 23 medical books and published more than 500 articles and chapters in medical publications. His numerous contributions to the Surgical Forum of the American College of Surgeons led to the Forum’s limitation on the number of first-authored contributions (the “Mississippi rule”). Ironically, the Regents’ concern was transmitted to Dr. Hardy by his former mentor, Dr. Ravdin, then Chair of the
Board of Regents. The ultimate recognition by the Surgical Forum came when the 1983 Forum was dedicated to him as “an outstanding surgical educator, investigator, clinical surgeon and international leader.”

Two of his books became recognized standard surgery texts and his two autobiographical memoirs, The World of Surgery, 1945-1985, and The Academic Surgeon, are wonderful reading. The latter, published in 2002, reflects his sharp and insightful mind even in advancing age.

Dr. Hardy served on numerous editorial boards and was editor-in-chief of The World Journal of Surgery. He had a dynamic and indefatigable personality and was admired by his students, residents, and fellow faculty as a charismatic teacher.

Dr. Hardy was a pioneer in transplantation. He was the first to perform a renal autotransplant for a proximal ureteral injury and, in 1963, he performed the first human lung transplant. Martin Dalton, MD, FACS, then a resident, was a member of the operating team but was called out of the procedure to see a patient in the emergency room with a gunshot wound of the chest. The patient was the civil rights leader Medgar Evers, who had been brought to the University of Mississippi Medical Center after being fatally wounded by Byron de la Beckwith. The historic nature of the transplant was lost in the commotion over Evers’ murder. As happenstance would have it, this shooting would again interplay with the history of the medical center. The third (and final) trial of de la Beckwith began in Jackson in 1994, weeks before the scheduled meeting there of the Society of University Surgeons (SUS). The proceedings and the publicity of the trial filled much of the available hotel space. Had the trial lasted any longer, there would have been insufficient space to accommodate the SUS attendees.

Dr. Hardy’s interest in transplantation put him at the center of controversy in 1964 when he performed the first human heart transplant. Since no suitable donor was available, the donor heart came from a chimpanzee. The patient died after 90 minutes. The subsequent controversy included issues of the transplant itself, the fact that it was a xenograft, and the ongoing civil rights controversies in Mississippi. He braved this storm of criticism and the subsequent shift in sentiments regarding heart transplantation paved the way for the first successful human-to-human heart transplant by Christian Barnard in 1967.

Dr. Hardy’s leadership in American surgery is reflected by the fact that he was elected president of the most prestigious surgical organizations, including the American College of Surgeons (1980), the Society of University Surgeons (1961), the Society for Surgery of the Alimentary Tract (1969-1970), the Southern Surgical Association (1972-1973), the American Surgical Association (1975), the Society of Surgical Chairmen (1976-1978), and the International Surgical Society (1985-1987). In another irony, Dr. Hardy’s first office in the College was an appointment as Second Vice-President to complete the term vacated by the death of Dr. Curtis Artz.

Dr. Hardy was also vice-chair of the American Board of Surgery (1969-1970) and a founding member of the International Surgical Group and the Society for the Surgery of the Alimentary Tract. He received international recognition for his work and was an honorary member of The Royal College of Surgeons (London), l’Academie National de Medicine, and l’Association Française de Chirurgie. In 1971, he was honored with two medals from the Vishnevsky Institute in Moscow for his pioneering role in the field of transplantation.

After his retirement as department chair in 1987, he served as Distinguished VA Physician from 1987 to 1990. In 1991, he became the twelfth recipient of the Rudolph Matas Award in Cardiovascular Surgery. Previous honorees included Alfred Blalock, MD; Michael DeBakey, MD, FACS; and Norman Shumway, MD, FACS. Dr. Shumway has stated that Dr. Hardy was a generation ahead of his time.

In 1992, Dr. Hardy became the inaugural honoree of an annual award initiated by the University of Pennsylvania to honor an outstanding resident alumnus. An annual James D. Hardy Lectureship has been established in his honor in the department of surgery at the University of Mississippi Medical Center.
The National Board of Medical Examiners (NBME) recently announced that David L. Nahrwold, MD, FACS, was selected as the recipient of the 2003 John P. Hubbard Award. The award is given to individuals recognized as making significant contributions to the pursuit of excellence in the field of evaluation in medicine.

Dr. Nahrwold is currently the president of the American Board of Medical Specialties and emeritus professor of surgery at Northwestern University Medical School. He became a Fellow of the College in 1971 and was elected to the Board of Governors in 1992, serving as its Chair from 1996 to 1998. He was a member of the Board of Regents from 1998 to 2001, and served as Interim Director of the College from 1999 to 2000.

