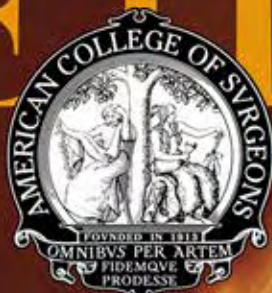


BULLETIN

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The dilemma of the EXPERT WITNESS



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From my perspective

The August 13, 2003, issue of the *Journal of the American Medical Association (JAMA)* features an interesting article titled, "Proposal of the Physicians Workgroup for Single Payor National Health Insurance." Given the subject matter, this article effectively reopens the debate about whether the ongoing inadequacies of our current health care system could best be resolved through a national health insurance program or through narrower modifications.

An old wound

This article also brings to mind the conflict in which the American College of Surgeons found itself in February of 1994 when the Clinton health plan was being vigorously debated. At that time, the then-Chair of the Board of Regents, David Murray, MD, FACS, testified before the House Committee on Education and Labor and was misquoted in the press as stating that the College had endorsed a single-payor system. What he actually said was that the College was of the view that single-payor approaches probably provide the best assurance that patients would be able to seek care from the physician of their choice.

We did not support any specific health care reform model at that time; rather, we said that any proposal should adhere to the principles of a patient's right to choose, access to quality care, physician autonomy in medical decision making, and equitable physician payment for services rendered. The College also applauded the governments goals of controlling health care costs and developing a more workable system.

Ongoing problems

In the nine years subsequent to the dispute about what the College said and meant versus



“ I do believe that health care reform will be heavily debated by the 109th Congress and will affect the 2004 elections. ”

what the press misinterpreted as our position, the health care system has sustained and developed numerous stresses and inadequacies. As the *JAMA* article notes, we spend twice as much as other industrialized countries on health care, and, yet, 40 million Americans are uninsured. The article, which is endorsed by approximately 8,000 physicians, including academics and former Surgeons General, indicates that reversal of these trends will require systematic and systemic change.

Indeed, much money is wasted under the current system. Tremendous administrative costs and competition between plans that have a for-profit mentality have resulted in an arcane and

costly system, which diverts money from patient care and breeds the corporate mind set that has become pervasive in the medical profession.

Clearly, change has been necessary for some time. The federal government has passed laws that have resulted in some incremental changes to the system, but the passage of significant reforms, such as the adoption of a patient bill of rights or prescription drug coverage under Medicare, remains difficult.

It is impossible to predict the form and scope of the future health care system, but given the range of stakeholders that have special interests in the system and the political climate today, it is hard to imagine that the major reconstruction called for in the *JAMA* piece could occur. I, for one, do not believe that the crisis in health care has reached a threshold that would command such a startling transformation.

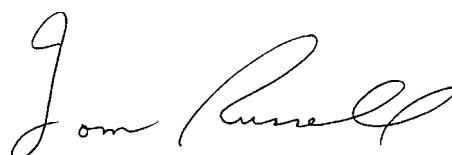
Nonetheless, I do believe that health care reform will be heavily debated by the 109th Congress and will affect the 2004 elections. The number of Americans without health insurance and the spiraling costs will thrust the issue into the legislative limelight.

What's the College doing?

The American College of Surgeons must be prepared with a plan. The organization as a whole and each of its members on a daily basis experience the problems and frailties inherent to our current health care system. Hence, our Health Policy Steering Committee is actively working to determine the key elements of an improved system (see related story, p. 15). All of the committee's recommendations will adhere to the binding principles to which I alluded earlier, including freedom for patients to choose their physicians, physician autonomy, access to

quality care, and so on. The committee members are engaged in a very important and productive debate about this issue, and we anticipate that their efforts will assist the College in taking a decisive position on health care reform.

I'm sure that many of you have given some thought to this matter. The Health Policy Steering Committee and I welcome your ideas.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

❖ An online “**Medical Liability Action Guide**” has been added to the pages of the College’s Web site devoted to the Division of Advocacy and Health Policy. This new section provides members with tools they can use to help educate lawmakers on the need for strong medical liability reforms. The guide can be found online at <http://www.facs.org/ahp/proliability.html>.

