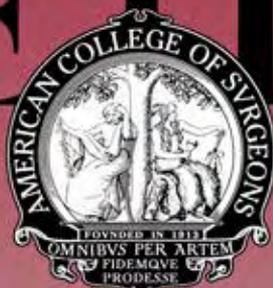


# BULLETIN

AMERICAN COLLEGE OF SURGEONS



November 2003  
Volume 88, Number 11

## "DEVIL DOCS" IN IRAQ

**TRAUMA ON THE BATTLEFIELD**



# BULLETIN

AMERICAN COLLEGE OF SURGEONS



NOVEMBER 2003  
Volume 88, Number 11

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## About the cover...

“Devil docs” withstood sandstorms, threats of attack, and austere working conditions to help save the lives of U.S. soldiers and Iraqi citizens during Operation Iraqi Freedom. Three surgeons who offered their skills and services in the war zone relay their experiences in this month’s cover story on page 8.

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# From my perspective

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**A**fter hearing from hundreds of surgeons by e-mail or letter, or through personal contact, it is clear to those of us who comprise the College's leadership that socioeconomic issues continue to take a significant toll on surgical practices. It doesn't seem to matter whether a surgeon is at an academic medical center or practicing in an urban community or in rural America—the stark reality is that there are significant financial implications associated with running a viable surgical practice today.

Surgeons now are expected to understand economic and business theory, in addition to clinical surgery and science, if they intend to run a successful practice. In many ways it is sad to see the principles of market economics overtake the profession's long-held emphasis on the precepts of quality, self-regulation, education, training, and patient care. The reality, however, is that we are witnessing the transformation of American surgery from a profession to a business. Simply stated, we are seeing the corporatization of American medicine and surgery.

## *Identifying the pressures*

Perhaps the most obvious socioeconomic burden affecting surgeons today is the continuing fluctuation in reimbursement for services provided under the Medicare program. Each year, Medicare bases the formula used to calculate payment for physicians services on elements that are outdated, flawed, or beyond a surgeon's control. The resultant reductions in reimbursement are creating great stresses on the house of medicine, and the profession has attempted to respond appropriately. Nevertheless, we will clearly need to work patiently and persistently with the federal government to resolve the payment issues.

In addition to concerns about Medicare reimbursement, other stressors inhibit the ability of surgeons to remain focused on the values and ethics instilled in us when we entered this profession. Indeed, the issues affecting the surgical profession come from many directions and take many forms, including compliance with regulatory reforms, the professional liability crisis, lifestyle issues, competitive forces, and concerns about the viability of many of the hospitals and other providers of health care, especially in rural America.



**“Unfortunately, the practice of surgery today is as much a business as it is a science and an art.”**

## *What surgeons can do*

What can surgeons do to counteract the societal and economic demands that so profoundly influence their practices and livelihoods? Clearly, one of the most important steps we need to take is to become more savvy with respect to practice management techniques. This area is uncharted territory for most of us, and, quite frankly, it interests few among us. However, due to the current circumstances, surgeons must become more attuned to effective management techniques or join health care networks that have greater negotiating power.

Many surgeons are opting to pursue the second alternative, forming specialty or multispecialty groups and creating a larger geographic footprint with a greater share of the market and thus gaining more bargaining influence. Robert L. Howisey, MD, FACS, and Martin B. Durtschi, MD, FACS, have written about how they and other surgeons have effectively applied this concept in Washington State (see “Surgeons offer survival strategy

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for the new millennium,” *Bulletin*, November 2001, p. 24, and “Medical practices update” in “Letters,” March 2002, p. 51).

Other surgeons are joining well-established systems that hire other staff to handle their business interests. Both models ensure that the surgeon’s business needs are met without requiring their direct involvement.

### *College efforts*

In addition to forming group practices, surgeons must become more knowledgeable about the basic business skills that are needed to manage a practice. For more than a decade, the College has offered programs for active surgeons who are trying to effectively cope with the changing demands on their practices. Current workshop topics include coding and practice management for surgeons. The latter course is conducted by two Fellows of the College—Charles Mabry and Frank Opelka—and came out of discussions by the General Surgery Coding and Reimbursement Committee, which is chaired by John Gage. In addition, we provide a coding hotline and seminars on issues such as compliance with the Health Insurance Portability and Accountability Act regulations, Medicare updates, and negotiating third-party contracts. These are all examples of courses and activities intended to further practicing surgeons’ business acumen.

It is important, however, that we bring this training to young people who are preparing to face the realities of modern-day practice. The College is responding to this need by broadening our practice management course selections to include programs designed for residents, so that we can get them thinking not only about clinical problems, but about negotiating contracts, financial planning, and so on. This sort of curriculum is woefully missing from our educational activities today and, yet, is so key to the professional survival of our future leaders.

The College also is attempting to help surgeons understand the concept of efficiency of scale. Successful practices need to take a hard look at the cost of doing business today. Hospitals have been doing serious cost analysis since the late 1980s, when they began to receive payment based on a prospective payment system. Firms such as the Hunter Group advise hospitals on ways to significantly cut their costs. Surgical practices need to

start seeking similar expert guidance to examine the expenses associated with personnel, benefit packages, the use of electronic medical records, and more mundane matters, such as phone service and cell phone contracts. Surgeons also may need to start instituting cost accounting policies for each member of a group to achieve more significant cost savings.

Unfortunately, the practice of surgery today is as much a business as it is a science and an art. Thus, we must be willing to consider changing our practices to incorporate continually evolving practice models and viable business plans that will allow us to enjoy the privilege of being a surgeon while running a fiscally responsible practice. The College stands ready to help its members and will focus its attention particularly on the needs of younger surgeons, as they are about to enter a very different world than many of us have experienced in the past.



*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).

# FYI: *STAT*

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R. Scott Jones, MD, FACS, Director of the Division of Research and Optimal Patient Care, presented **the College's surgical quality improvement and research agenda** to the annual meeting of the National Quality Forum in Washington, DC, on September 29. The American College of Surgeons continues to emphasize to national policymakers the need for evidence-based, risk-adjusted outcomes measurement of surgical indicators and is vocal in national dialogues about what constitutes appropriate measurement, reporting, and maintenance of indicators that are useful for patients to use in making good decisions about their health care. For more information, contact [kritchards@facs.org](mailto:kritchards@facs.org).

Registration is now open for the **Young Surgical Investigators Conference**, to be held March 5-7, 2004, at the Lansdowne Resort Conference Center in Leesburg, VA. Sponsored by the College's Surgical Research Committee, this conference is designed to introduce young surgeon-scientists to the process of obtaining extramural, peer-reviewed grant support. The conference includes intensive exposure to National Institutes of Health (NIH) programs and policies, grant-writing strategies, mock study section review of model grants, information from the NIH institutes, and workshops on hypothesis testing, methodology, background and significance, and renewals. Additional information and a registration form are available at <http://www.facs.org/oeps/src/young surg.html>. The deadline for registration is December 2.

Roman Gonzalez, MD, FACS, President of the Northeast Mexico Chapter, has announced that the **Eighth Latin American Congress** will take place May 5-8, 2004, in Monterrey, Mexico. The four-day education program will include postgraduate courses, panel discussions, and surgical videos that will highlight the following types of surgery: thoracic, colorectal, vascular, head/neck and breast cancer, bariatric, and trauma. Faculty members will include Fellows from the U.S. as well as Latin America. For more information about the Eighth Latin American Congress and to register, visit <http://www.congreso latinoamericanoacs.com>.

The American College of Surgeons and HEALTHeCAREERS, an online network of health care association career center Web sites, have created a partnership to provide **ACS Career Opportunities**, an online surgical career center for its members. By becoming part of a large health care network, ACS Career Opportunities offers more features and functionality than any other job bank system and ensures the broadest exposure for resume and job opportunity postings for surgeons. As part of this growing network, ACS Career Opportunities is participating in a system that links nearly one million health care professionals from more than 200 disciplines with thousands of medical groups, hospitals, and other health care employers. To post a resume at no cost or a job opportunity at competitive classified advertising rates, visit the ACS home page at [www.facs.org](http://www.facs.org) and click on the "Job Bank" link in the left-hand column.

# Dateline Washington

prepared by the Division of Advocacy and Health Policy

## **2004 Medicare physician payment update announced**

On Friday, November 7, the Centers for Medicare & Medicaid Services (CMS) published a final rule announcing that Medicare physician payments will be reduced by 4.5 percent in 2004. The across-the-board payment reduction, which had been projected earlier in the year, is the result of a statutory payment formula that takes into account inflation, the health of the domestic economy, the number of Medicare fee-for-service enrollees, and the rate of growth in total Medicare physician spending.

The regulation also revised a number of other policies affecting Medicare fee schedule payments. Of particular interest to surgeons, changes made in the way CMS calculates the Medicare Economic Index led to slight increases in the relative value units used to reimburse physicians for their medical liability premium costs. Revisions were also made in the geographic adjustment factors that are intended to reflect geographic differences in medical liability costs. Of additional interest, a proposal made this summer to revise Medicare payments for benign and malignant skin lesions was not implemented.

The fee schedule changes take effect on January 1, unless Congress intervenes and establishes a different payment update by passing legislation. College comments that were submitted in early October in response to a proposed rule on the 2004 fee schedule can be viewed at <http://www.facs.org/ahp/views/medicare2004.html>.

## **New Jersey surgeons make house calls**

Facing a stalemate in state tort reform efforts, members of the New Jersey Chapter of the American College of Surgeons took their concerns directly to patients by going door to door in key legislative districts on October 7. "Operation House Call," initiated by the Medical Society of New Jersey, proved to be an important way for physicians to illustrate the urgency of persuading the state assembly to support a reasonable cap on noneconomic damages. The American College of Surgeons Professional Association (ACSPA) provided needed support for the public education efforts. Surgeons who are interested in ongoing grassroots programs may be interested in the newly launched Web-based state affairs newsletter, *ACS Cross Country*. To access the newsletter, go to <http://www.facs.org/ahp/ACScrosscountry/>.

## **Fellow testifies before FDA medical devices panel**

On October 14, general surgeon Shawna Willey, MD, FACS, testified before the General and Plastic Surgery Devices Panel of the Food and Drug Administration's Medical Devices Advisory Committee. In her testimony, Dr. Willey explained how access to silicone gel-filled breast implants enhances the quality of life for breast cancer patients. According to Dr. Willey, "Breast reconstruction provides enormous benefits to women, including an improved self-image, greater confidence, a sense of normalcy, and an ability to enjoy life more fully. These procedures should not be held to a higher standard without science-based evidence."

Since 1992, the National Institutes of Health (NIH) has been conducting clinical trials and various studies on silicone breast implants.

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## **Medicare, Blues implement HIPAA TCS contingency plans**

A report, "Follow-Up of Women with Augmentation Mammoplasty," revealed that "...researchers found no significant increase in breast cancer incidence or mortality among women with implants."

After two days of testimony and deliberation, the panel voted 9-6 in favor of FDA approval. It is now up to the FDA to either reject or accept the panel's recommendation for approval of the implants. This decision is expected by January.

For a copy of the College's statement, go to [www.facs.org/ahp/testimony/101403.html](http://www.facs.org/ahp/testimony/101403.html).

On September 23, CMS and the National Association of Blue Cross and Blue Shield Plans announced that they will implement contingency plans to continue to process all electronic claims after the October 16 deadline for complying with the Transaction and Code Set Standards (TCS). The standards were developed as mandated by the Health Insurance Portability and Accountability Act. All Medicare fiscal intermediaries and carriers and all 24 Blue Cross and Blue Shield plans will participate. The contingency plans allow the payors to process and pay claims that are submitted in electronic formats currently in use ("legacy claims"), as well as those submitted in HIPAA-compliant formats. In addition, providers will have sufficient time to complete the process of testing HIPAA-compliant electronic transactions with any payors that have announced a contingency plan. CMS has encouraged all private payors to assess the readiness of their trading partners and implement contingency plans if appropriate.

Both CMS and the Blues plans will regularly reassess the readiness of the provider and payor communities to determine how long the contingency plans will remain in effect. The College urges Fellows to continue their testing processes with all payors and to document their efforts to comply so that they can appropriately respond in the unlikely event of a postpayment audit.