Mark A. Albanese, PhD, chair of the 2003 Hubbard Award Committee, announced Dr. Nahrwold’s selection at the annual meeting of the NBME this past March. In presenting the award, Dr. Albanese stated:

“Dr. Nahrwold, through his leadership in establishing the competency-oriented direction for the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education, has made outstanding contributions to the field of evaluation in medicine. He has had impact on the state of assessment and evaluation in medical education and outstanding achievement in improving the quality of medical evaluation at an organizational level and beyond.

His leadership role through the American Board of Medical Specialties in the establishment of the ACGME competencies is clearly recognized. Dr. Nahrwold spearheaded the competency movement. He has written extensively and lectured on the area of competency, broadening it beyond the cognitive knowledge and technical skills to other areas such as communications and working in an atmosphere of a systems-based approach. The competency movement is fostering the development of evaluation methods and measurement techniques that will provide more comprehensive assessment of future physicians.”
Dr. Nahrwold’s accomplishments have had a monumental impact on the state of assessment and evaluation in medical education at all levels and exemplify the essence of the Hubbard Award.

The NBME established the John P. Hubbard Award in 1983 in special tribute to the late John P. Hubbard, MD. Honoring Dr. Hubbard as a principal guiding force of the NBME, this award acknowledges his creative and inspired leadership of the organization during his 25-year tenure as its chief executive. Dr. Nahrwold joins the ranks of the distinguished individuals whom the NBME has honored over the years with this prestigious award.

Dr. Russell conducts grand rounds

Thomas R. Russell, MD, FACS, ACS Executive Director, recently served as a visiting professor in the department of surgery at the University of Utah, Salt Lake City. As part of this activity, he conducted grand rounds at the university’s medical center, which included the participation of the three chief residents in general surgery pictured here: (left to right) Jeanne Cleveland, MD; Dr. Russell; Michelle Mueller, MD; and Clint Webster, MD. During the grand rounds, Dr. Russell spoke on career paths in surgery. Additionally, Dr. Russell gave an update on College activities to the Salt Lake Surgical Society and participated in teaching conferences with the university’s surgical and medical residents.
Winners of residents trauma papers competition announced

The ACS Committee on Trauma announced the winners of the 2003 Residents Trauma Papers Competition at its annual meeting in Chicago, IL, March 13-15, 2003. This year, 13 regional winners received prize money of $500, with additional first-place prize money of $1,000 and second-place prize money of $500.

The Residents Trauma Papers Competition is funded by the Eastern and Western States Committees on Trauma, and Region VII (Iowa, Kansas, Missouri and Nebraska), Wyeth Pharmaceuticals, and the American College of Surgeons.

This competition is open to surgical residents and trauma fellows in the U.S., Canada, and Latin America. Papers are submitted to the individual state or provincial chair. Winning papers are selected and sent to each region chief so they may conduct a regional competition.

Papers describe original research in the area of trauma care and/or prevention categorized in either basic laboratory research or clinical investigation.

Winning papers from 13 regions were presented at the scientific session at the Committee on Trauma meeting, and the final four winners were announced at the trauma banquet. Winning senior authors and their spouses had an expense-paid trip to the meeting. Gregory J. Jurkovich, MD, FACS, Chair of the Regional Committees on Trauma, served as moderator.

The 2003 final winners were as follows:

**First Place—Basic Laboratory Research:** Eve C. Tsai, MD, Toronto, ON: Strict Glycemic Control Reduces the Incidence of Bacteremia in Critically Ill Surgical Patients.

**Second Place—Basic Laboratory Research:** Katherine A. Barsness, MD, Denver, CO: Hemorrhage-Induced Lung Injury is TLR-4 Dependent.

**Second Place—Clinical Investigation:** David J. Schultz, MD, Milwaukee, WI: Incidence of Asymptomatic Pulmonary Embolism in Moderately to Severely Injured Trauma Patients.

**First Place—Clinical Investigation:** Steven Fox, MD, Hartford, CT: Novel Synthetic Grafts That Promote Axonal Regeneration and Functional Recovery after Spinal Cord Injury.
The American College of Surgeons’ Division of Education has established four special task forces to address the competencies of Interpersonal and Communication Skills, Systems-based Practice, Practice-based Learning and Improvement, and Professionalism. These competencies have been adopted by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. The task forces will address the spectrum of educational items relating to the aforementioned competencies within the context of both residency training and maintenance of certification. Educational models will be developed to serve the needs of learners across the various surgical specialties.

The Education Task Force on Professionalism met at the College’s headquarters in Chicago, IL, February 15-16, 2003. The task force was chaired by Alden H. Harken, MD, FACS. Membership of this task force included representatives from the various surgical specialties. A draft of a document outlining a Code of Professional Conduct was developed and several major educational recommendations were outlined by the task force. These recommendations will serve as the foundation for further steps to address the various elements of this competency.

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

The Education Task Force on Professionalism, left to right: front row: Kathleen R. Liscum, MD, FACS; Ellen M. Cosgrove, MD, FACP; Dr. Harken; Jyoti Arya, MD; and Sylvia R. Cruess, MD.