❖ The second issue of **CAS-ACS News**, a quarterly e-mail newsletter for the Candidate and Associate Society (CAS), was disseminated to interested individuals in mid-September. The CAS-ACS was formed in 1997 to meet the needs of surgical residents and newly practicing surgeons and to benefit the surgeons of the future through involvement in the activities of the College. The group’s goal is to provide CAS members with an avenue for participation in College affairs and with an opportunity for the opinions and concerns specific to residents and young surgeons to be heard by College leaders. To facilitate this mission, *CAS-ACS News* is published for its own members but is also available to Fellows of the College and other interested parties. To subscribe, simply send your name, e-mail address, and street address to cas-news@facs.org. If you have already signed up for the newsletter, you need do nothing because your information is already in the College’s subscriber database for the publication.

❖ A “**Residency Assist Page**” (RAP) has been added to the College’s Web site to address a spectrum of issues related to the restrictions on the duty hours of residents that were recently mandated by the Accreditation Council for Graduate Medical Education and implemented July 1, 2003. Developed by the College’s Division of Education, this section will be specific to surgery and will serve as a unique resource for surgery program directors and others as they consider changes in residency programs to ensure optimum educational outcomes under the new guidelines. Information to be available in the RAP includes: editorials accompanied by selected references; examples of practical solutions; reactions to the topics covered in previous columns; and responses by the editors to questions posed by program directors. An overview of the intent and goals of the RAP and more information is available at <http://www.facs.org/education/residencyassist.html>.

❖ The online resource *So You Want To Be a Surgeon... A Medical Student Guide to Finding, and Matching with, the Best Possible Surgery Residency* has been updated and is now available on the College’s Web site at <http://www.facs.org/residencysearch/index.html>. Hosted by the ACS Division of Education, this online, contemporary version of the popular “Little Red Book” has proved to be an invaluable resource for medical students seeking opportunities in graduate medical education. The revised online version of this helpful reference includes a searchable database containing a complete list of accredited surgical specialty residency programs, as well as a section devoted to assisting students in choosing a residency program that is their best match. For more information, contact bpalis@facs.org.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

CMS releases revisions to EMTALA

The Centers for Medicare & Medicaid Services (CMS), on September 9, formally issued a final rule modifying the Emergency Medical Treatment and Labor Act (EMTALA), frequently referred to as the “patient anti-dumping statute.” EMTALA requires hospitals to provide medical screening, treatment, and stabilization for patients who present to a hospital emergency department seeking treatment for an emergency medical condition.

The final rule, effective November 10, 2003, reflects most of the changes previously proposed by the College and clarifies the obligations for physician and hospital on-call coverage. Major provisions include the following:

- A hospital must maintain its on-call list in a manner that best meets the needs of patients who are receiving services required under EMTALA in accordance with the capability of the hospital. This revision explicitly acknowledges the limits on availability of on-call staff in many specialties and geographic areas.

- Medicare does not set requirements on how frequently a hospital’s on-call physician staff are expected to be available to provide coverage. Such determinations are to be made by the hospital and the physicians on its on-call roster.

- There is no predetermined “ratio” used to identify how many days a hospital must provide medical staff for a particular specialty. In particular, EMTALA does not require that a hospital provide 24/7/365 coverage whenever there are at least three physicians in a specialty.

- A hospital may permit simultaneous on-call services at different hospitals and the scheduling of elective surgery by on-call physicians, but must have policies in place to follow when a specialist is unavailable.

Other provisions of the final rule that may interest surgeons include:

- A patient who requests treatment, without specifying that the condition is not an emergency, need only receive the appropriate screening to determine whether he or she has an urgent condition.

- Prior authorization may be sought from an insurance company, as long as the process does not delay screening and stabilization services.

- EMTALA does not extend to a patient who has been admitted as an inpatient subsequent to being seen in the emergency room or who has begun to receive outpatient services as a part of another nonemergency encounter.

- A dedicated emergency department is defined as any department on or off the main hospital campus that is licensed by the state, is presented to the public as providing emergency care, or had provided at least one-third of its outpatient treatment on an urgent basis during the previous year.

A copy of the final EMTALA rule may be found at <http://www.cms.gov/physicians/default.asp>, and the text of the rule can be obtained at <http://a257.g.akamaitech.net/7/257/2422/14mar20010800/ed>.