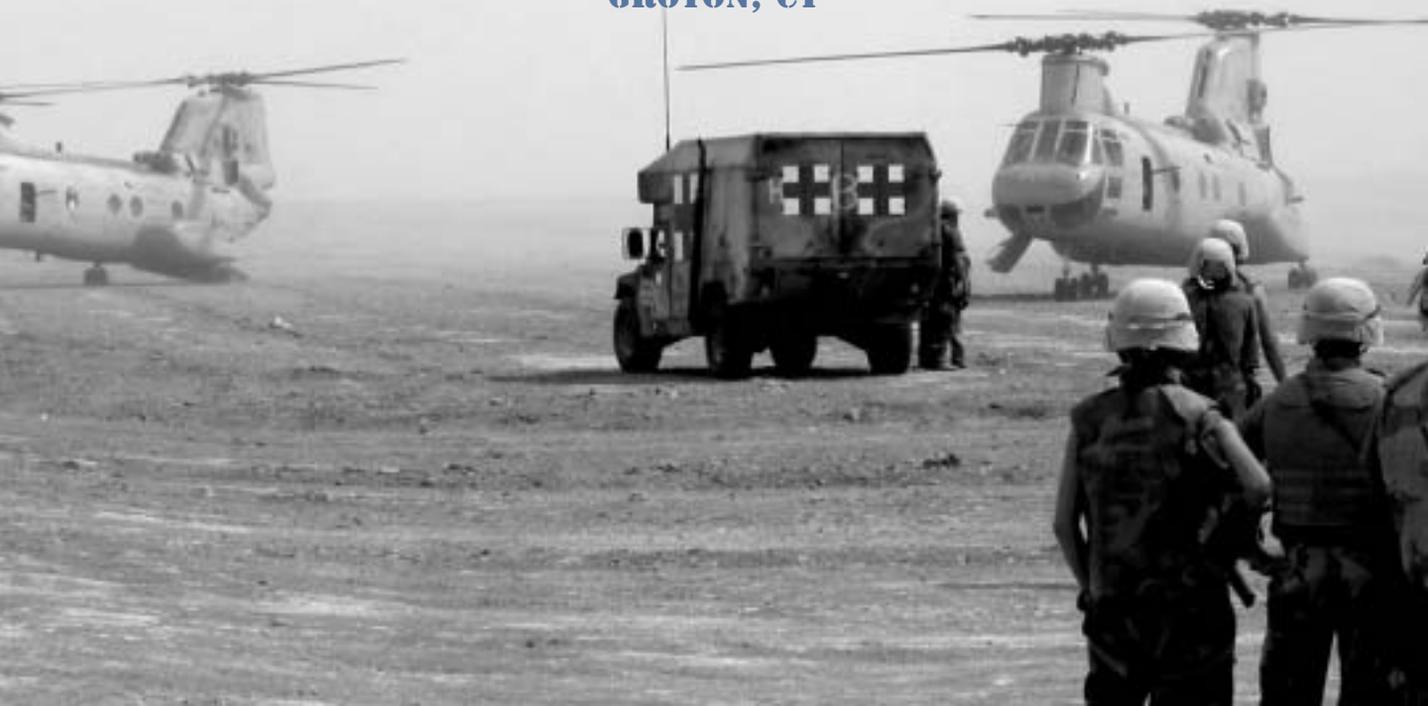
## **Number of U.S. uninsured continues to grow**

A U.S. Census Bureau report showed that the number of uninsured Americans increased 5.7 percent from the last time the data were collected to a total of 43.6 million individuals. The overall percentage of uninsured people in the U.S. rose from 14.6 percent in 2001 to 15.2 percent in 2002. The largest jump occurred among individuals who previously had employer-based health benefits, the result of companies laying off workers or reducing coverage. The report can be found at <http://www.census.gov/hhes/www/hlthin02.html>.

# **“DEVIL DOCS” IN IRAQ TELL THEIR STORY**

**BY**

**CDR. VISWANDHAM POTHULA, MD, FACS,  
YOKOSUKA, JAPAN,  
CAPT. JAMES CHIMIAK, MD,  
LEJEUNE, NC,  
AND CDR. ANIL TANEJA, MD,  
GROTON, CT**



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**T**he media, particularly CNN, popularized the military term “devil docs” during Operation Iraqi Freedom. Devil docs are the physicians who went into action in Iraq to save the lives of many U.S. Marines and Iraqis wounded during the war. This article describes our lives as part of Bravo Surgical Company in Kuwait and Iraq during Gulf War II.

### SHIPPING OUT

Cdr. Taneja, MC, USN, detached from the Groton sub base in Connecticut, while Capt. Chimiak, MC, USN, and Cdr. Pothula, MC, USNR, were dispatched from the Naval Hospital at Camp Lejeune in North Carolina on January 29. We volunteered to deploy with Marines as part of Camp Lejeune’s Second Field Service Support Group (FSSG) platoon. We were assigned to Bravo Surgical Company of the Second Medical Battalion, which, in turn, is run by the Second FSSG.

After reporting to the Second FSSG, we spent the next few days at Lejeune, collecting our 782 gear (a rucksack called Aliss/Mollie that is carried on one’s back), flak jacket, and helmet. Nuclear, biological, and chemical (NBC) gear, consisting of pants and a top specially coated with charcoal, along with a gas mask, were also issued to us. We were told each pair of clothing cost \$300, and we would have to pay out of our own pockets if we lost them in the theater. Few of us were as concerned about the possible expense as the fact that we would lose our lives without the gear if an NBC attack occurred. We were also issued a 9mm Beretta pistol for self-protection only.

We waited patiently for the next two-and-one-half weeks, expecting a plane to take us to southwest Asia. Meanwhile, we began our series of anthrax vaccinations—a minimum of three is required. Finally, we received word that we would leave from Cherry Point Marine Air Corps Station in North Carolina on February 15. We said goodbye to our families and hopped onto buses, which took us to Cherry Point. Just before we boarded the plane, we were all vaccinated for smallpox, eliminating the worries about isolating vaccinated people from the others. As a result, we had a planeload of servicemen with a live, attenu-



Black Hawk helo



Convoy ride

ated virus. It took 20 hours for the vaccination to run its course, and, as a result, we were exhausted even before we left the U.S.

The chartered United Airlines Boeing 747 took us to Ramstein Air Base in Germany. The captain of the plane, a retired Air Force officer, announced that we might be stuck in Germany for several days because there was no fuel in Kuwait for the return flight. We were shocked that Kuwait was experiencing an oil shortage. Two hours later the captain said he would take us to Kuwait, and we should not concern ourselves

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Photo opposite: CH-46 helos bringing in patients.



Iraqi patient being brought into the SST.

with how he would get back. We hoped he made it back safely.

We arrived in Kuwait City in the darkness of the early morning of February 17. Air Force personnel sitting in SUVs with laptop computers greeted us on the tarmac. Our arrival was entered into a database by swiping our ID cards into a contraption attached to the laptop. After checking in, we were whisked off to a waiting area near the airport. A little past sunrise, we were again shuttled by bus deep into the Kuwaiti desert. U.S. Marines and Kuwaiti police dotted the highway. The heightened security was instituted after one American was killed and another wounded days before in a sniper attack.

We were assigned to the First FSSG, which is the support group for the First Marine Expeditionary Force (MEF) based at Camp Pendleton in

California. The First MEF was assigned to defeating the Iraqi military with the assistance of the Third Infantry of the U.S. Army and the British forces. Our job was to provide medical and surgical care for First MEF during Operation Iraqi Freedom.

#### **SETTING UP CAMP**

We settled down at Camp Guadalcanal, which became our home for the next six weeks. It was a rectangular area covering three quarters of a mile in a God-forsaken place, protected all around by earthen berms. Camp Guadalcanal was one of dozens of small camps within the larger Camp Coyote. We spent time acclimatizing to the desert, building tents, practicing mock trauma runs. Initially, the days were comfort-



A Marine with gunshot wound to zone 3 of neck, intubated.



An eight-year-old Iraqi boy with significant blast injury to face, intubated.

able and the nights cold. We took three-minute “Navy showers,” mostly cold ones, on alternate days and kept ourselves in good physical shape by running 30 to 35 miles per week.

It seems that at some point during our deployment, time lost its value, and no longer did we talk in terms of minutes, hours, days, nights, weeks, or months. Our time scale was changed to sunrise, sunset, and the changes in the moon, much like the system used by stereotyped Native American characters in the old Westerns.

Several sandstorms pummeled some of our berthing tents. We worked hard to shore up the remaining tents with engineering stakes pounded into the ground with sledgehammers. Fortunately, no one suffered major injuries in the process, other than one shoulder dislocation. The wind blew dust and sand into every hole and crevice. Our eyes, ears, and noses were full of it. The dust became part of our lives, and we came to accept it.

Initially, we slept on plywood floors, and subsequently we got folding cots. Food consisted of a hot breakfast and dinner served by a local contractor. Meal Ready to Eat (MRE) was our lunch.

The gas alarm sounded on the very first day we arrived, and we had several alarms afterwards. When the alarms sounded, we had to don

the gas masks within seconds and leave them in place until the alert was suspended. We practiced drinking water through the masks in case we had to wear them for extended periods in hot weather.

Along with Bravo, Alpha and Charlie Surgical Companies and six Forward Resuscitative Surgical Service (FRSS) units were in our camp to support the First MEF medical/surgical needs. FRSS units are smaller (eight people) and more mobile than surgical companies (200+ people), and they had one OR table instead of the six in the surgical companies.

Alpha company set up shop in the northern Kuwaiti desert (Camp Okinawa). Once the war started on March 20, the company began receiving casualties by helicopter, or “helo.” Charlie Company was tapped for the next mission. We in Bravo felt left out. Charlie was airlifted to Camp Viper in southern Iraq. FRSS units joined long convoys into Iraq. Now we really felt left out. Adding to our misery, we endured more than 50 Scud missile alarms, requiring us to head into a bunker with all the NBC gear. Obviously, our sleep was interrupted several times on successive nights. Cdr. Pothula seriously considered sleeping in the open bunker, but his colleagues persuaded him to do otherwise.



A two-year-old Iraqi toddler with shrapnel injury to both feet.

## INTO THE WAR ZONE

We had a false start April 1. We waited 15 hours in an open field for lift by helo into Iraq. After waiting all day, we were told at approximately 8:00 pm that no choppers were coming. April fool!

The next day, we were awakened at 4:00 am and told to get ready for transport to an airfield where we would board aircraft to take us north. We herded into the bellies of two C-130 planes, packing 90 people into each. We were literally sitting in each others' laps, wearing our heavy gear. After a one-hour flight, we landed on a makeshift runway (a highway cleared of all utility poles) in south central Iraq. From there we traveled 20 miles by truck, reaching our final destination around 3:00 am. After the 23-hour trip, we were

exhausted by the time we reached Camp Anderson. Our operations officer told us that the Iraqis had attempted a sneak attack on the camp the night before. They were found hiding in tall grass, and a strong Marine presence forced them to surrender. All the while, our FRSS surgeon colleagues were on the berm with weapons drawn. After a three-hour rest, we spent six hours setting up the tents and preparing to receive the casualties.

The core surgical company consisted of the SST (the military term for the ER), two operating rooms, one ICU, and two wards. All these modules were housed in tents, which were transported in shipping containers. On average, it took six hours to set up these facilities. The ORs had air conditioners, but climate control was only minimally effective.

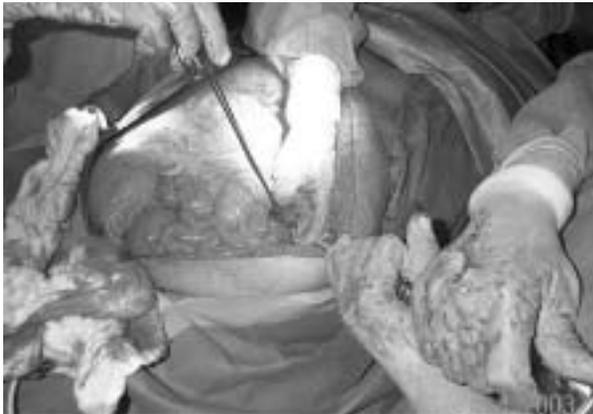
The OR team consisted of two general surgeons, one orthopaedic surgeon, two anesthesiologists, and five certified registered nurse anesthetists. Three gynecologists were helpful in assisting with surgeries and also readily available for any emergency conditions that might arise among the large contingent of women in Bravo Surgical Company. Fortunately, this situation never occurred. We practiced several mock casualty drills to foster unit cohesiveness.

We soon started receiving casualties at Camp Anderson. It was a mix of Marines, enemy prisoners of war (EPWs), and civilians. Patients arrived by Blackhawks or CH-46s (twin rotor helos). It was nonstop flow for 72 hours. The helos would arrive with little or no notice, other than the clatter of helicopter blades, and unload the patients. Not knowing the number or severity of the casualties kept the SST and OR teams in an ever-ready state.

## CASUALTIES OF WAR

General surgery cases included debridement and hemostasis of compound, comminuted skull fractures, debridement of facial wounds, exploration of neck wounds, thoracotomy for lung injury, and repair of bowel injuries. Vascular injuries were repaired with temporary shunts.

Between 75 to 80 percent of the injuries Marines sustained were orthopaedic. The helmet and flak jacket with special plates seemed to prevent significant head and trunk injuries. In all, we saw



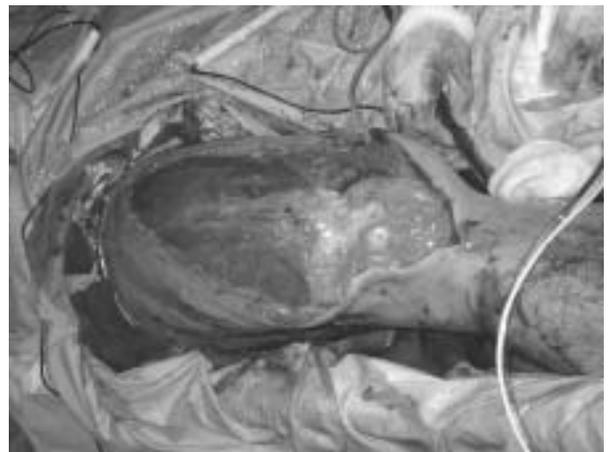
Gunshot wound to sigmoid colon.



Hand injury with finger amputation.