Back row: Thomas D. Kirksey, MD, FACS; Patrice Gabler Blair, MPH; Joel C. Rosenfeld, MD, FACS; Paul Friedmann, MD, FACS; Russell Gruen, MBBS; Dr. Sachdeva; A. Brent Eastman, MD, FACS; Richard L. Cruess, MD; P. Jeffrey Fabri, MD, FACS; Ira J. Kodner, MD, FACS, and Elvin G. Zook, MD, FACS.

Not pictured: Frank R. Lewis, Jr., MD, FACS; Claude H. Organ, Jr., MD, FACS; Rosemary Morrison; and Thomas R. Russell, MD, FACS, ACS Executive Director.

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The second annual report of the National Trauma Data Bank™ (NTDB) was released this past fall. Data have been submitted from 130 trauma centers across the U.S. and include 430,577 records. This compilation represents the largest aggregation of trauma registry data that has ever been assembled.

Not since 1990, when Champion and others published The Major Trauma Outcome Study: Establishing National Norms for Trauma Care (MTOS), have we had the opportunity to take a critical look at the patterns of injury and delivery of trauma care. The MTOS was conducted under the auspices of the American College of Surgeons from 1982 to 1989. Investigators at 140 hospitals utilized a standard collection form for data submission. This project ultimately led to the development of a national trauma registry and subsequently this national trauma data repository. Unlike the MTOS, which accumulated 80,000 cases over a period of eight years, the NTDB has eclipsed that rate fivefold and in a shorter time frame. The current record accrual rate is approaching 200,000 cases per year. There is a broad geographic representation from trauma centers located in 22 states across the country, Puerto Rico, and the District of Columbia (see figure). These 130 trauma centers submitting data represent roughly 25 percent of all Level I and Level II trauma centers nationwide.

The mission of the American College of Surgeons’ Committee on Trauma is “to improve the care of the injured through systematic efforts in prevention, care and rehabilitation.” Publishing the NTDB Annual Report 2002 is one way in which the College is able to carry out this mission. By informing the medical community, the public, and decision makers regarding the current state of trauma care we can identify the strengths of our current trauma care delivery system. Of equal importance is to identify areas for improvement as we look toward the future. Trauma care has achieved national attention in light of the past year’s events. Now more than ever, we need to become and stay informed about the delivery of care to the injured person.

Throughout the year we will be highlighting these data through “NTDB data points,” which will be found regularly in the Bulletin.

For a complete copy of the NTDB Annual Report 2002, visit us on the ACS Web site at http://www.facs.org/dept/trauma/ntdbannualreport2002.pdf. If you are interested in submitting your trauma center’s data, contact Melanie Neal, NTDB Manager, at mneal@facs.org.

NTDB™ data points

How national is the trauma data bank?

by Richard J. Fantus, MD, FACS, Chicago, IL, and John Fildes, MD, FACS, Las Vegas, NV
Wright State University School of Medicine, Dayton, OH, presented its 2003 Outstanding Alumni Award to Linda M. Barney, MD, FACS, assistant professor of surgery and associate program director in general surgery at Miami Valley Hospital. In both 2000 and 2001, Dr. Barney received the Miami Valley Hospital Resident Teaching Award. She is the chair of the Miami Valley Hospital department of surgery.

The president of Uruguay, Jorge Battle, has appointed Conrado Bonilla, MD, FACS, to serve as that country’s minister of public health. Dr. Bonilla, a general surgeon, began performing his duties February 26.

In recognition of his notable contributions to the Accreditation Council for Graduate Medical Education (ACGME), Paul Friedmann, MD, FACS, Springfield, MA, received the council’s 2003 John C. Gienapp award earlier this year. The award is presented annually to honor individuals who have made distinguished contributions to graduate medical education and the accreditation process.

Dr. Friedmann recently co-chaired the ACGME’s work group on resident duty hours, which developed the new 80-hour work week standards that become effective in July. Dr. Friedmann’s co-chair of the work hours’ task force was William T. Williams, Jr., MD, a pediatrician, who received the Gienapp award with Dr. Friedmann.

At the 88th annual meeting of the American Academy of Pediatrics, Jay L. Grosfeld, MD, FACS, FRCSEng(Eng)(Hon), received the William E. Ladd Medal—the highest distinction of achievement in pediatric surgery awarded in the U.S. Dr. Grosfeld is LaFayette Page Professor and chair, department of surgery, Indiana University School of Medicine, and surgeon-in-chief, Riley Children’s Hospital, Indianapolis. He is best known for his expertise in neonatal surgery and pediatric surgical oncology, as well as his reputation as a surgical leader, an educator, and an advocate for children in the U.S. and abroad.