Medicare announces 2004 fee schedule proposals

In early August, CMS announced proposed changes in the Medicare physician fee schedule. Days later, the agency provided comprehensive proposals for modifying the payment of drugs administered in a physician's office. Although drugs are not covered by the fee schedule, some of the provisions in the drug proposal would affect it. The proposed rules provided no new information on the annual physician payment update factor, estimated in March 2003 to be -4.2 percent.

Major proposed changes in the fee schedule include:

- Adoption of all the recommendations made by the Practice Expense Advisory Committee (PEAC) in the practice expense portion of the fee schedule. Approximately 650 surgical procedures were reviewed by the PEAC, and the practice expense inputs suggested will produce relative value units that are generally lower than the old charge-based practice expense values.

- Revision of the malpractice geographic practice cost index (GPCI) this year and the remaining GPCIs (for work and practice expense) next year. GPCIs are applied to the national relative values to bring payments in line with the local cost of practice. The malpractice GPCIs, which are of special interest to surgeons, will be recalculated later this summer when new malpractice data are available.

- Use of more recent data for the consumer price index-urban in the computation of the Medicare Economic Index.

- Revision of the payments for removing benign and malignant skin lesions so the same payment is made for benign and malignant skin lesions of the same size and anatomic location.

- A survey taken by the American Society of Clinical Oncology (ASCO) showed that drug administration practice expenses were undervalued. If a drug pricing proposal (see below) is adopted, CMS proposes to use the ASCO survey data instead of the data from the American Medical Association's Socioeconomic Monitoring System (SMS) in the calculation of practice expense. In the past, CMS had used data from a survey done by the Society of Thoracic Surgeons but had blended it with the SMS data. They are now proposing to remove the blend from the data, giving the thoracic surgeons a small, unexpected increase in practice expenses.

Medicare currently pays 95 percent of the average wholesale price (AWP) for drugs administered in a physician's office, but physicians are able to obtain drugs at prices substantially lower than the AWP. CMS is seeking comments on four alternative methods of paying for drugs: (1) paying the same amount for drugs that carriers pay in their private business; (2) applying a discount from the inflated AWP for 2004 and establishing more reasonable updates in the future; (3) using existing and new sources of market-based prices; and (4) creating a competitive bidding process for drugs.

The College will submit comments on the fee schedule, which are due on October 7, and on the drug provisions on October 14. The notices may be accessed at <http://www.cms.hhs.gov>.

What surgeons should know about...

Medical liability reform deep in the heart of Texas

by Jon H. Sutton, State Affairs Associate, Division of Advocacy and Health Policy

Throughout this past year, a number of states have tried to tackle medical liability reform. While most legislatures were deadlocked on this issue, a handful did make progress. For example, in the state of Texas, the medical community has won a major battle. But the jury is still out on who will win the war across the country—physicians and their patients or the trial attorneys.

This article examines the evolution of medical liability reform in the Lone Star State over the last year—from the Rio Grande protests, to the summer success of Gov. Rick Perry (R) and the legislature, to the medical community's recent effort to bring this issue to the people.

Texas-size problem

With the onset of the latest medical liability insurance crisis, Texas found itself in the national headlines when a number of physicians in the Rio Grande area launched a series of protests at county courthouses in the southern part of the state. These events were the beginning of a movement that spread rapidly across the rest of Texas with specialists of virtually every stripe attempting to educate the public and their legislators about yet another round of escalating rate hikes for liability coverage.

With premium increases in excess of 100 percent over the past two years, surgeons, obstetrician-gynecologists, and other specialists started shunning complex, high-risk procedures. In fact, many physicians closed their practices and relocated to other states that already had medical liability reforms in place. As a result, access to care issues began to arise in a number of areas of the state—a situation that drew considerable media attention.

As one of the states that the American Medical Association identified early on as “a state in crisis,” members of the Texas legislature already had been receiving a great deal of heat from a

Texas medical liability reform (H.B. 4)

- \$250,000 cap on noneconomic damages applies to all physicians and health care providers on a per case/occurrence basis.
- Periodic payment for future damages.
- Proportionate liability for defendants.
- Expert witness qualifications clarified.
- Limited liability of \$100,000 for physicians considered public servants when working for state and local agencies.

broad spectrum of community leaders, both inside and outside of health care. This collection of organizations, including the North and South Texas Chapters of the College, the Texas Medical Association, the state specialty societies, and the National Federation of Independent Business, coalesced behind the leadership of Governor Perry and other Republican leaders to secure a significant medical liability reform package (H.B. 4) that was signed into law on June 11 (see box, above).