Forearm faciotomy.



Thigh faciotomy.

667 patients in the SST and operated on 63 patients, performing over 100 procedures. Orthopaedic injuries included multiple fractures and open and closed dislocations of both upper and lower extremities from blasts and gunshot wounds. A good number of those cases had compartment syndromes. The compartments were faciotomized, the wounds were debrided, limbs amputated, and fractures stabilized either with splints or external fixative.

After stabilization, patients were transferred to an expeditionary medical facility (EMF), which

had more staff, equipment, and facilities. From there, the Marines were transferred to the USNS *Comfort* or the Army Regional Medical Center in Landstuhl, Germany. Transfer of EPWs to local civilian hospitals was problematic. The process did not always run smoothly, and often they had to remain at EMF for a more extended stay.

Regardless of their degree of injury or how convoluted the process was in terms of getting them transferred, the Marines we treated demonstrated immense stoicism, professionalism, and dignity. They never expressed self-pity. When it was ex-



Ankle external fixator.

plained to them what was being planned medically, they understood and accepted the situation with courage. Minimally injured Marines wanted to go back to the firefight. It was such an emotionally moving attitude—one not often seen in nonmilitary trauma facilities. The injured Marines were kept as comfortable as possible with analgesics from the battlefield to surgical company. These heroic individuals were extremely thankful for the care that we rendered to them and delighted to be able to sleep on a rack with a blanket over their bodies.

In addition to soldiers, we also treated civilians who were caught in the crossfire. One heartbreaking story involved a two-year-old girl, who was brought in with shrapnel wounds to both legs. We were told that both of her parents had died in the crossfire. The child was so cute; she stole everyone's heart. Many servicemen and women wanted to adopt her. She was later transferred to Kuwait Children's Hospital for further care.

An eight-year-old boy was at the center of another gut-wrenching story. His face had been blown off by ordnance. When he arrived, he could talk, apparently asking for his mother. His father was by his side to comfort him. He was expeditiously intubated by Captain Chimiak and transferred to Kuwait Children's Hospital for reconstructive surgery.

A more uplifting case involved an eight-year-old girl who had shrapnel in the brain with minimal neurological deficit. She was seen at our surgical company and transferred to EMF. There, she was operated on by a neurosurgeon. She recuperated at the USNS *Comfort* with full recovery. She was such a darling on the boat. She returned to Iraq loaded down with an ambulance full of toys. Her uncle, who served as her guardian, reportedly collected from the staff \$600 in donations—a huge sum of money by Iraqi standards.

### LIMITED RESOURCES

We were fortunate to be able to deliver care that produced good outcomes given that we were in the middle of the desert and were a mobile unit. Needless to say, the working conditions were austere. The supplies were limited in terms of range and quality. We had to be mindful of that fact whenever operating. We would squeeze out the blood-soaked sponges and keep using them rather than asking for new ones. Many times we improvised, bringing out the Thomas Edison in each of us. We heated IV fluids in the sun during the day and used blankets to keep them warm. One of our nurses came up with the idea of using a regular water heater and dipping the IV bags in it. We used a sterile IV bag as temporary cover for exposed brain in a head injury case. We also used IV bags as colostomy bags. Commander Taneja used dental acrylic cement (methyl methacrylate) as a spacer for a bad forearm fracture with significant bone loss. Sterile anosopes were used as a guide for driving pins for external fixators.

The exercise physically and mentally drained most of the physicians. As mentioned previously, when we left for Iraq at the beginning of April, we slept very little due to the constant Scud alarms. It took us much time and effort to reach our first location in Iraq, and then we set about building tents, which was also physically demanding. Then we worked nonstop for 72 hours and repeated the process of moving two more times. We had to operate in protective gear a few times, resulting in dehydration that left us all a few pounds lighter by the time we finished the cases. It took all the strength we could muster to shore up our mental and physical stamina.

We ate MREs for nutrition and drank a lot of



Commander Pothula



Captain Chimiak

water brought from the Tigris River in a “water bull” to offset the dehydration. Apparently, the polluted water of the Tigris was made drinkable through reverse osmosis. We did away with showers. We all smelled bad, so it did not matter. We emptied our bladders in an open field and evacuated our rectums in a small hole dug with a mini shovel, then covered it with dirt. It was a communal exercise that included the females in our company. The area cleared of unexploded ordnance was very limited and obviously we did not venture too far for fear of being blown up while answering calls from nature.

#### **ANOTHER BATTLEGROUND**

After 72 hours at Camp Anderson, we were told that we had to move north. We packed up our tents and gear and headed out in trucks during the early afternoon. Our convoy went through several small

towns. We were held up by a firefight nearby. We saw flashes from explosions, and some of us went into “condition one” with our weapons ready to fire. Even so, most of us felt pretty secure. We had a CNN team and their escort in our truck, along with Marines who carried heavy-duty arsenal. After the firefight subsided, the convoy proceeded. By this time it was night, and we were traveling without lights for tactical reasons. Our truck hit a big ditch in the dark, and we were all thrown about on the back of the truck, some of us landing atop others and a few sustaining significant injuries. We made it to Camp Chesty after 12 hours on the road, traveling approximately 50 miles.

We put up the tents again very quickly and started receiving casualties. The pace was intense initially and gradually eased up, reflecting the progress made by the Marines.

We slowly started getting some amenities back, including gender-specific, warm, communal show-



Commander Taneja (in foreground).

ers and hot chow. We also visited a local Iraqi hospital to assist them with their needs.

After 10 days, we were told to move again, this time east to Camp Geiger. We went through the motions of packing and unpacking. This was a relatively short ride—30 miles in four hours.

This time we set up shop on an abandoned Iraqi air base. The hardened bunkers for the planes were used as ORs and wards. The walls were several feet thick and it helped to keep us cool during the day. The surgical load had significantly diminished by this time. We started seeing a lot of blunt trauma from vehicle accidents. We also had a significant problem with the flies. They were numerous and all over the place. Nearly the entire surgical company came down with gastroenteritis. Most of them received IV hydration and Phenergan for nausea. Family practice colleagues say the culprit was either *Shigella* or Norwalk virus.

## GOING HOME

Finally we were told our mission was complete, and it was time to move back to the south. We hopped back into two C-130s and made it back to Kuwait.

We spent another two weeks in Kuwait waiting to be retrograded back to the continental U.S. We answered a detailed questionnaire regarding any medical or mental health issues. On May 29, we boarded a United Airlines 747 and landed at Cherry Point Marine Corps Air Station. The all-volunteer flight crew was wonderful. Upon arrival we thought it was a fantastic sight to see green all around us, and we were especially glad to be back with our families.

We slowly got back to our lives, relearning some of the basics in the life, like sleeping on comfortable beds and flushing the toilets. □

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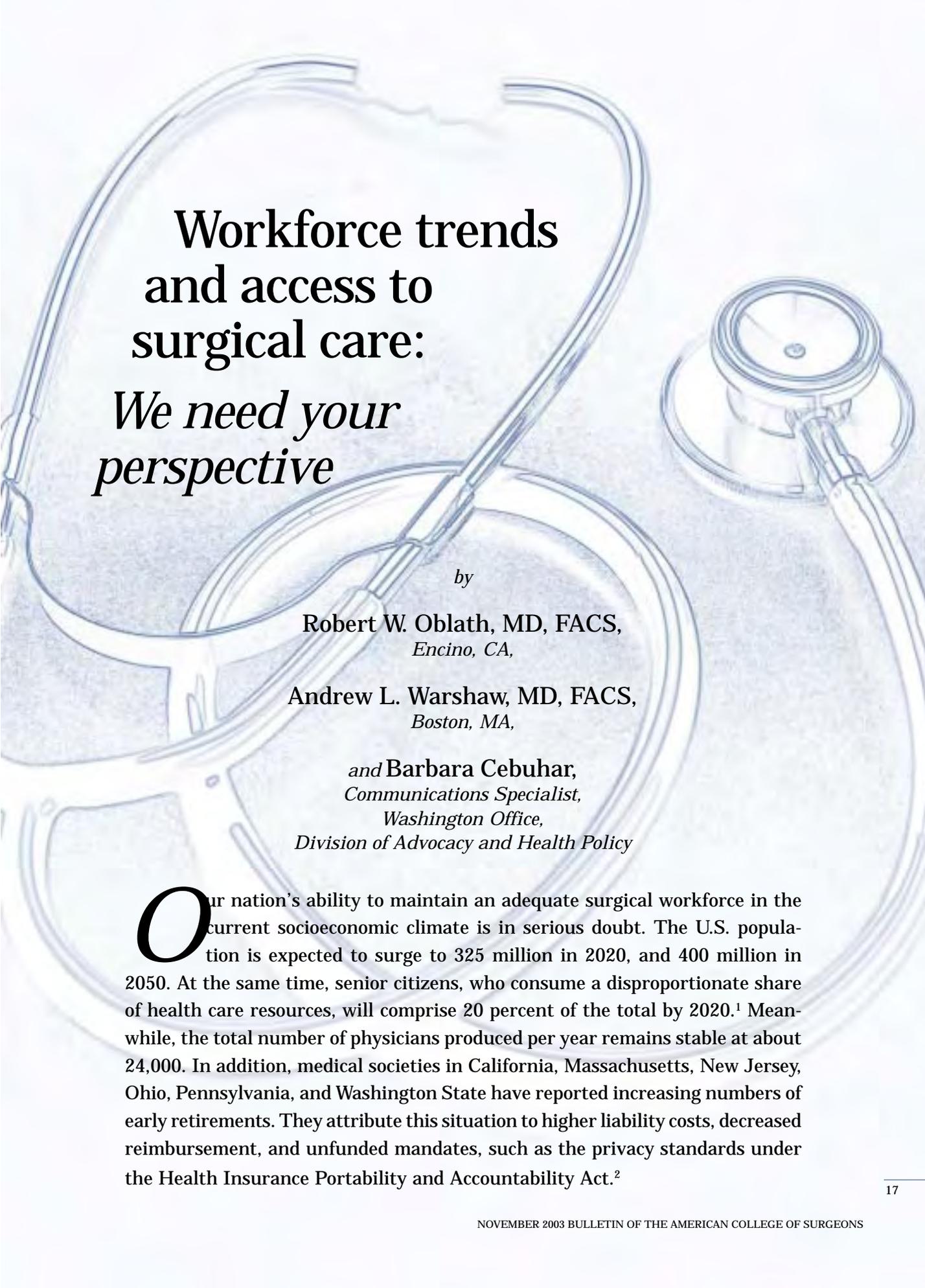
**Commander Pothula** is head of general surgery, U.S. Naval Hospital, Yokosuka, Japan.

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**Captain Chimiak** is head of anesthesia, U.S. Naval Hospital, Camp Lejeune, NC.

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**Commander Taneja** is head of orthopaedics, U.S. Naval Hospital, Groton, CT.



# Workforce trends and access to surgical care:

*We need your  
perspective*

*by*

Robert W. Oblath, MD, FACS,  
*Encino, CA,*

Andrew L. Warshaw, MD, FACS,  
*Boston, MA,*

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Communications Specialist,  
Washington Office,  
Division of Advocacy and Health Policy*

**O**ur nation's ability to maintain an adequate surgical workforce in the current socioeconomic climate is in serious doubt. The U.S. population is expected to surge to 325 million in 2020, and 400 million in 2050. At the same time, senior citizens, who consume a disproportionate share of health care resources, will comprise 20 percent of the total by 2020.<sup>1</sup> Meanwhile, the total number of physicians produced per year remains stable at about 24,000. In addition, medical societies in California, Massachusetts, New Jersey, Ohio, Pennsylvania, and Washington State have reported increasing numbers of early retirements. They attribute this situation to higher liability costs, decreased reimbursement, and unfunded mandates, such as the privacy standards under the Health Insurance Portability and Accountability Act.<sup>2</sup>

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Complicating the picture is our inability to determine what constitutes an adequate surgical workforce to meet the demands of a growing population. Such assessments are hampered by a substantial gap in real data about surgeons' practices, the number of years they expect to remain active, the patients they serve, and the intensity of their work.

We are concerned that, in the not-too-distant future, patient access to prompt surgical care will very likely be threatened by a workforce that is simply strained beyond its limits. We believe that policymakers need to understand the urgency for congressional action that creates a climate that promotes an adequate supply of surgeons who will be prepared to respond to the needs of our nation's growing population.

Hence, the Health Policy Steering Committee of the American College of Surgeons is asking for your help identifying indicators that will assist us in determining whether there is an impending shortfall of surgeons in coming years and how access to surgical care problems are beginning to emerge and affect patients.

### **Lessons from abroad**

Work-hour limitations in Europe have resulted in a significant restructuring of health care delivery by residents and practicing surgeons.<sup>3</sup> Foreign residents faced with limited work hours, smaller populations, and less varied cases than in the U.S. found that it takes longer to acquire the experience needed to meet the requirements for board certification.



**Dr. Oblath** is a vascular surgeon in private practice in Encino, CA. He also chairs the Health Policy Steering Committee's task force on Surgical Workforce and Access.