Jonas T. Johnson, MD, FACS, was elected president of the American Academy of Otolaryngology-Head and Neck Surgery Foundation. Dr. Johnson is a professor and vice-chair of otolaryngology at the University of Pittsburgh (PA) School of Medicine.

The Society of Medical Consultants to the Armed Forces elected David M. Lichtman, MD, FACS, to the post of vice-president (president-elect). The organization is composed of physicians who have held senior positions in the uniformed services and who now serve as medical consultants to the senior staff of the U.S. Armed Forces, the Department of Defense, and Congress. Dr. Lichtman is the chair, department of orthopaedic surgery, at JPS Health Network, Fort Worth, TX.

Eugene N. Meyers, MD, FACS, professor of otolaryngology and chair, eye and ear foundation, University of Pittsburgh (PA) School of Medicine, presented several international lectures in otolaryngology during the last few months. Among other international meetings, Dr. Meyers spoke at: the Second International Conference and European Meeting of the European Organization for Research and Treatment of Cancer, Abano Terme, Italy; the XI Congreso Peruano de Otorrinolaringología y Cirugía Facial, Cuzco, Peru; the Second World Congress of the International Federation of Head and Neck Oncologic Societies, Rio de Janeiro, Brazil; the Laryngeal Carcinoma-Multidisciplinary Approach Symposium, Bursa, Turkey; the Second National Meeting of the Foundation for Head and Neck Oncology, Calcutta, India; the Fifty-Fifth Annual Conference of the Association of Otolaryngology, Calcutta, India; and the Primera Reunion de las Academias Americana y Ecuatoriana de Otorrinolaringología: IV Curso Internacional de Cirugía Endoscópica Nasosinusual, Quito, Ecuador.

Kenneth J. Printen, MD, FACS, was elected to the post...
of president-elect of the Illinois State Medical Society (ISMS) during its recent annual meeting. Dr. Printen, associate professor of surgery at Northwestern University Medical School, is considered a pioneer in the area of bariatricsurgery. He also is a practicing general surgeon based in Evanston, IL.

The Royal College of Surgeons of England recently awarded honorary fellowship to Martin C. Robson, MD, FACS, emeritus professor, department of surgery, University of South Florida, Tampa. Dr. Robson was one of three physicians receiving the honor and the only one from outside the United Kingdom. He is a recognized expert in the field of wound healing and is currently involved in active clinical and basic science research on the subject at the Bay Pine Veterans Affairs Medical Center.

The Joint Commission on Accreditation of Healthcare Organizations named Robert B. Smith III, MD, FACS, to serve as its treasurer this year. Dr. Smith is the medical director at Emory University Hospital in Atlanta, GA, and has served on the JCAHO’s board since 1996. Additionally, he served on the College’s Board of Governors from 1991 to 1997.

The College’s New Jersey Chapter passed a resolution late last year recognizing Kenneth B. Swan, MD, FACS, for 20 years of dedicated effort to presenting and maintaining the Advanced Trauma Life Support course at the University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark. Dr. Swan is a professor of surgery at the institution.

IN COMPLIANCE, from page 26

of-access controls on the computer system), ensuring that only the individuals who need to create or update patient records can do so. The practice is making sure that medical records maintained electronically are regularly backed up so that a power outage or a computer crash will not prevent necessary access to those records. All of these tasks are part of security compliance.

Just as the HIPAA privacy standard required practices to appoint a privacy officer, the security standard requires that a member of each physician’s staff is designated as the officer for security activities. In a small practice, it is very likely that the same individual will serve in both capacities, while a larger practice might look to the staff member who is responsible for office and/or personnel management. The security officer’s responsibilities will include working with both staff members and vendors.

Practices should conduct self-audits to examine current security practices. A beginning point for this could be the development of a diagram that tracks how patient information is handled from the time a new patient arrives to when that patient’s records are purged or destroyed. Once again, as with the privacy standards, the findings from the self-audits should be used to develop written policies and procedures to document how confidential information is handled. Practices also must conduct training sessions to ensure that their employees understand and abide by the business procedures for securing patient information.

The College has identified resources in the public domain that will help surgeons and their staffs comply with all the HIPAA standards. A number of regional public/private industry groups have developed compliance tools and sponsor both face-to-face seminars and Web-based courses. Additionally, most state governments have created HIPAA-specific Web sites that provide information and guidance on state-specific issues, such as state privacy laws. A directory with links to these Web sites is posted at http://www.facs.org/.

Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents in February 2003:

- An otolaryngologist from Athens, PA, was placed on probation. The period of probation will run until such time as the surgeon has a full and unrestricted license in Pennsylvania; until he/she has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada; and until his/her practice pattern has been reviewed and approved by the Central Judiciary Committee (CJC).

The states of New York and Pennsylvania have placed this surgeon’s license on probation following a guilty plea to charges of fraudulently obtaining controlled substances on more than one occasion for personal use.