Informing the voters

While the stroke of Governor Perry's pen signified a major battle victory for physicians and their patients, one final line of defense remained open to the trial attorneys: a constitutional challenge to the legislature's authority to limit noneconomic damages. To address this problem, lawmakers passed House Joint Resolution 3, which placed “Proposition 12” on the Septem-

ber 13 ballot. Under this referendum, voters would decide whether to amend the state constitution to “authorize the legislature to determine limitations on non-economic damages” in civil lawsuits against physicians and other health care providers.

Advocacy efforts kicked into high gear with a voter education campaign dubbed “Yes on 12.” This effort involved the same coalition of medical and business organizations that supported the liability reform legislation. As part of this campaign, numerous patient-education materials—such as brochures, fact sheets, buttons, bumper stickers, and posters (see figure, this page)—found their way into patient waiting rooms across the state during July and August. These “subtle” reminders were accompanied by face-to-face chats between surgeons and their patients regarding how passage of Proposition 12 would directly affect future access to care.

Facing a trial attorney-financed war chest of nearly \$15 million, “Yes on 12” fought an uphill battle in educating the general public about why Proposition 12 was crucial to ensuring that health care is both affordable and available. The coalition was hopeful that voters would see through the opposition’s misinformation campaign and vote “yes” on Proposition 12.

Indeed, Texas voters went to the polls on September 13 and voiced their support for caps on noneconomic damages by approving Proposition 12. The Texas constitution has now been amended to authorize the legislature to cap non-economic damages in health care liability cases, ensuring implementation of medical liability reform passed by the legislature earlier this year.

Footprints for success

Surgeons and other physicians, along with their patients, should be pleased with their reform efforts and congratulated for their hard work and focused commitment to this cause. However, these positive steps did not just happen. They involved a long-term advocacy plan. A few useful grassroots lobbying strategies can be gleaned from this experience, which may be applicable to various issues:

- *Start early.* The Texas legislature meets every other year, so advocates for medical liability reform used 2002 as a year to educate legisla-



tors and the public about the crisis and the need for medical liability reform. Regardless of the issue, do as much advance work as possible before the legislative session begins. It can mean the difference between success and failure. The more legislators who support a bill before the session begins, the more likely it is to advance past procedural hurdles.

- *Build coalitions.* A diverse group of Texas organizations united to advocate for medical liability reform, and this widespread and heterogeneous support can make a huge impact on leg-

islators who are trying to maintain a following among constituents.

- *Communication and education.* Patient education materials are very useful in physicians' offices and help to generate discussion of the issue with patients. Texas surgeons were effective in contacting their legislators through the Surgery State Legislative Action Center

- **91 percent** of Texas voters feel medical liability insurance is a problem.


- **85 percent** of Texas voters feel lawyers' contingency fees are unfair.

- **69 percent** of Texas voters support a constitutional amendment to allow a cap on noneconomic damages.

- **60 percent** of Texas voters feel a \$250,000 cap on noneconomic damages is "about right" or "too high."

Source: Texas Medical Association, March 2003 statewide survey.

(SSLAC)—often using many of the materials included in the College's Medical Liability Reform Action Guide (<http://www.facs.org/ahp/proliability.html>).

Finally, it is important to make use of the staff resources available to assist with advocacy activities. The College has a knowledgeable state affairs staff, and ACS chapters are encouraged to contact these individuals for assistance in the development and implementation of state advocacy strategies. Christopher Gallagher, Manager of State Affairs in the Washington Office, may be reached at 202/672-1502 or by e-mail at cgallagher@facs.org; Jon Sutton, State Affairs Associate in the College's Chicago office, may be contacted at 312/202-5358 or by e-mail at jsutton@facs.org. 

“ Frivolous lawsuits against doctors are harming patients because some doctors are choosing not to practice medicine because of skyrocketing medical liability premiums.... The only way to truly protect Texas patients, and ensure access to affordable health care, is to vote 'yes' on Proposition 12. I look forward to working with health care professionals, business leaders and involved citizens to protect and preserve healthcare in Texas. ”

—Rick Perry
Governor of Texas

EXPERT WITNESSES

**caught in a moral
and ethical dilemma**

**by
Mark Gorney, MD, FACS,
Napa, CA**



In a recent press release published by the *New York Times* (and repeated in most major newspapers across the U.S.), the American Trial Lawyer's Association complained that their members are finding it increasingly difficult to retain expert witnesses for the plaintiff. Their assumption is that this newfound obstruction can be traced to expanding activism by specialty societies that take disciplinary action against members who testify against another member on behalf of the plaintiff.