A recent issue of *Surgery* explores how restrictions in these countries resulted in higher levels of specialization, less availability of broad-based capabilities, a tendency toward standardized hours, and more difficulty securing evening and emergency coverage. Some of these requirements also limit the surgeon's ability to acquire critical care and trauma experience and reduce the availability of comprehensive surgical care in some communities.<sup>3</sup>

In this country, there already are indications that the workforce is working harder and longer, and that it is barely able to care for the patients who need services today. With the intensity of practice increasing, many surgeons feel they cannot spend enough time with their patients. Some of them are narrowing the scope of their practices and now perform only specific procedures or treat selected disease states.<sup>4</sup>

### **Socioeconomic climate**

Socioeconomic factors complicate delivery of surgical care. Recent Centers for Medicare & Medicaid Services data indicate that the U.S. health care budget will rise to \$3.1 trillion by 2011, growing at an annual rate of 7.3 percent during the forecast period of 2002-2012.<sup>5</sup> This is up from only \$1.3 trillion in 2000. And, as the current state of the economy drives spending, budget deficits, and health care decision making, the resulting increases create significant challenges for appropriate resource allocation in the U.S. With the cost of health care services growing to almost 18 percent of the gross domestic product, employers and payors are placing greater emphasis on the documentation of the net value and benefit of that investment. Members of Congress, and society overall, feel pressure to appropriately prioritize the kinds of care provided in order to control costs.

The medical liability crisis further compounds the problem with surgeon supply. A recent study by the Agency for Healthcare Research and Quality showed that states with limits on noneconomic damages in medical malpractice lawsuits have about 12 percent more physicians per capita than states without caps.<sup>6</sup> By 2000, states that had enacted caps had a significantly higher number of physicians per 100,000 county residents compared with states without caps. In contrast, in 1970, there was no statistically significant difference between states and their per capita supply of physicians.

Another factor in surgeons' willingness to continue practicing is the net impact of substantial payment inequities. From 1992 to 2003, the Medicare Economic Index—or Medicare's inflation rate—increased almost 30 percent, while the physician fee schedule conversion factor lagged significantly behind, with a cumulative increase of only 18.7 percent for the same period. The rate of payment increases simply has not kept up with the rate of inflation—or with the true cost of delivering services.<sup>7</sup>

Increased demand, coupled with decreased reimbursement and a shortage of surgical capacity, creates a perverse form of rationing that limits the patient's ability to secure needed care. Recent reports by the Center for Health System Change suggest that wait times for nonemergency care have increased, resulting in treatment delays. The same study found that fewer physicians are accepting new Medicare or Medicaid patients, and even fewer are able to provide uncompensated or voluntary care.<sup>8</sup>

All indicators suggest that a shortage in the surgical workforce will present a significant access problem for patients. Given the length of training required, it will become more difficult to reverse this decline and fill the surgical workforce gaps. In light of these pressures, how do we foster the entry of more surgical talent and encourage more senior surgeons to continue practice to meet the needs of the aging population? Changing desires in lifestyles coupled with payor efforts to control costs of care, the uncertainty of medical liability premiums, and the challenge of running a complicated business, could also be driving experienced physicians from practice.

### **We need information**

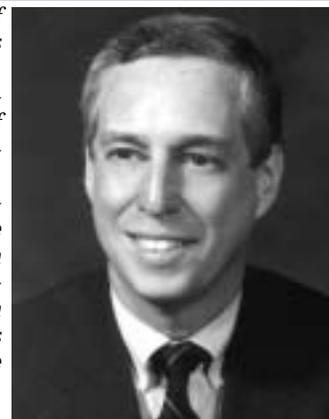
It is incumbent on the profession to actively promote the value and importance of a career in surgery to promising young surgeons and students. However, surgeons also need to help policymakers understand that government policy, as it affects surgeons' practices, is undermining efforts to improve access. Unfortunately, incomplete data regarding surgical capacity make it difficult for the College to show policymakers how their actions are causing these problems. They need information from practicing surgeons so they can truly understand the problems their constituents are beginning to encounter.

We are asking Fellows to visit <http://www.facs.org/ahp/workforcesurvey/index.html> to take a short survey and help us collect data on how market forces and legislation are affecting patient access to care (or you can fill out and fax the copy of the survey on pages 20-21). Your frontline experience with patients and practice can help legislators understand the unintended consequences of problematic policies. We also welcome personal stories about patients and local community issues that illustrate these troublesome trends, which may be forwarded by e-mail to [ahp@facs.org](mailto:ahp@facs.org). 

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**Dr. Warshaw** is chief of surgery, Massachusetts General Hospital, Boston. He is Immediate Past-Chair of the Board of Governors' Socioeconomic Issues Committee, and First Vice-President-Elect of the College. He serves on the Health Policy Steering Committee and the American Surgical Association's Blue Ribbon Committee on Surgical Education.



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## Surgical Workforce Survey 2003 - Are We Prepared for the Future?



for  
Fellows of the American College of Surgeons

Dear Member:

The College is very aware and deeply concerned about the current difficulties facing surgeons, their practices, and their patients. For us to best represent your concerns before federal and state policy makers, we are asking for a few minutes of your time. Information from this confidential survey will help us assess and inform your legislators about current trends that may be influencing patient access to surgical care. Under no circumstances will identifiable data about you or your practice be used. If you give us your email address we will be happy to provide you with a summary of our findings.

Thank you for your help  
Health Policy Steering Committee  
and the ACS Division of Advocacy and Health Policy

**If possible, please take this survey on-line at:**  
[www.facs.org/ahp/workforcesurvey/index.html](http://www.facs.org/ahp/workforcesurvey/index.html). Tell your colleagues that we need their input now. If you need to fax it in, send it to 847-647-6821. If you need to mail it, send it to: DLC, Inc. 7333 N. Oak Park Ave., Niles, IL 60714.

Name:  email:

Member number (optional)

Zip code

Age  
 30 - 39     40 - 49     50 - 59     60 - 65     66 +

Gender  
 Male     Female

Years out of residency  
 1 - 5     6 - 10     11 - 20     21 - 30     More than 30

Specialty    Dual medical career family     Yes     No

Colon & Rectal Surgery     Pediatric Surgery  
 General Surgery     Plastic Surgery  
 Neurological Surgery     Thoracic Surgery  
 Obstetrics/Gynecological Surgery     Urological Surgery  
 Ophthalmic Surgery     Vascular Surgery  
 Orthopaedic Surgery     Other (Please specify)   
 Otorhinolaryngology   

1. Are you currently retired?     Yes     No

If yes, in what year did you stop practice?  
Your age when you stopped?

- 1998 or earlier     50 or younger  
 1999     51 - 55  
 2000     56 - 59  
 2001     60 - 65  
 2002 or later     over 65

2. Why did you stop practicing?

(If retired, no need to continue)

3. If still practicing, at what age do you plan to retire?

- 50 or younger     60 - 65  
 51 - 55     over 65  
 56 - 59

4. Is this earlier than originally planned?

- Yes     No

5. Is this later than originally planned?

- Yes     No

6. If different, why the change?

7. What are your plans?

8. How would you characterize your practice size or setting?

- Solo (1)     Academic  
 Small group (2 - 15)     Government or Military (No need to finish)  
 Medium group (16 - 80)     Group staff HMO  
 Large group (> 80)     Hospital  
 Ambulatory care     Other:

9. How many hours each week do you provide:

1 = 5 or less    4 = 16-20  
2 = 6-10    5 = 21-25  
3 = 11-15    6 = more than 25

	1	2	3	4	5	6
Elective surgery	<input type="radio"/>					
Emergency surgery	<input type="radio"/>					
Non-surgical activities in hospital or other facility	<input type="radio"/>					
Office visits	<input type="radio"/>					
Teaching	<input type="radio"/>					
Volunteer work	<input type="radio"/>					
Administrative duties	<input type="radio"/>					
Critical/intensive care administration	<input type="radio"/>					
Trauma or emergencies	<input type="radio"/>					
Other activities, such as:	<input type="radio"/>					

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**10. Do you take trauma or emergency calls?**

- Yes  No

**If yes, how many hours per month?**

- less than 10  31 to 40  
 11 to 20  more than 40  
 21 to 30

**11. Approximately what percent of your practice revenue is derived from:**

- 1 = 5 % or less    4 = 21-40 %  
 2 = 6-10 %    5 = 41-60 %  
 3 = 11-20 %    6 = > 60%

	1	2	3	4	5	6
Medicare	<input type="radio"/>					
Private fee-for-service	<input type="radio"/>					
Private HMO's	<input type="radio"/>					
Private PPO's or other contractual arrangements	<input type="radio"/>					
Worker's compensation	<input type="radio"/>					
Medicaid	<input type="radio"/>					
Self pay	<input type="radio"/>					
Uncompensated	<input type="radio"/>					
Other	<input type="radio"/>					

**12. About how long after scheduling an appointment must a new patient typically wait to see a surgeon in your practice for a non-emergency condition?**

- No waiting  between 3 - 4 weeks  
 < 5 days  1 - 2 months  
 1 - 2 weeks  more than 2 months  
 between 2 - 3 weeks

**13. In the last two years has this waiting time:**

- Increased  Remained the same  
 Decreased

**14. Does your practice limit the number of new patients with the following type of insurance coverage?(indicate all that apply)**

- Medicare  Worker's compensation  
 Private fee-for-service  Medicaid  
 Private HMO  Self-pay  
 Private PPO  Uncompensated  
 Other

**15. In your community, the supply of surgeons in your specialty is:**

- Inadequate  More than necessary  
 About right

**16. If there are any other medical or surgical specialties in short supply in your community, please list them below:**

**17. Have you tried to recruit a new surgeon to your practice in the past two years?**  Yes  No

**If yes, how long did it take?**

- Less than 3 months  12 - 18 months  
 3 - 6 months  More than 18 months  
 6 - 12 months

**18. Over the past two years, have you experienced difficulty finding primary care physicians or other specialists to provide follow up or chronic care for your Medicare patients?**  Yes  No

**If yes, what kind?**

**19. Are you referring more patients to the emergency room for care?**  Yes  No

**20. Anecdotal evidence suggests that physicians are making a variety of changes in their practice in order to adjust to the current socio-economic conditions. Have you taken or do you plan to take any of the following steps in the next 2 years?**

	Have taken	Plan to do
Limit the number of Medicare patients	<input type="radio"/>	<input type="radio"/>
Limit the number of Medicaid patients	<input type="radio"/>	<input type="radio"/>
Limit on-call emergency/trauma patients	<input type="radio"/>	<input type="radio"/>
Seeking stipend for emergency calls	<input type="radio"/>	<input type="radio"/>
Drop privileges at certain hospitals	<input type="radio"/>	<input type="radio"/>
Decrease time spent with patients	<input type="radio"/>	<input type="radio"/>
Increase total hours spent in patient care	<input type="radio"/>	<input type="radio"/>
Make greater use of "physician extenders" or allied health staff	<input type="radio"/>	<input type="radio"/>
Stop performing poorly reimbursed services	<input type="radio"/>	<input type="radio"/>
Perform more non-covered elective services (e.g., cosmetic surgery, Lasik, etc.)	<input type="radio"/>	<input type="radio"/>
Stop performing high risk procedures	<input type="radio"/>	<input type="radio"/>
Reduce office staff	<input type="radio"/>	<input type="radio"/>
Pursue non-clinical career	<input type="radio"/>	<input type="radio"/>
Relocate to a more favorable practice environment	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

**21. Tell us about actual examples of changes you have encountered, and how it has directly affected your patients.**

**Thank you for your participation!**

Any questions or cases you think would highlight these challenges, contact us at [AHP@facs.org](mailto:AHP@facs.org) or call us at 202-337-2701.

Survey on-line at: [www.facs.org/ahp/workforcesurvey/index.html](http://www.facs.org/ahp/workforcesurvey/index.html)  
 or FAX to: 847-647-6821  
 or MAIL to: DLC, Inc., 7333 N. Oak Park, Niles, IL 60714

The number of specialty, or “boutique,” hospitals has proliferated in recent years. As more of these centers open, concerns about how these facilities might be affected by the “Stark Act” and related legislation have emerged. This article summarizes the purposes of these laws and considers how they might influence boutique care.

### **Background**

The Ethics in Patient Referrals Act (EPRA) is commonly referred to as the Stark Act in reference to the legislation’s author, Rep. Fortney H. “Pete” Stark (D-CA). The law was enacted in 1989 after studies purported to show that medical services were being excessively used if the physician requesting them had a financial interest in the entity delivering that item/service. Amendments to the EPRA became informally known as “Stark I,” which prohibits referrals to entities in which a physician or a family member has a financial relationship for certain health-related services that may be reimbursed by a federal program.<sup>1,2</sup> A case in point would be if a physician referred

a patient for laboratory testing to a facility in which he/she or a family member had ownership interest. Another violation would be if the physician received an incentive bonus that was tied to the volume of patients that were referred to the laboratory.

There are major differences between the previously enacted Anti-Kickback Statute (AKBS) and the Stark Act. The AKBS applies to any business, whereas the Stark Act applies expressly to physicians. Another difference is that the AKBS places the burden of proof on the government to prove

that the physician “knowingly and willfully” committed a violation, whereas no such proof of intent is required under the Stark Act. In essence, under the Stark Act it is immaterial whether the defendant acted in good faith or was unaware of the law.