- Robert Barry Miller, MD, an otolaryngologist from Mooresville, NC, was expelled from the College following a felony conviction for mail fraud in U.S. District Court in West Virginia.

- A thoracic surgeon from San Francisco, CA, was placed on probation. The period of probation will run until such time as the surgeon has a full and unrestricted license to practice medicine; until he/she has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada; and until his/her practice pattern has been reviewed and approved by the CJC.

This surgeon’s license in California was placed on probation for five years with terms and conditions following charges of unprofessional conduct in the care and treatment of several patients.

- A general surgeon from Springfield, IL, was placed on probation. The period of probation will run until such time as the surgeon has a full and unrestricted license to practice medicine; until he/she has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada; and until his/her practice pattern has been reviewed and approved by the CJC.

This surgeon’s license in Illinois was suspended for 90 days and then placed on probation for five years with terms and conditions following a finding of guilty to charges of: gross negligence; dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public; and a pattern of practice which demonstrated incapacity or incompetence to practice with reasonable judgment, skill, or safety.

- A neurologist from Fayetteville, AR, had his Fellowship restored to full status after being on probation since June of 2000. This Fellow had been placed on probation for a period of time to run concurrent with his medical license probation; concurrent with the aftercare contract imposed by the state of Arkansas; and until such time as he has full and unrestricted surgical privileges in an accredited hospital in the U.S. or Canada. This surgeon fulfilled all of those requirements and was fully reinstated by the Board.

- A thoracic surgeon from Floral Park, NY, had his Fellowship restored to full status after being on probation since October 2001.

This Fellow was placed on probation until such time as he had a full and unrestricted medical license; until he had full and unrestricted privileges in an accredited hospital in the U.S. or Canada; and until such time as the CJC had reviewed and approved his pattern. The surgeon demonstrated that these requirements have been fulfilled.

Omission

The April issue of the Bulletin contained a news story (p. 60) regarding the activities of the ACS Division of Education’s Task Force on Practice-based Environment. The accompanying photograph neglected to identify Robin S. McLeod, MD, FACS, FRCSC (third from left, front row). The editors regret the omission.
The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the “From my perspective” columns written by Executive Director Thomas R. Russell, MD, FACS.

Retirement

Dr. Condon’s article in the February Bulletin concerning retirement is certainly one that offers worthwhile material to the surgeon who is contemplating retirement. As an 80-year-old eye surgeon who has been happily retired from a solo practice for seven years, may I offer a few suggestions in addition to those made by Dr. Condon?

The sine qua non of a happy retirement is your own health—especially freedom from pain. Next in importance is the health of your spouse, children, and grandchildren. The retired surgeon who is family-oriented will find a godsend in his or her children and grandchildren—little chance of boredom and loneliness when they are in your life. The retiring physician, hopefully, will be financially secure.

Something not mentioned by Dr. Condon: In this, the computer age, I cannot imagine my or any other person’s retirement without almost immediate access to a computer. My initial experience with a computer was more than 20 years ago with the primitive Atari. That was followed by the original IBM PC model that I bought for my son while he was in law school. Then came the Internet through a more advanced IBM computer and Prodigy. Later came MSN and ATT as Internet service providers. Now I am using an IBM computer with cable RoadRunner for Internet connection. A retired physician without a computer and cable Internet accessibility is missing an opportunity for an exciting retirement experience. I have immediate access to endless information on countless subjects—medical and otherwise.

The computer allows me to write innumerable letters to friends anywhere in the world, authors, and editors. The computer provides me with the equivalent of an endless library that is immediately available in my own study with merely the click of the cursor. Yes, I could live in retirement without my computer, but that would produce a needless void.

If the retiring surgeon is not computer literate, I suggest that he become literate. There are many introductory computer courses available—at community schools, computer stores, senior citizen facilities, and so on. In addition, I have found that my grandchildren are always a ready source of practical computer wisdom.

The surgeon who is contemplating retirement has a wonderful opportunity for an extremely happy experience. Just plan it and play it properly. Your years of retirement could be the happiest years of your life.

William Charles Caccamise, Sr., MD, FACS

Two very fitting articles appeared in the February issue of the Bulletin. The first was written by Dr. Robert Condon, and the second by Dr. Josef Fischer.

Dr. Condon’s article was most entertaining to me because I retired several years ago and faced some of the same problems of which he spoke. One situation that he failed to mention, however, is the lack of physicians retiring now. This situation is directly related to the poor economy. The 401(k) investment funds have hit bottom, and there is no evidence that the economy is going to rebound any time soon.

Physicians at retirement age are coming back to work or just not leaving practice. This situation hurts the young physician who is trying to come out and begin a life in medicine.

Dr. Fisher’s article, to me, was particularly poignant. I have trouble when someone tries to classify “liberal” and “conservative.” I recall in the early 1990s when one group ran on the platform of a balanced national budget, and now, in the early twenty-first century, this same group wants to develop the largest U.S. deficit in some time. What is this group other than politicians trying to serve their constituents and be reelected?