This renewed interventionism stems from a case in which the American Association of Neurological Surgeons (AANS) did, in fact, take disciplinary action against a member who not only frequently testified for the plaintiff's side, but also testified differently in almost identical cases. The member in question promptly sued AANS, but the association prevailed, not only in the original suit, but also in all the subsequent appeals to higher authority. Perhaps not surprisingly, specialty societies soon began to react to this significant and unusual development. As a result, professional organizations seem to be overcoming their sense of impotence in responding to the plaintiff bar's widely perceived intimidation.

New dilemma

Those who have experienced leadership in organized medicine, on the one hand, but are also familiar with the unique American tort system on the other, perceive a different dimension to the problem. We see a very real moral and ethical dilemma emerging, which simply adds ammunition to the increasingly open public brawl between medicine and the law.

The dilemma has to do with the ethical and moral responsibility of any physician who agrees to be the expert witness for the plaintiff in a medical malpractice trial. Although the legal system in this country descends from our English forebears, during the last three centuries some substantial differences have developed. No other country in the world routinely tries medical lawsuits before a jury of lay people. Elsewhere, magistrates preside over the cases and seek professional advice from a pool of medical experts attached to the court. An expert in a specific case may be interrogated by counsel for either side but has no other

relationship to either one of them. In the American system, both sides recruit expert witnesses who are, in fact, paid for their service by the attorney who hired them. Understandably, this arrangement transfers the naturally adversarial relationship between both counsel to the experts for either side.

Our current system does something else. It automatically creates an unspoken sense of advocacy toward the viewpoint of plaintiff or defense. It inevitably then becomes difficult to remain completely objective. More importantly, the high honoraria offered experts become a clear incentive to testify, thus further clouding the objectivity required of an expert witness. Understandably, the opinions then tend to fall on whatever side the expert is helping.

The expert must bear in mind that many diagnoses are just as adequately treated through one of several perfectly acceptable means. For example, a basal cell carcinoma may be equally well treated by surgery, X ray, or topical chemotherapy. Provided it is supported in peer reviewed literature, a surgeon certainly may use his or her best medical judgment to decide which is the best option. It is the mark of a truly objective expert witness that he or she has the knowledge and experience, as well as the intellectual elasticity, to recognize a treatment that may not be his or her first choice but that is different from one that clearly falls outside the standard of care.

Accept or decline?

For the physician inclined to accept the responsibility of acting as an expert witness, a review of the medical record quickly allows him to decide whether to accept or reject the assignment. If the invitation is from the defense team, and the case is truly defensible, the decision should be easy and the prospect appealing. After all, what doctor would not be pleased to help defend a confrere? Even if the case is seen as insupportable, a polite declination may produce disappointment but few, if any, bruised egos.

An invitation to act as an expert for the plaintiff brings with it an array of totally unfamiliar exposures for the physician. How often have we heard the trial bar express their inability to understand why a physician should have any sense

of conflict—much less any emotional distress. To them an accusation of malpractice is routine, everyday business. They keep telling us, “It does not mean you are a bad doctor; it just means that you made a mistake, that’s all. There is no need to get emotional about it!” This attitude reflects total disregard for the effect a malpractice allegation has

(win or lose, guilty or not) on a physician’s competence, integrity, self-confidence, and values. Certainly plaintiff’s counsel fail to understand (or care little) about the potential effects on a physician’s practice or well-being. The principles of advocacy requires that he or she do whatever is necessary to win for their client.

Tips for dealing with the dilemma

A plethora of advice is available to those physicians contemplating whether to serve as an expert witness in a medical malpractice trial. Virtually all of this advice deals with the reality of sitting in a witness chair. It deals with how to respond, how to behave, how to dress, what to do, what not to do, and so on. The attorney representing the side for which you are testifying will cover all of this in detail before the trial. However, little has been said about the ethical and moral responsibility of making the original commitment to testify. The decision to volunteer is yours and yours alone to make. Following are some guidelines to help in making this difficult choice.