As passed, the Stark Act was complicated, largely ambiguous, and interfered with day-to-day physician-patient interactions. To better define the scope of the law, it was expanded under the Omnibus Budget Reconciliation Act of 1993 to Medicaid patients and additional “designated health services.” The additional services in “Stark II” included: physical therapy, occupational therapy, radiology, radiation therapy, durable medical equipment and supplies, parental and enteral nutrients, prosthetics, orthotics, and prosthetic devices and supplies, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services.

Congress also identified several exceptions where legitimate services and financial relationships were exempt from the law, which include: referrals for services provided by other surgeons within the same group practice;

referrals within health maintenance organizations; one-time sale of a practice or property by a physician; and referrals to a hospital where the physician has privileges to perform services and he or she holds an ownership or investment interest.

The exception that allows a physician to refer patients to a hospital in which he or she has ownership interests comes with some caveats.<sup>3</sup> The first stipulation is that the physician must have privileges to perform services at the hospital and the ownership (or investment) must be in the hos-

**SPECIALTY  
HOSPITALS  
and the Stark Act**

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**Bhagwan Satiani, MD, MBA, FACS,  
Columbus, OH**

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pital itself and not in a department or subdivision of the hospital. This limitation may be easily addressed by granting the investor physician staff privileges. However, if the physician then does not provide services at the hospital, regulators may either consider the act of granting privileges a façade, or they may invoke the AKBS by arguing that referrals were being made in exchange for compensation. Investing physicians owning more than 40 percent of the specialty hospital or generating more than 40 percent of the volume will not be protected by current safe harbor laws and expert legal advice is necessary to deal with the AKBS. The second exemption regarding the investment not being in a department/subdivision but the entire hospital was designed to dilute the economic effect of any physician referrals/activity.

The hospital lobby is attempting to strengthen this second loophole in order to curtail the growth of specialty hospitals. In 2001, a total of 133 heart and 82 cancer centers were built, and another 300 facilities entered the construction/design phase.<sup>4</sup> Rep. Jerry Kleczka (D-WI) and Representative Stark introduced The Hospital Investment Act of 2001, which aims to close the loophole in the current conflict of interest laws exempting physician self-referrals to hospitals in which they have ownership interests. Under the legislation, physicians could refer patients to hospitals in which they have ownership interests, but only if the interests were purchased on terms also available to the general public at the time. This may imply that shares in this investment be publicly traded under current securities regulations and be offered to nonphysician investors as well. The House Ways and Means Committee has asked the General Accounting Office (GAO) to investigate the entire specialty hospital issue. Following are some of the questions that the committee raised:

- Do specialty hospitals raise or lower health care costs?
- What will be the financial impact of specialty hospitals on full-service hospitals?
- Is there likely to be increased use in areas served by these hospitals?
- Will these hospitals negatively affect the nursing shortage?
- Will ownership by physicians in specialty hospitals create perverse incentives to overuse services? Does the current exception to the Stark Act

of allowing physicians to invest in the entire hospital still make sense for specialty hospitals?

- Is health care in the community served by these hospitals improved due to super-specialization and increased efficiency? Are there provisions to arrange for transfer of patients to full-service hospitals if needed?

### ***Boutique hospitals***

Not-for-profit (NFP) hospitals have already taken steps to attract well-paying customers and give current ones more value for their money by taking advantage of their brand name. These offerings include luxury suites, catered meals, private nursing, and specialty centers within the hospital. Another niche service is “premium” outpatient service of the sort offered by the Dana Center at the NFP Virginia Mason Hospital in Seattle, WA. The Dana Center offers individual subscribers round-the-clock access to internists by cell phone or e-mail, as well as house and office calls by physicians who spend more time with subscribers for a \$3,000 annual fee.

Numerous hospitals have constructed “centers of excellence” within their NFP structure to cater to patients with cardiac, vascular, neurological, orthopaedic, and other illnesses as joint ventures with their medical staffs. It is only when physicians elect to provide the same service outside the hospital-physician joint venture framework that objections are voiced.

The American Hospital Association (AHA) and NFP hospital groups have raised several concerns regarding the growth of boutique centers. They are as follows:<sup>3</sup>

1. Investor physicians would “cherry pick” the most paying patients and treat the rest at the NFP facilities. The AHA is concerned about the willingness of the for-profits (FPs) to care for the indigent. Under current law, all hospitals that receive Medicare and Medicaid funding are required to participate in a program that equalizes the impact of indigent care. Many states have “fair share” laws that require all new providers to offer up to one-third of their services to Medicare, Medicaid, or indigent patients, or else compensate the state for the difference. Lewin Group, a consulting firm, compared patient illness severity, in-hospital mortality, length of stay, and discharge patterns among eight MedCath heart hospitals and 1,139 commu-

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nity and teaching hospitals that perform open-heart surgery.<sup>5</sup> MedCath patients had a higher case-mix severity, a 12.1 percent lower mortality compared to Medicare cardiac patients in other hospitals, a 17.4 percent shorter length of stay, and a greater proportion of patients discharged to their home compared to area hospitals.

2. Community hospitals already are stretched to their limits in terms of low reimbursements, staffing shortages, and high operational costs. However, the average hospital operating margin has increased from 2.45 percent in 1999 to 4.27 percent in 2001, and profitability has stabilized at 4.2 percent in 2001.<sup>6</sup> The hospital lobby points to studies that show that Medicare costs have risen faster in communities with only for-profit hospitals<sup>7</sup> and that the latter have higher administrative and nonpersonnel costs than NFP hospitals.<sup>8</sup>

3. Specialty hospitals deprive NFP hospitals of the profit that the latter use to subsidize less-profitable areas such as burns, trauma, and transplant care.

NFP hospitals argue that their efforts to tie hospital privileges to lack of ownership interest in specialty hospitals is not intended to be an “economic credentialing” issue, but more of a conflict of interest issue. The hospital boards have revoked privileges for medical staff members who invest in these specialty hospitals.<sup>9</sup> One health system estimates it would lose \$28 million to a specialty orthopaedic hospital planned by physician investors—money that is being used to subsidize almost \$85 million in uncompensated charity care.<sup>9</sup> However, an AHA survey of 4,908 facilities in 2001 showed that hospital spending on uncompensated care has fallen to its lowest level in two decades to 5.6 percent of their total expenses.<sup>10</sup> Case law clearly gives hospital boards the broad authority to protect the hospital’s interests.<sup>11,12</sup> Legal precedent notwithstanding, Burda urges the not-for-profit hospitals to compete against specialty centers and asks, “Why not embrace competition? Rather than acting like spoiled brats whose best friend went to play at someone else’s house, why not offer the same service, albeit better and cheaper?”<sup>13</sup>

The physicians contend that these specialty hospitals will create competition and thereby reduce costs and improve patient services. They also point to the fact that in contrast to NFPs, the FP cen-

ters will pay their fair share of income, real estate, sales, and property tax, which will benefit the community. They object to the use of economic credentialing and claim it is not in the public interest.

### ***Penalties under the Stark Act***

Penalties under the Stark Act include: civil penalties of up to \$15,000 for each illegal referral, exclusion from Medicare/Medicaid, denial of payment for services, refunding of payments already made, a fine of up to \$100,000 for each arrangement that involves an illegal cross-referral agreement, and civil penalties of up to \$10,000 per day for organizations that fail to report details of any violations. To avoid the perception of impropriety, specialty hospitals should grant medical staff privileges to physicians who are likely to provide services at the hospital in some fashion. A surgical hospital may have to be careful in having a primary care physician as an investor who may not be in a position to provide any legitimate services at the facility.<sup>1,2</sup>

### ***Conclusions***

NFP hospitals are faced with an increasingly competitive environment, potential loss of market share in the most lucrative specialties (cardiac and orthopaedic care), and static reimbursement from health care payors. While they wait for long-term help from the state legislatures and Congress to possibly strengthen the Stark Act, they are using short-term measures, such as economic criteria, to discourage physician investment in specialty cen-

*continued on page 44*

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***Dr. Satiani*** is in private practice at Vascular Services of Ohio, Inc., and is associate clinical professor of surgery at Ohio State University, Columbus.



## *The role of the compliance officer*

by ALBERT BOTHE, JR., MD, FACS, *Chicago, IL*

*“He’s such a strange man. He doesn’t seem to know what’s right, only what’s legal.”*

—*Agatha Christie*

**M**any compliance officers share the unease expressed in this quotation from one of Agatha Christie’s fictional characters. Compliance officers are a relatively new component of American medicine. Until 1996, individuals concerned with regulatory compliance were primarily found in the manufacturing and financial services sectors of the economy. However, once the U.S. Department of Health and Human Services (HHS) took an active interest in eliminating errors from the reimbursement for services provided under federally funded health care programs, health care institutions began to establish their own compliance programs and appoint compliance officers to oversee those programs. The programs all are designed to ensure that individuals within the institution are aware of, and are following, the complex regulations that relate to reimbursement. According to a 2002 survey by the Health Care Compliance Association (HCCA), 87 percent of health care organizations have active compliance programs in place.

In early 1998, the HHS Office of Inspector General (OIG) issued its compliance program guidance for hospitals (63 FR

8987). It was the second of 11 such guidances issued by the OIG to assist various segments within health care in establishing effective programs. In general, all of the guidelines are based on the seven steps of the federal sentencing guidelines (see sidebar, right). It is generally believed that implementation of the seven elements will prevent health care fraud and abuse, or at least mitigate the occurrence while demonstrating a good-faith effort by the institution to develop internal controls that promote adherence to applicable regulations. Fellows of the College may also be familiar with the OIG guidance issued for individual and small group practices (65 FR 59434), which was discussed in an article on page 8 of the March 2001 issue of the *Bulletin*. Recently, the OIG indicated its intent to issue compliance guidance for recipients of NIH research grants (68 FR 52783).

### **What I do**

As executive director of the University of Chicago (IL) Practice Plan, in 1997, I was assigned the task of serving as the compliance officer for the university's Pritzker School of Medicine. A nascent compliance effort was in place at that time, which grew rapidly at the direction of the dean of the medical school and the hospital president to encompass the entire medical center. An oversight committee, consisting of the most senior officers of the institutions, was established to regularly review the compliance activities. Periodic reporting to trustee committees of the university and the hospitals also was established. The medical center compliance office has grown over the past six years in both personnel and resources to meet the ongoing challenges of effective compliance education and monitoring.

The role of the compliance officer in an academic medical center is fairly well prescribed as a constant element of each of the OIG's compliance guidances. It is recommended that the compliance officer be relatively high level, with direct access to the institution's governing structure. The compliance officer's responsibilities include overseeing and reporting on the compliance program, revising the program in response to changing needs or regulations, and coordinating the institution's compliance educational effort. The compliance officer plays a key role in the human resources area to coordinate, screen, investigate, and/or partici-

### **Elements of effective compliance programs**

- Developing standards of conduct; implementing policies and procedures.
- Designating a compliance officer and compliance committee.
- Conducting effective training and education.
- Developing effective lines of communication, including a hotline and policy of nonretaliation.
- Conducting internal monitoring and auditing.
- Enforcing standards through disciplinary guidelines.
- Responding to potential problems; corrective action procedures.

Source: U.S. Sentencing Commission Guidelines, *Guidelines Manual*, § 3E1.1, November 2002.

pate in corrective actions and to ensure that the atmosphere promotes ethical conduct, free of retaliation. The OIG also recommends that the compliance officer have unfettered access to all pertinent records and to staff members, as well as high-level cooperation from the institution's legal counsel.

The University of Chicago Medical Center devotes significant effort to these tasks. For instance, each year we provide two hours of mandatory compliance education to all physicians, residents, and staff who are involved in any aspect of health care reimbursement. In addition to providing compliance training to several hundred new house staff, support staff, and faculty who join the medical center each year, we provide ongoing education to approximately 2,400 individuals through a series of training options, including Web-based interactive learning modules and in-person didactic sessions. This extensive educational undertaking is only accomplished with the full backing of department chairs and senior managers who help remind staff of the yearly training and who support the rare suspension for failure to meet the educational requirement. The compliance office staff review thousands of medical records annually according to a predetermined schedule to ensure accurate

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coding and billing. As a result of these internal audits, faculty members and coding personnel receive individual reports regarding their level of accuracy, along with focused education and reauditing where necessary. The goal is to provide the information and tools to foster ethical behavior by each individual. Organizations are far better off when an intrinsic culture of ethical behavior is cultivated rather than when they rely solely on a compliance program that is externally motivated.

Thousands of compliance professionals from various disciplines are working within health care today. More than 55 percent of compliance officers have held their position for less than three years. Most compliance officers hold a master's degree or have an advanced accounting degree. According to HCCA, 16 percent of compliance officers have a JD. Only 4 percent have a medical degree, and they are usually at large academic medical centers where such physicians frequently fulfill other roles. Regardless of whether an institution has a physician as a compliance officer, it is critical to involve physicians in the compliance process. The more visible that involvement is, the more likely it is that physicians will be fully engaged. Open and candid communication, within the limits of due process, engenders a sense that all of the compliance procedures are fair and equitable.

### **HIPAA compliance**

Finally, effective compliance programs may serve as both a model and a resource for other regulatory challenges. In 2002, 89 percent of compliance officers had the Health Insurance Portability and Accountability Act (HIPAA) privacy regulation as part of their yearly goals. Given the nature of the implementation tasks and deadlines required by HIPAA, it was not surprising that the accountability and collaboration that grow out of effective compliance programs was tapped for HIPAA.