The other part of Dr. Fischer’s article that disturbed me was how he ripped Britain’s National Health Service, but gave no solution to our own problem. So long as this mentality exists in our country, we will be faced with the present system being run by the insurance companies and hospitals. The physician, along with the customer, must reenter the arena and have a major part in the health care delivery system in this country. Money should not be part of the solution. There are too many advantages to being a physician. “Living within your means” should be important both in retirement and in practice.

W S. Houck, Jr., MD, FACS

Tort reform

I believe that the emphasis on tort reform may not by itself result in a long-term solution to the malpractice crisis. Greater emphasis on prevention and understanding of factors responsible for patients and their families bringing suits against physicians (surgeons) should be considered.

I am a retired surgeon. While in practice in Massachusetts, I reviewed dozens of malpractice allegations against surgeons for the
defense. I participated extensively in peer review and quality assurance activities at the hospital level. I recently served on a jury in federal court in a nonhealth-related case.

It is important to remember that there is always an event that is perceived as wrong by a patient or family that leads to litigation. Good, expected results do not result in lawsuits.

J urors take their responsibilities seriously. In most civil or criminal trials, the jurors have no prior experience with the issues and situations. They rely on witness testimony, documents, and so on, to reach a verdict. In malpractice cases, all jurors have had previous interactions with physicians and hospitals. J urors are more likely to relate to the allegedly injured patient than to plaintiffs where money alone is the issue. It is my contention that similar previous experiences lead to decisions to bring suits by patients and cause jurors to be biased in favor of plaintiffs in malpractice cases. I believe that a better understanding of why some patients sue and others do not under similar circumstances would be helpful in avoiding some suits.

A few examples of factors that might predispose patients to sue and jurors to favor patients follow:

- Arrogance and a superior demeanor on the part of the physician and his or her staff.
- Lengthy delays in obtaining appointments and long waits in offices to be seen.
- Failure to inform a patient that a different surgeon will be operating after a major operation.
- Overemphasis on payment and overzealous collection efforts, particularly when the service concerned was an emergency.

Our education at all levels should devote greater emphasis on avoidance of patient resentment. Our medical schools should consider giving more influence to humanistic qualities and less to academic achievement alone. Our “risk management” courses should focus more on actual cases rather than “mock trials.”

The following avoidable problems occurred in many of the cases that I reviewed:

- Poor and illegible notes in office and hospital records.
- Failure to become aware of lab and X-ray results that indicated the presence of postoperative problems.
- Failure on the part of the operating surgeon to obtain all pertinent information before embarking upon a major procedure.
- Delay in investigating postoperative complications.

I hope that sharing my experience may be helpful to other surgeons.

Lorne C. Smith, MD, FACS

Future of surgery

Thank you once again, Dr. Russell, for a timely and informative editorial in the February Bulletin. I couldn’t agree more with you that we need to be looking toward the future.

I am concerned that many “third-party overseers” are using “quality” as a canard. In my opinion, the majority of surgeons have been practicing high-quality surgical care despite the obstacles thrown in our way. What these third parties want is expert care for unrealistically low reimbursement. The net result so far has been gradual and persistent erosion in care as more surgeons try the impossible—to provide more services to as many patients as possible in order to generate enough revenue to pay overhead and still take home a decent income. Quality has suffered as the time spent per patient, operation, and so on, has diminished. Unless dramatic changes are undertaken, quality will continue to diminish.

I believe one of two essential changes must occur. The first would be a dramatic increase in reimbursement for surgical procedures. This increase would allow for surgeons to accept fewer patients, to spend more time with their patients, hire ancillary personnel to assist with difficult and complex problems, and provide optimum quality through a thoughtful, methodical approach.

Appropriate financial rewards would encourage more people to enter the profession and continue to reduce workload to appropriate levels. More rest and family time will reduce stress among surgeons and improve oversight of patient care. I don’t think this will realistically happen.

The second change that must occur is acceptance of the fact that current economic pressures are not compatible with traditional surgical (or general medical) care. It is quite simply impossible to be available, rested, and in peak form 24 hours a day, especially with the ever-increasing number of patients who require care and the complexity of today’s cases. The amount of work necessary to take care of each patient has grown steadily and older patients with multiple medical problems have become the rule. It is simply not possible to be the doctor for so many people. Naturally, errors will occur, as pressure to do more in less time continues.

I believe that surgery, and medicine in general, will have to adopt a different approach. The concept of the individual doctor will have to be revisited. I think we must start looking at the concept of the medical “team” that will include surgeons. As a broad overview, each physician and surgeon would be expected to work a certain “shift” and be relieved of
his or her responsibilities at the end of the shift. This system would prevent fatigue and poor decision making by forcing individual physicians to share decision making with others and presumably relieve the pressure to overwork. Certainly, this idea directly collides with the concepts of continuity of care and “captain of the ship,” but, face it, look where we are today using the traditional approach.