As a case in point, the University of Chicago Medical Center's Compliance Office assumed responsibility for planning and providing the education and training to more than 10,000 individuals throughout the institution in preparation for the April 2003 effective date of the HIPAA privacy rule. In addition, the organizational model for cor-

porate oversight of compliance was adapted to create a similar oversight group for the various components of the HIPAA regulations. In serving as the medical center's privacy officer, I have engaged many of the same key individuals in making the HIPAA regulations part of the fabric of the institution. Although a central coordination and monitoring function is in place, privacy and security are becoming the daily responsibility of all members of the organization with access to protected health information. It is clear that our patients expect us to safeguard their information; only by following the regulations will we continue to earn their trust. Whether it relates to honest and accurate billing, or to patient confidentiality, we should accept only the highest standards of ethical conduct. □

**Dr. Bothe** is professor of surgery and compliance officer at the University of Chicago (IL).



## Claude H. Organ, Jr., installed as 84th ACS President

Claude H. Organ, Jr., MD, FACS, FRCSSA, FRACS, FRCS, of Oakland, CA, was installed as the 84th President of the American College of Surgeons during the Convocation ceremonies that preceded the College's 2003 Clinical Congress in Chicago, IL.

Dr. Organ is emeritus professor, department of surgery, University of California, San Francisco. A native Texan, Dr. Organ received his secondary education in the public schools of Denison, TX. He received a BS degree from Xavier University, New Orleans, LA (1948), and his MD degree from Creighton University School of Medicine, Omaha, NE (1952).

His time at Creighton continued while he completed a surgical residency in the Creighton University Affiliated Hospitals. His dissertation for his MS degree in surgery was titled, "The Acid Reducing Mechanisms of the Duodenum," which he completed with the assistance of his scientific advisors C. M. Wilhmenj, MD, and R.S.K. Lim, MD (1957).

After serving as a Lieutenant Commander MC in the U.S. Navy Medical Corps (1957-1959), Dr. Organ joined the faculty of the department of surgery at Creighton University (1960). There, he rose to the rank of professor and chair of the department (1971-1982), before becoming a professor of surgery at the University of Oklahoma Health Sciences Center, Oklahoma City (1982-1988).

Dr. Organ became a Fellow of the American College of Surgeons in 1961, and has since served as an active participant in and leader of numerous College activities. In 1999, the ACS Board of Regents presented him with its Distinguished Service Award, the highest honor awarded by the College. Dr. Organ served as Second Vice-President of the College from 2001 to 2002. He was a member of the Commission on Cancer (1979-1989), a senior member of the Pre- and Postoperative Care Committee (1986-1996), and a member of the International Relations Committee (1991-2001).

Throughout his academic career, Dr. Organ has been committed to surgical education at both the graduate and undergraduate levels. At Creighton University he developed an elective surgical honors program for senior medical students who were pursuing a career in academic surgery. His work to support and encourage surgical residents to pursue biomolecular research and enter academic surgery has been a valued part of his career. Thirty residents in the University of California San Francisco-East Bay program have undertaken two to three years of research experience in prominent laboratories due to their work with Dr. Organ.

Dr. Organ has served in leadership positions for numerous surgical organizations and soci-



Dr. Organ

eties. In 1984, he was elected president of the Southwestern Surgical Congress, and his presidency in that organization was characterized by significant changes in the association's policy, programs, and new initiatives. Furthermore, a lecture named in his honor—the Claude H. Organ, Jr., Basic Science Lecture of the Southwestern Surgical Congress—was inaugurated in 1995. He also served as a national director of Alpha Omega Alpha Honor Medical Society (1979-1989), director (1978-1986) and chairman (1984-1986) of the American Board of Surgery, and president of the Western Surgical Association (2002). In addition, he holds memberships in numerous professional

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scientific organizations including the American, Western, Pacific Coast, and Southern Surgical Associations. Dr. Organ holds honorary fellowships in the Royal Australasian College of Surgeons, the Royal College of Surgeons of South Africa, the Royal College of Surgeons (Edinburgh and England), and the Association of Surgeons of Great Britain and Ireland. Additionally, he has been awarded honorary doctorate degrees from the University of Nebraska, Xavier University, and the University of Athens, Greece.

With a professional interest in general and endocrine surgery, Dr. Organ is the author or co-author of more than 250 sci-

entific articles and book chapters and is currently editor of the *Archives of Surgery*, a position he has held since 1989. He is also the author or co-author of five books including a two-volume set, *A Century of Black Surgeons: The U.S.A. Experience* (1987), *Gasless Laparoscopy with Conventional Instruments* (1993), and *Abdominal Access in Open and Laparoscopic Surgery* (1996).

He has lectured worldwide, served as a visiting professor at many institutions, and delivered numerous named lectureships, including having twice given the Opening Ceremony Lecture at the Clinical Congress of the American College of Surgeons (1990 and 1995), the Archibald Watson Lecture (Australia), the

Zollicoffer Lecture (North Carolina), Michael and Jamie Miller Lecture (South Africa), Gibbons Lecture, Benjamin Parks Memorial Lecture, James Reinsch Lecture, Ralph R. Coffey seminar, John Hodgken Lecture, James Burton Visiting Professor lecture, Drew-Syphax Lecture, Gross Lecture, Schrier Lecture, and Lynwood Herrington Lecture.

Dr. Organ's contributions outside of organized surgery include serving on the board of directors of Omaha-based Boys Town. In the past, he also served as director of the National Catholic Conference for Human Justice (1972-1974), and as a trustee of both Howard University and Meharry Medical College.

## J. Roland Folse receives Distinguished Service Award

The Distinguished Service Award—the highest honor awarded by the American College of Surgeons—was presented to J. Roland Folse, MD, FACS, of Springfield, IL, during the Clinical Congress last month in Chicago, IL.

In presenting the Distinguished Service Award to Dr. Folse, the Board of Regents highly commended him for his service to the American College of Surgeons, recognized him for his national leadership in surgery, acknowledged his contributions to the Southern Illinois University (SIU) School of Medicine, and expressed admiration

for his three decades of tireless commitment to the highest quality and scholarship in surgical education and for his role as an exemplary mentor for a generation of surgical educators.

A 1958 graduate of the Johns Hopkins Medical School, Baltimore, MD, Dr. Folse served as a senior assistant surgeon in the U.S. Public Health Service, Clinic of Surgery of the National Institutes of Health's National Heart Institute (1959-1961), and completed his general and thoracic surgery residency at the University of Washington (1961-1967), where he remained on the faculty until 1971. As a resident,



Dr. Folse

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he received the ACS 14th Annual Mead-Johnson Award for Graduate Training in Surgery. Today, he serves as professor emeritus of the department of surgery at Southern Illinois University School of Medicine.

Since becoming a Fellow of the College in 1970, Dr. Folse has served the College through his role as a member of the Committee on Surgical Education in Medical Schools (1982-1992), Chair of the Graduate Medical Education Committee (1994-1998), a member of the Board of Governors (1988-1994), President of the College's Illinois Chapter (1980-1981), and the founder of the College's Surgeons As Educators course, now in its 10th year.

His dedication to the SIU School of Medicine has spanned 32 years and includes serving as professor and chairman of the department of surgery (1971-2000), medical director of the SIU School of Medicine (1985-1990), and the first chair of the Board of Southern Illinois Uni-

versity Physicians and Surgeons Practice Plan (1997-2000). He also worked to develop resources to facilitate surgical education, including the creation of the school's first surgical education fellowship.

In addition, his work as a surgical educator led to his being honored with the Illinois State Medical Society's Edwin S. Hamilton Teaching Award (1996), the Excellence in Teaching Award from Southern Illinois University Medical School's department of surgery every year from 1993 to 1998, and the Distinguished Service Lifetime Achievement Award presented by the Association for Surgical Education (2000). He also received the Physician Executive Award (2000) from the American College of Medical Practice Executives.

Dr. Folse has been a leader in many associations in organized surgery, including serving as chair of the Residency Review Committee for Surgery (1985-1987), president of the Central

Surgical Association (1985), chair of the Central Surgical Association Foundation (1998), vice-president of the American Surgical Association (2000), and president of the Illinois Surgical Society (1982). He was also a founding member of the Association for Surgical Education.

He holds memberships in the American Board of Surgery, American Board of Thoracic and Cardiovascular Surgery, American Surgical Association, Central Surgical Association, North Pacific Surgical Association, Society for Vascular Surgery, International Society of Surgery, Association for Academic Surgery, and Midwest Surgical Association. In addition, Dr. Folse has contributed to the surgical literature by being author or co-author of numerous articles published in peer-reviewed journals.

The College's Board of Regents is pleased to recognize Dr. Folse's outstanding contributions by naming him the 2003 recipient of its highest honor.

## College names five Honorary Fellows

Honorary Fellowship in the American College of Surgeons was awarded to five prominent surgeons from Australia, Chile, Denmark, Ethiopia, and South Africa during Convocation ceremonies at last month's Clinical Congress in Chicago, IL. The awards presentation is one of the highlights of the Clinical Congress. The recipients were:

**Attila Csendes, MD, FACS.** Professor Csendes is

chairman of the department of surgery at the Clinical Hospital, University of Chile, Santiago, Chile.

**Sidney Cywes, OMSG, M. Med (Surg), FACS, FRCS, (Eng, Ed), FRCPS (Glas), FAAP (Hon), FCS (SA-Hon), DSc (UCT-Hon).** Professor Cywes is professor emeritus of the department of pediatric surgery at the University of Cape Town, South Africa.

**E. Catherine Hamlin, MB, BS, DRCOG.** Dr. Hamlin is a co-founder and current chief executive director of the Addis Ababa Fistula Hospital, Ethiopia.

**Henrik Kehlet, MD, PhD.** Professor Kehlet is currently chief surgeon in the department of surgical gastroenterology at Hvidovre University Hospital, Hvidovre, Denmark.

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**Marcus J. Killingback, AM, MS(Hon), FRACS, FRCS, FRCS (Ed).** Dr. Killingback is a former general and colorectal surgeon, who helped establish the Edward Wilson Colon and Rectum Unit, the first unit of its kind at Sydney Hospital, Sydney, Australia.

Presenting the Honorary Fellowships on behalf of the College were Stanley M. Goldberg, MD, FACS, Minne-

apolis, MN; James C. Thompson, MD, FACS, Galveston, TX; Jonathan L. Meakins, MD, FACS, Headington, Oxford, England; Maurice J. Webb, MD, FACS, Rochester, MN; and Bradley M. Rodgers, MD, FACS, Charlottesville, VA.

During the College's Convocation ceremonies this year, 1,442 surgeons from around the world were admitted into Fellowship. With a membership of more than 65,000, the

College is the largest organization of surgeons in the world.

Sir Rickman Godlee, President of the Royal College of Surgeons (England), was awarded the first Honorary Fellowship in the College during the College's first Convocation in 1913. Since then, 383 internationally prominent surgeons, including the five chosen this year, have been named Honorary Fellows of the American College of Surgeons.

## Citation for Prof. Attila Csendes

*by James C. Thompson, MD, FACS, Galveston, TX*

President Sabo, I am honored to present to you Prof. Attila Csendes, chairman of the department of surgery of the University of Chile in Santiago, for Honorary Fellowship in the American College of Surgeons. Professor Csendes is one of those unusual, nay rare, individuals whose accomplishments and personality have influenced the practice of surgery in his entire country and in all of Latin America.

Attila Csendes was born September 22, 1941, in Szeged, Hungary, during the Second World War. His father was a physician in the Hungarian army, and at the end of the war, he left Hungary with his family because he did not want to live under Communist rule. After four years in Austria as displaced persons, the family moved to Chile on chance opportunity. They landed on Au-

gust 10, 1949, at Valparaiso, Chile, on a boat laden with refugees from Europe. The eight-year old Attila went with his family to Santiago. His basic education was at the German Grammar School. Professor Csendes went to undergraduate and medical school at the University of Chile, from which he received his MD degree in 1966, ranking third in a class of 172.

He completed his surgical residency at the University of Chile, and in 1969, a flash of pure luck occurred that changed his entire life. As a surgical resident, he requested a reprint of an article from a Japanese surgeon, and soon he received a letter stating that a group of Japanese surgeons was coming to visit Chile. One of the visitors was the president of the Japan Society for Gastric Cancer, who invited



Professor Csendes

Professor Csendes to come to Japan in 1969 to participate in the first seminar on early gastric cancer. He was apparently the first Chilean surgeon ever

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to visit Japan. This initial contact was followed by a meeting in December 1975 at the National Cancer Center in Tokyo, at which he spoke on advances in diagnostic methods for cancer.

In 1970, Professor Csendes received a scholarship from the National Institutes of Health and spent two years at the Veterans Administration Hospital in Los Angeles (CA) working with the renowned gastric physiologist, Morton I. Grossman. Working with Dr. Grossman, Professor Csendes became familiar with research techniques in gastrointestinal physiology and gastrointestinal regulatory peptides, and especially with the importance of prospective randomized studies in developing scientific methods for research.

On his return to Chile in 1972, he developed an esophageal manometry laboratory in the department of surgery at the university hospital, where he recruited a team for clinical research. He was appointed assistant professor of surgery in 1973 and associate professor of surgery in 1975. Dr. Csendes has maintained close relationships with the group who trained under Morton Grossman and who later became leaders in American gastroenterology and surgery (John Walsh, Jon Isenberg, and Haile Debas, among others).

A new period began in 1977, when he spent a year in clinical research at the University of Aarhus, Denmark, under the direction of Professor Erik Amdrup, one of the world's leading exponents of highly se-

lective vagotomy for the treatment of peptic ulcer disease. In the same year, he was nominated as the International Guest Scholar of the American College of Surgeons and stayed in the U.S. for a month, during which time he developed close relationships with David Skinner, Lucius Hill, and Lloyd Nyhus; during that time he also visited our department and laboratory in Galveston, TX.

Dr. Csendes was promoted to professor in 1982, and was chairman of the department of surgery from 1983 to 1986. He is again serving as chair for another term, extending from 1995 to 2006. He served as President of the Chilean Chapter of the American College of Surgeons and president of the Chilean Surgical Society. For 30 years, Professor Csendes has organized and directed postgraduate training programs in gut physiology and in clinical surgery of the biliary and gastrointestinal tracts.

Throughout his career, Professor Csendes has focused on clinical and scientific experiences with diseases of the upper gastrointestinal tract. He has made 16 movies, published 22 books, and has participated in nearly 70 international congresses. He has published more than 400 papers, most as first author, with a special focus on benign esophageal diseases, on gastric cancer, and on diseases of the biliary tract. His main contributions are in the manometric evaluation of antireflux surgery before and after hiatal herniorrhaphy; in late results of randomized studies compar-

ing pneumatic dilatation versus Heller myotomy in achalasia; and in late results of surgical treatment for Barrett's esophagitis. His contributions to the *British Journal of Surgery* have been the classification of Mirizzi's syndrome and the quantification of the severity of acute cholangitis. He and his colleagues have been greatly interested in the late results of the primary repair of surgical injuries to the biliary ductal system.

Professor Csendes has maintained an extraordinarily close relationship with colleagues, in the clinic, in the laboratory, and notably on the football (soccer) field.

Professor Csendes is a surgical citizen of the world. He belongs to 16 international surgical societies and is a member of learned organizations on four continents. He is a Fellow of this College, and was made an honorary fellow of the American Surgical Association in the year 2000.

Professor Csendes has a highly supportive and loving family, headed by Irene, his wife of more than 30 years, and three children—Paula, a radiologist, Christian, an engineer, and Barbara, an architect.

I am sure, President Sabo, that the American College of Surgeons will, by means of this Honorary Fellowship, add luster to our future, here, and especially, in Latin America. I am honored to present Professor Atilla Csendes for Honorary Fellowship in the American College of Surgeons.

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## Citation for Prof. Sidney Cywes

by Bradley M. Rodgers, MD, FACS, Charlottesville, VA

Mr. President, I am honored to present to you Professor Sidney Cywes, emeritus professor in the department of pediatric surgery at the University of Cape Town, and principal pediatric surgeon at the Red Cross War Memorial Children's Hospital in Cape Town, South Africa, for Honorary Fellowship in the American College of Surgeons.

Dr. Cywes received his undergraduate and medical training at the University of Cape Town, graduating in 1953. He continued his surgical training at the University, studying under the renowned surgeon, Dr. Yannie Louw, who was at this time performing his classical experimental studies with Dr. Cywes' roommate, Dr. Christian Barnard, which ultimately elucidated the etiologic mechanisms for congenital intestinal atresia. This period of training with Dr. Louw began a period of lifelong collaboration and mutual admiration.

After completing his surgical training in 1958, Professor Cywes decided to devote his surgical practice to the care of children, thus becoming the first full-time pediatric surgeon on the continent of Africa. In 1975, Dr. Cywes and his colleagues established the first freestanding Children's Hospital in Africa in Cape Town—the Red Cross War Memorial Children's Hospital—and insisted that this institution be fully integrated racially, even

in the midst of apartheid. In that institution, he established the first neonatal intensive care unit for surgical patients and the first pediatric trauma center in Africa.

Professor Cywes has made innumerable original contributions to the care of children. His fundamental studies on hemoperitoneum in the newborn led to the routine prophylactic use of Vitamin K and the virtual elimination of this lethal condition. He has introduced and studied several innovative surgical therapies for short bowel syndrome and anorectal anomalies. He is recognized throughout the world for his studies on conjoined twins. He received the Andries Brignat Memorial Medal for his work on the effect on parents and siblings following the birth of an infant with a congenital abnormality.

Dr. Cywes retired as chief pediatric surgeon at the Red Cross War Memorial Children's Hospital in 1996 to become professor emeritus. His retirement party was truly a Who's Who of international pediatric surgery. In addition to surgeons from seven continents, the party was attended by an assemblage of Dr. Cywes' former patients, many of whom traveled for great distances to express their gratitude for his care.

To review Professor Cywes' curriculum vitae is like reviewing the history of pediatric surgery. Indeed, it is the history of



Professor Cywes

pediatric surgery on the African continent. He was a founding member of the South African Association of Pediatric Surgeons and served as president of that association on two separate occasions. He was a founding member of the African Pediatric Surgical Association (the other APSA) and served on the executive committee of that organization. In 1987, he was elected a fellow of the University of Cape Town "in recognition of Original Distinguished Academic Work of such quality to merit special recognition." In 1992, he was awarded honorary fellowship in the Royal College of Surgeons of Edinburgh and the following year in the Royal College of Physicians and Sur-

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geons of Glasgow. Over the next five years he was awarded honorary fellowship in the American Academy of Pediatrics, the American Pediatric Surgical Association (the original APSA), and the British Association of Pediatric Surgeons in recognition of his outstanding contributions to pediatric surgery.

He has served as the president of the World Federation of Associations of Pediatric Surgeons and has worked vigorously with that group to coordinate and improve pediatric surgical care in developing nations throughout the world. Dr. Cywes was appointed the Sir Arthur Sims Commonwealth Professor for 1997, the first South African and the first pediatric surgeon to receive that honor. In 1998, he received from the South African Pediatric Surgical Association the J. H. Louw Gold Medal for Outstanding Contributions to Pediatric Surgery and Honorary Fellowship in the College of Surgeons of South Africa. The following year, he was awarded

an Honorary Doctor of Science and Medicine from the University of Cape Town. Dr. Cywes has presented his original scientific work throughout the world and has been invited as visiting professor by most of the major pediatric surgery training institutions in the world.

Lest I make this introduction sound like Professor Cywes is a unidimensional man, nothing could be further from the truth. He and his lovely wife, Marlene, have raised two highly successful children, both of whom currently live in the U.S. Their son, Robert, is a successful pediatric surgeon in Jacksonville, FL, and their daughter, Colette, is a research scientist at Harvard University.

In addition to his professional recognition, Dr. Cywes is equally well known internationally for his horticultural achievements. As a medical student, he became interested in the cultivation of dahlias (similar to the interests of William Halsted), and won many awards for his cultivation of

those blooms. His interests subsequently turned to roses, and he has served as the president of the International Society of Rose Growers. Incidentally, Mr. President, I have it on very good authority that there are over 1,500 roses in his garden! More recently, he has focused on a particular South African orchid species, the Disa, that had proven particularly difficult to cultivate. Not only has he mastered cultivation of these beautiful flowers, he has enhanced the species by hybridization. He has won many awards internationally for this work and has named many of the hybrids after family members.

Mr. President, it is a great privilege and honor for me to present to you a pediatric surgeon of spectacular talents and accomplishments, Prof. Sidney Cywes of Cape Town, South Africa, for Honorary Fellowship in the American College of Surgeons. I should add that Dr. Cywes is only the third pediatric surgeon in the history of the College to be accorded this honor.

## Citation for Dr. E. Catherine Hamlin

*by Maurice J. Webb, MD, FACS, Rochester, MN*

Mr. President, I am honored, both professionally and personally, to present to you Dr. E. Catherine Hamlin of Ethiopia, Africa, for Honorary Fellowship in the American College of Surgeons. I am honored professionally as a fellow gynecologic sur-

geon, and personally as a fellow Australian, having heard Dr. Hamlin's name spoken with awe and respect for decades among colleagues in my discipline and in my home country.

Dr. Catherine Hamlin is recognized as the world's best fis-

tula surgeon, a skill she perfected, together with her late husband Dr. Reginald Hamlin, at the Addis Ababa Fistula Hospital they established in Ethiopia.

Vesicovaginal and rectovaginal fistulas occur when tissues

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necrose after prolonged obstructed labor. In impoverished areas of the world where there is little help for such women during labor, one in 20 women, many little more than children, are left with bodies so damaged that they lose all control of bowel and bladder function. They are condemned to a life of shame and destitution, as in many instances husbands and families abandon them. Thanks to the dedication of Dr. Catherine Hamlin and her late husband, this devastating fate for young girls, in Ethiopia at least, has been alleviated. The Hamlins have repaired over 24,000 fistulas at their hospital during the last 40 years.

Catherine Hamlin was born in Sydney, Australia, and graduated from the University of Sydney Medical School in 1946. She and Dr. Reginald Hamlin married while Catherine was doing her residency in Sydney, and they went to London, earning specialty degrees in obstetrics and gynecology. After initially returning to Australia to practice, they felt a commitment to work instead in an area poorly served by physicians.

This place turned out to be Addis Ababa, where they accepted government appointments as obstetricians and gynecologists at Princess Tsahai Hospital in 1959. Immediately exposed to the very common but appalling problem of vesicovaginal fistulas, about which little was written at the time, they perfected surgical repair techniques and soon attracted not only patients from all over Ethiopia, but interested col-

leagues from around the world who came to train under them.

Using money raised from donations, they established a separate Fistula Hospital in 1974, giving such women, previously turned away untreated, a place where they could be cared for with dignity.

Unbelievable stories are told of desperate women, constantly soiled and wet, traveling for weeks by camel, mule, or even on foot for treatment. One woman begged at a bus stop every day for many years to raise the meager amount for the bus fare to the hospital.

The fistula hospital is run entirely through voluntary contributions and many of the trained nursing staff are former patients. All women are treated free of charge, and the total cost for a fistula repair is only \$450 U.S. The hospital, however, cares for more than just the fistula problem. Many young girls arrive filthy and malnourished with nerve or muscle injuries related to prolonged labor, together with emotional scars from this experience and their family's rejection. When a woman is cured (and the Hamlins' technique has over a 90 percent success rate), she is given the bus fare and a new dress in which to go home. Patients who require longer rehabilitation enter literacy classes and are taught skills to help them become more independent. One success story stayed on to become head nurse at the hospital and became so adept at the fistula operations herself that she was awarded the gold medal of the Royal College of Surgeons, London.



Dr. Hamlin

Several Ethiopian gynecologists work at the hospital with Dr. Hamlin, and gynecology residents at the medical school rotate through her hospital. Dr. Reginald Hamlin passed away in 1993, but Dr. Catherine continues to direct the hospital, fund-raise, and operate on more difficult cases.

Her vision, skill, and commitment both to training and to her patients is rarely equaled around the world, as the plethora of honors already bestowed on her attests. She is a fellow of the Royal College of Obstetricians and Gynecologists (London) and was decorated, with her late husband, with Ethiopia's highest award by His Imperial Majesty the Emperor, Haile Selassie. She was made a member of the Order of Australia, and was awarded, with her husband, the Australia and New Zealand Peace prize. She has received the Gold Medal of Merit

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of the Order of St. Gregory the Great from Pope John Paul, and, with her husband, the Gold Medal of the Royal College of Surgeons of England. In 1992, the American College of Obstetricians and Gynecologists honored her with their distinguished service award.

These many tributes and awards embarrass Catherine. She has done what she does so well for so many years out of

compassion for young women who suffer such destitution when no help is available. Serving others, for her, is serving God, and the reward is the transformation of young women from absolute despair to normality—dignified citizens of the world once more.

It is with great pride, Mr. President, that I present my colleague in gynecologic surgery, my sister in national heritage,

and a model of what it means to dedicate oneself and one's skills to the people of the world regardless of race, class, gender, religious persuasion, or economic status. Please share with me the honor and delight of welcoming as an Honorary Fellow of the American College of Surgeons such a distinguished surgeon, innovator, educator, and world citizen, Dr. E. Catherine Hamlin.

## Citation for Prof. Henrik Kehlet

*by Jonathan L. Meakins, MD, FACS, Oxford, England*

Mr. President, it is a privilege to present to you Henrik Kehlet, professor of surgery, Copenhagen University, and chief surgeon, Hvidovre Hospital, Copenhagen, Denmark, for Honorary Fellowship in the American College of Surgeons.

Graduating from medical school in 1968, Professor Kehlet completed his surgical training in the Copenhagen University Hospital system in 1979 and promptly joined the faculty—becoming professor of surgery in 1991, having been chief surgeon in the hospital department of gastroenterologic surgery since 1989.

During residency, his research was focused on hypothalamic-pituitary-adrenocortical function in surgical patients and in particular those surgical patients on glucocorticoids, work for which he received his PhD. Understanding early the significance of the neuroendocrine re-

sponse to surgery, the stage was set for an extraordinarily productive academic clinical career. Author or co-author of over 500 papers or book chapters, the range of subjects he has studied is daunting; however, all have their roots in the intellectual capital of the early studies into the biology of the stress response. This capacity to recognize the future directions of clinical surgery, physiology, and the significant areas to be investigated has informed his research. International recognition of the significance and originality of his work came early in his career and initially from departments of anesthesiology and their learned societies. The first clinical studies were in the effect of regional anesthesia in the interruption of the neuroendocrine response to surgery, at a time when spinal and epidural approaches were not common in clinical practice.