As long as we encourage the “lone wolf” concept, we will continue to see a decline in quality care. Most other industries have realized that the team approach (that is, Six Sigma) has produced far more predictable quality at less cost with higher consumer satisfaction. It is time for medicine to realize its current limitations and act accordingly.

Daniel T. McDevitt, MD, FACS

International Guest Scholars

Although the majority of the February 2003 issue of the Bulletin focused on socioeconomic issues, the brief section on the 2003 International Guest Scholars was most significant. Kofi Annan’s recent editorial in Science (299:1485, 2003) speaks to surgeons as well as scientists: “Peacemaking and peacebuilding should never be the exclusive preserve of diplomats and politicians.” Efforts to build a stronger international community of surgeons are timely.

Each of us can make his or her own small contributions. Those who teach and operate abroad should continue to do so. Those involved in medical editing and publishing should seek contributions from the global community and ensure all surgeons have access to the latest scientific information. Those directing fellowships and other training programs should open them as possible to candidates from outside North America. Most importantly, we should nurture and preserve our personal relationships with colleagues around the globe. I was saddened, for example, to hear from a surgeon friend, who sponsored my teaching trip to Egypt last year, that he wouldn’t be attending U.S. meetings in the future because of reported harassment of Arab men here.

The College’s International Guest Scholar program is to be commended. Perhaps we could expand international programs to serve more specialties and geographic areas. One thought would be to sponsor an increased number of visiting surgeons nominated by specialty societies.

Wayne F. Larrabee, Jr., MD, FACS

Clinical trials

I just finished the most recent issue of the ACS Bulletin and your monthly “From my perspective” column struck a chord with me.

Late last summer, I began to notice a vague fullness in my abdomen. To make a long story short, I ended up having a gastrointestinal stromal tumor arising off the anterior wall of my stomach, which I had resected last November. I had never heard of this tumor, but I know a lot about it now. Mine had a very low mitotic count, probably the most reliable predictor, but it was quite large. It was interesting having abdominal surgery after having spent a career operating on other people. I thought it was a piece of cake.

I talked with an oncologist after my surgery about using Gleevec as an adjuvant therapy for four to six months. He learned that the American College of Surgeons Oncology Group (ACOSOG) was just beginning a clinical trial with 80 patients using Gleevec as an adjuvant for a year.

As a result, I am now enrolled in that trial and have been on the medication for two months with no significant side effects. I have no idea how ASOSOG decided to begin what really is a trial about medication, but I am grateful because I was seriously considering doing just that on my own—so finding the clinical trial made my decision easy.

My thanks to ACOSOG.

Ralph Keill, MD, FACS, MBA
Highlights
of the ACSPA
Board of Directors
and the ACS
Board of Regents
meeting

February 7-8, 2003
by Paul E. Collicott, MD, FACS,
Director,
Division of Member Services

American College of Surgeons Profes-
sional Association (ACSPA)

During the 2002 Clinical Congress and in
the weeks that followed, the ACSPA-
SurgeonsPAC raised approximately $28,000,
which the political action committee used for
donations to 10 candidates in last year’s elec-
tion cycle. All 10 candidates were elected. As
of mid-January, the PAC had raised $70,000
from 305 donors. Staff and members of the
ACSPA-SurgeonsPAC Board of Directors
have begun the process of participating in
local chapter meetings to educate members
directly about ACSPA and the PAC.

American College of Surgeons (ACS)

Erie Street properties
The Board of Regents approved a transac-
tion between the College and the Richard H.
Driehaus Museum. Attorneys have drafted
an agreement to document the transaction
as a result of negotiations that will allow the
College to retain the title to the John B.
Murphy Memorial Auditorium and the right
to use the Nickerson Mansion. The agree-
ment could be finalized as early as April or
May.

Association management program
The Regents approved an ACS business
plan for association management. The Col-
lege has received proposals that range from
the rental of office space to full management
services from various surgical societies. To
qualify for such services, organizations must
be recognized by the American Board of
Medical Specialties.

Business and finance
The Board of Regents approved a bond re-
demption and refinancing plan relating to
the rental or lease of College space under the
condition that the bonds are budget-neutral.
Any further lease transactions by the Col-
lege, including the use of conference rooms,
will require redemption of nontaxable
bonds. The College would need to redeem only a conservative amount of these bonds to lease out the remaining portion of one of its floors and provide future flexibility to rent additional space, conference rooms, and so forth.

**Development program**

The College received 658 gifts totaling $817,142 during the fiscal year period of July 1, 2002 to January 9, 2003. During the same period last year, the College received 294 gifts totaling $631,553.

**New membership category**

The Regents approved a new category of College membership for medical students. The new category will provide a vehicle for the ACS to educate, encourage, and mentor medical students.