Professor Kehlet

In time, the significance of his work was recognized by surgical departments and societies. He has been visiting professor to over 50 departments of surgery and anesthesia in the U.S. and

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Canada and another 50 around the world. Invited lectures to over 200 learned societies worldwide testify to the broad recognition of his contributions to our understanding of the pathophysiology of the response to surgery and its management. The impact of his original clinical thinking has changed and will continue to influence our clinical practice in both disciplines, highlighting the interdependency of our clinical roles.

From the original investigations into the stress response, his wide-ranging research has touched upon most areas of perioperative care. The concept of blocking the stress response has led to many contributions to the world of pain control and regional anesthesia. The natural extension of these concepts has led to studies in the immunological responses to surgery and their control, preemptive anesthesia, perioperative physiologic changes, nutrition in and feeding of the postoperative patient,

postoperative fatigue, and novel approaches to management of surgical pain.

He has been a leader in establishing the role of regional anesthesia in surgical practice not simply for pain control but for the benefits to the patient's physiologic response to surgery. Effective pain control reduces the physiologic cost of the operation to the patient. An advocate of nonsteroidal anti-inflammatory drugs as adjuvants to other forms of pain management, he is a significant contributor to the move to multimodal perioperative pain management—a consequence of which is reduced use or elimination of opioids and a more rapid return to health.

His principal clinical interests have been in colorectal surgery and the application of all these ideas into patient-centered surgical management. Each of these subjects could have been the basis of a career but have in their entirety led to an integrated clinical approach com-

bining changes in clinical practice by all members of the surgical team leading to a patient-centered, short-stay fast-track surgical program. In this area, Professor Kehlet has been a frequent participant in the Clinical Congress and contributor to *ACS Surgery*. In these roles, his clinical leadership becomes apparent. The implementation of genuine changes in practice is difficult. His approach to systems and process, team management, and patient education are evident in the clinical results.

In addition to his surgical and academic achievements, he is a competitive and accomplished athlete, a philosopher, a loving father to his children, and companion to Suzanne, who is an accomplished artist.

Mr. President, it is with great pleasure that I present to you Prof. Henrik Kehlet for Honorary Fellowship in the American College of Surgeons.

## **Citation for Prof. Markus James Killingback**

*by Stanley M. Goldberg, MD, FACS, Minneapolis, MN*

Mr. President, it is with the greatest pleasure and honor that I present to you and to the Fellowship of the American College of Surgeons Prof. Mark J. Killingback of Sydney, Australia, for Honorary Fellowship in the American College of Surgeons. Rarely does one have the opportunity to honor an individual who has influenced the

entire field of colon and rectal surgery throughout the world as has Professor Killingback.

Professor Killingback was born in Sydney, Australia, and matriculated at the University of Sydney. Shortly after graduation from medical school, he sailed for London on a freighter with his new wife Bobbie. Aboard ship, he performed his

first unsupervised appendectomy in the middle of a tumultuous Indian Ocean with drop ether anesthesia, and the patient did well.

He spent four years as a surgical registrar at the Middlesex, Hammersmith, and St. Mark's Hospitals in London. It was at St. Mark's that his interest in colon and rectal surgery was

kindled. It was here on “the Old City Road” in Islington that the likes of Sir Naughton Morgan, Sir Hugh Lynn Lockhardt-Mummery, and Cuthbert Dukes inspired him to focus his surgical talents on the lower bowel. On returning to Sydney, Professor Killingback had the benefit of another tutor—namely, Dr. Edward Wilson.

In 1970, Professor Killingback proposed the establishment of the first colon and rectal unit in Australia at the University of Sydney. This was the forerunner for other teaching colon and rectal surgery units Down Under. In addition to the teaching unit in Sydney, he was the founder of the Sydney Colorectal Surgical Society and Colorectal Surgical Society of Australia. In addition, he has worked continuously for the Royal Australasian College of Surgeons as an examiner and as chairman of the Section for Colon and Rectal Surgery.

Several years ago, the Royal Australasian College of Surgeons honored Professor Killingback for his leadership and teaching in the field. The Royal College inaugurated the Mark J. Killingback Prize for the best surgical paper at the annual scientific meeting of the Royal Australasian College of Surgeons.

Professor Killingback has had a lifelong interest in lower gastrointestinal surgery. His primary focuses have been rectal cancer and the management of perforated sigmoid diverticular disease. He was a pioneer in the use of the intraluminal stapling device, and he has one of the best, if not the best, series of rectal excision with low anastomosis in the world. The leak rate is an enviable 2 percent!

He has presented 15 eponymous lectures including a Hunterian Professor Lecture and a Sir Alan Parks Memorial Lecture. In addition, Professor Killingback has lectured extensively in the U.S., Canada, Europe, and Asia. In 1989, he made the Queen’s Birthday Honors List and was made a member of the Order of Australia (A.M). This honor is the Australian equivalent of Knighthood.

Mark married his beautiful wife, Bobbie, in 1954. Their four children have given them many wonderful grandchildren. The Killingbacks are a close-knit family and enjoy outdoor activities together. Since he was a shortstop in college, Mark is a great fan of American baseball. He also is a serious collector of toy soldiers.

The characteristics that have allowed Professor Killingback to



Professor Killingback

achieve the pinnacle of his chosen profession include a keen intellect, a wonderful sense of humor, the ability to communicate both orally and with the pen (he even does all the illustrations for his presentations himself), and most of all, his excellence in the operating theater.

Mr. President, it is with great pleasure that I present Mister Colon and Rectal Surgeon of Australasia, Prof. Mark Killingback of Sydney, for Honorary Fellowship in the American College of Surgeons.



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*Journal of the American College of Surgeons*

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•  
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•  
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\* Abstract Supplement published in  
*JACS* September 2004 issue.

## *Who*

- Young surgical investigators (principal investigator is first named author).
- Up to ten (10) co-authors allowed.

## *What*

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

## *When*

- Abstracts accepted from November 1, 2003, through March 1, 2004.

## *Where*

- Online submissions ONLY: <http://www.facs.org/sfabstracts/>.
- *Final Decision:* May 2004 (principal author will be contacted).
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The Excellence in Research Awards Program has been established by the Surgical Forum Committee to recognize excellence in research performed by surgical residents and Fellows, further increase the visibility of the Surgical Forum as a venue for resident research presentation, facilitate and encourage attendance of residents and Fellows at the Forum sessions, encourage residents and Fellows to participate in research during their training period, and contribute to the overall quality of the Annual Meeting of the American College of Surgeons. The committee will consider all accepted abstracts for the award and will present awards during a special session at the Clinical Congress.



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**GS08:** Acquiring Skills to Perform New Procedures: Principles, Challenges, and Opportunities

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**GS13:** Key Issues in Management of Rectal Cancer

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**GS16:** Sentinel Lymph Node Biopsy for Breast Cancer

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## 2004 ANZ Travelling Fellow selected

Joseph J. Cullen, MD, FACS, associate professor of surgery, University of Iowa Hospitals and Clinics, Iowa City, IA, was selected as the 2004 Australia and New Zealand (ANZ) Chapter of the ACS Travelling Fellow.

As the Travelling Fellow, Doctor Cullen will participate in the Annual Scientific Congress of the Royal Australasian College of Surgeons in Melbourne, Australia, May 2-

7, 2004. He will attend the ANZ Chapter meeting during that congress, and will then travel to several surgical centres in Australia and New Zealand.

Requirements for the Year 2005 Travelling Fellowship appear in the December 2003 *Bulletin*.

They are also posted on the College's Web site, [www.facs.org](http://www.facs.org).



Dr. Cullen

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### Dr. Russell delivers keynote address at Army symposium

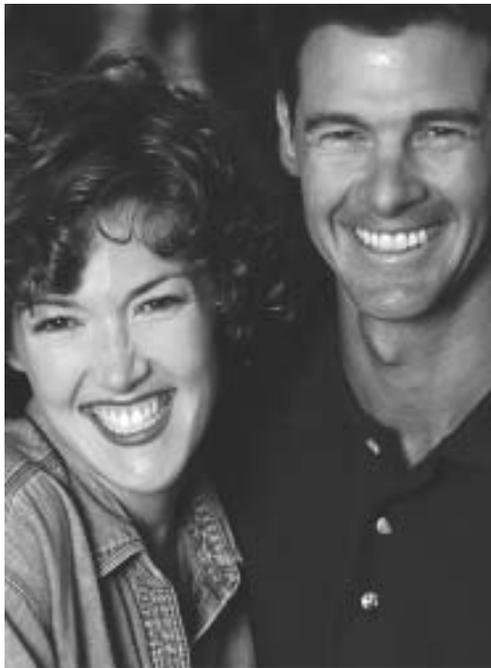
More than 80 Army surgeons met at Brooke Army Medical Center in San Antonio, TX, May 19-20, for the 25th Annual Gary P. Wratten Army Surgical Symposium, the first to occur in war time.

ACS Executive Director Thomas R. Russell, MD, FACS (center), presented the keynote address, "ACS and the Surgeon—Role in Homeland Security," in which he articulated the need for surgeons to be engaged in the community preparation for and medical response to man-made and natural disasters. Thirty-four abstracts and nine spectacular cases were presented.

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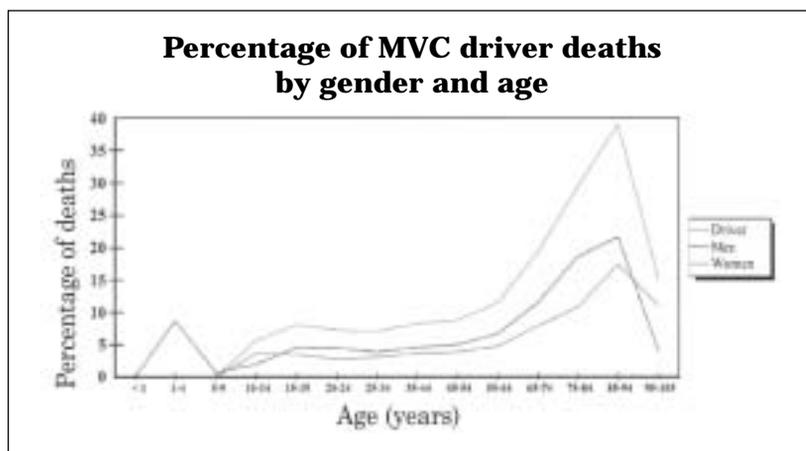
# To drive or not to drive?

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

As a follow-up to last month's focus on the beginning of the driving experience, we will now take a look at the other end of the spectrum. It is to no one's surprise that with the maturing of the baby boomers our population is aging at a rapid rate. Over the next 25 years it is estimated that elderly drivers will account for almost 20 percent of all miles driven, which represents nearly a threefold increase from 1990.

Through self-recognition elderly drivers may have already reduced the duration of their drives, avoided busy highways, used a conservative approach to speed limits, and restricted their driving time to daylight hours. These types of driving style modifications come as part of their more than 50 years of practical, behind-the-wheel training and experience. Driving a motor vehicle may be one of the last forms of independence our elderly population has to hold on to.

We must recognize, however, that with aging comes impaired hearing, slower reflexes, and use of prescription medications that may reduce reaction time. It is not uncommon to hear about an elderly driver who has gone off-road and injured pedestrians. Elderly drivers are also more likely to be involved in multi-vehicle crashes.



Percentage of driver deaths due to motor vehicle crashes for both men and women at each age range from 0 to 105 (percentage of deaths = number of deaths divided by the number of patients  $\times$  100 for MVC drivers by gender and age range).

The most striking concern about elderly drivers is depicted in the graph above. When looking at the percentage of motor vehicle driver deaths by age and gender contained in the National Trauma Data Bank™ (NTDB), there is a dramatic peak after age 75. It becomes a matter of life and death as one in five drivers involved in a motor vehicle crash in this age range dies.

Advising the elderly on driving and, more importantly, when it is time to hang up the car keys is not an easy task. Stripping them of their last bit of independence is hard for professionals and family members alike. These

data, however, support this counseling activity as a prevention measure, given the significant injury-associated mortality with driving in this age group.

Throughout the year we will be highlighting these data through brief reports that will be found monthly in the *Bulletin*. For a complete copy of the National Trauma Data Bank *Annual Report 2002*, visit us on the Web at <http://www.facs.org/dept/trauma/ntdbannualreport2002.pdf>. If you are interested in submitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at [mneal@facs.org](mailto:mneal@facs.org).

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## SPECIALTY HOSPITALS, from page 24

ters. NFP hospitals have a choice to make. They can look upon their medical staffs as equal partners with regard to specialty hospitals or let market forces determine which emerging models will succeed and create better value for consumers. 

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# Next month in JACS

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

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#### Original Scientific Articles

- Complex Pancreaticoduodenal Injuries
- Optimizing Operating Room Allocation
- Cholecystectomy in Cirrhotic Patients

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#### Collective Review

- Antifibrinolytic Agents in Fibrin Sealants

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#### What's New in Surgery

- Orthopaedic Surgery