To join, medical students will pay a one-time nonrefundable application fee of $20 and no annual dues during the duration of their medical school education. Students must be enrolled in a U.S. medical school accredited by the Liaison Committee on Medical Education or an accredited Canadian medical school. Some of the benefits of membership in this category are:

- Discounts on selected Lippincott/Williams/Wilkens textbooks.
- Health, life, auto, disability, and loan payment insurance policies.
- Online access to the *Journal of the American College of Surgeons*.
- Access to the “members only” side of ACS Web site.
- Student Surgical Education and Self-Assessment Program (SESAP).
- No registration fee for Clinical Congress.
- MBNA credit card.
- Personal data assistant and software discounts.
- Representation on selected ACS committees, including the Subcommittee on Medical Student Education and the Committee on Informatics.
- ACS membership card.
- Use of ACS travel agency.

**Scholarship/Fellowships**

The Board of Regents awarded six ACS Resident Research Scholarships and 10 ACS Faculty Research Fellowships for 2003-2005. The Resident Research Scholarship is supported by the generosity of Fellows, chapters, and friends of the College, to encourage residents to pursue careers in academic surgery. The Faculty Research Fellowship, also supported by the generosity of Fellows, chapters, and friends of the College, is offered to surgeons entering academic careers or a surgical specialty. The fellowship is intended to assist surgeons in the establishment of new and independent research programs. The College awards approximately $1.5 million annually in scholarships/fellowships.

**Education**

At the November 2002 meeting of the Accreditation Council for Continuing Medical Education (ACCME), the College was awarded accreditation for four years. The College also was recognized for “exemplary compliance” in element 3.1 of the accreditation standards. This element addresses the organizational framework for CME activities, including the committee structure and the processes used to review and continue improvement of the organizational framework.

The exemplary compliance rating was awarded for the new organizational structure of the Division of Education, including the various committees and their interrelationships and functions. The ACCME plans to include this information in the listing of best practices of its accredited providers, and the information will be published in the ACCME’s newsletter and on its Web site.

In other education-related business, a CD-ROM with the course content from selected didactic postgraduate courses offered during the 2002 Clinical Congress has been made
Communications

One of the major recommendations that came out of the June 6, 2002, strategic planning meeting of the Working Group on Communications issues was that a business plan should be developed for a major public relations program for the College. Although the need to sponsor such a program remains very important and interest in doing so is keen, practical realities preclude its development at present. However, the ongoing effort to gradually increase the College’s visibility through the media will continue, and with the help of Thomas R. Russell, MD, FACS, Executive Director, several possible alternative projects that might be undertaken for the public are under investigation. Activities also are being targeted at Fellows and other surgeons.

New features added to the ACS Web site since October include: a State Surgery Legislative Action Center, a new section on “The Surgeon and Palliative Care,” a Web cast of selected sessions from the 2002 Clinical Congress with opportunities for CME credit, and a redesign of the “members only” page that includes the information on member benefits.

The ACS Resource Center will include: a booth called “Member Benefits” that will have staff available to answer questions about College activities and also will have a computer set up with a link to the College’s online directory so that Fellows can update their directory listings on site during the meeting; an area earmarked for a “Meet the ACS Leaders” function, where ACS Officers and Regents will be available 12:00–1:00 pm Monday through Thursday; and a conference room so Fellows can meet with coding and practice management consultants.

Canadian members

An effort is under way to develop articles in the Bulletin that focus on issues of concern to our Canadian members.

Clinical Congress 2003

The Executive Committee of the Board of Regents approved proposed changes for the 2003 Clinical Congress. The changes were approved on a trial basis for one year. If the changes are not met in a favorable light, the program will return to its previous schedule. The most notable change in the 2003 program affects the activities on Sunday and Thursday. In the past, the Convocation Ceremony and the President’s Reception for New Fellows were held on Thursday evening. This year, these two events will occur on Sunday evening. The Annual Meeting of Fellows and Initiates will be renamed the Annual Meeting of Fellows and will continue to take place on Thursday afternoon. The Governors’ dinner that was held on Sunday evening will be moved to Tuesday evening.
Smile.
The lowest rates ever on
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Super preferred rates are for best health risks. Economical preferred and standard rates are also available. Policies are only available in the United States and Canada. Not available in all states.
TRAUMA AWARENESS MONTH, from page 23

References


Next month in JACS

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

Original Scientific Articles:
• Colorectal Adenocarcinoma in Cirrhotic Patients
• Skin Adhesive vs. Sutures for Laparoscopic Incisions

Collective Review:
Surgical Treatment of Pancreatic Cancer

Education:
Who Oversees Innovative Practice?

Palliative Care:
Family Perceptions of Surgical Intensive Care

What’s New in Surgery:
• Neurological Surgery
• General Surgery: Surgical Oncology