1. The actions of the defendant physician must be far enough removed from any reasonable standard of care as to fall well within the definition of negligence.

2. It is a mark of integrity when the decision to act as expert witness is based not only on the physician’s desire to do his or her utmost to exonerate the unjustly accused defendant physician, but equally to fulfill a civic and moral responsibility to the public by speaking out on behalf of the patient when the circumstances clearly call for it, regardless of personal consequence.

3. Expert medical witnesses must be able to prove beyond doubt that they possess sufficient experience and knowledge within the specific treatment modality in question so as to avoid any doubt as to their true qualifications. To do otherwise may result in strong prejudicial consequences. It will certainly guarantee that well-prepared opposing counsel will make them look foolish.

4. The inexperienced witness should remember the words of Charles O’Brien, Esq., a wise and respected legal scholar: “Most medical malpractice trials in the U.S. have little to do with science, truth,

fairness, or civil discourse. It is theater, pure and simple, and the best actors walk off the stage with the award.”

5. If the candidate expert witness has experienced the same or similar problems, such as the one at issue in the trial, it is far wiser to discuss the details of that occurrence with one’s attorney long before trial. The consequences of failing to do so can be disastrous.

6. The expert medical witness recruited by either side is in a unique position to affect the resolution of the medical dispute. By careful examination of the medical record and detailed interview with the attorney, he may either be able to get the case dropped and avoid a trial altogether or to encourage an out-of-court settlement. Experienced plaintiff attorneys specializing in medical liability are loath to waste their time and often drop the case on advice of an expert they trust. Defense counsel will be inclined toward settlement if the expert’s opinion calls for it. Thus, that expert witness may exert major influence on the outcome and save everyone considerable anguish and expense.

7. It is a test of your integrity whether you have the ego to stand up and point fingers at the defendant or opposing medical expert, regardless of their stature. You also should consider whether you have the courage to defend a colleague, even if you do not necessarily agree with the treatment, but believe that it still represents a valid therapeutic decision.

8. The “moment of truth” is at hand when you must elect, all circumstances considered, whether to agree to act as an expert witness against a colleague. Only you, in the loneliness of your own mind, can decide which road to follow, because in one direction, the circumstances may be overwhelmingly for it, whereas in the other, something inside is saying, “There but for the grace of God go I.”

On the other hand, peer approval is a very high priority among most physicians. Anything that will dull one's professional image is difficult to cope with. Our built-in psychological defense mechanisms block us from accepting that our professional behavior, in any given instance, might have been less than stellar. It is almost impossible for most of us to admit to ourselves, let alone others, that we "screwed up." Thus, none of us ever commit malpractice (at least judging by "curbside consults" in the hallways of medical conventions). Guilty or not, this defensive reaction is coupled with the conviction that anyone who helps the plaintiff's team, including the expert witness, has just bought a ticket to hell. Worse yet, the action is viewed akin to a knife in the back when it involves a colleague of the same specialty, lamentably sometimes one with a high national "profile."

The nature of the ethical and moral dilemma with regard to expert witnesses is multifaceted and complex. Suppose the medical records show that the treatment was clearly inappropriate, and its direct result was serious, disfiguring, or life-threatening? Worse yet, suppose you knew that this surgeon had experienced a similar outcome in more than one case? What looms higher in your conscience: the imperative to do your civic duty or your devotion to your specialty and impeccable image among your peers? Is your reputation more important than the prevention of severe damage to an unlucky future patient? What say you then to testifying against someone you know to be unscrupulous or incompetent? Are you sure you can always identify the sharp, bright line that defines those parameters?

Despite our conflict with the plaintiff's bar, a rational surgeon knows deep inside that ours is an inexact art. None of us argues that a patient injured by provable iatrogenic negligence deserves compensation. What all of us deplore are the glaring abuses that occur in our unique way of resolving medical disputes. What we find totally unacceptable is that "acts of God" are also clear liability in the U.S. tort system.

Acting responsibly

Nonetheless, until the unlikely day when our system changes, we need to accept that ours is a truly adversarial system. As part of that, we also

must accept the responsibility of participating in it with as much integrity as our conscience can muster.

The committees of the medical societies charged with identifying members whose testimony is questionable must have incontrovertible evidence of such abuse. They must filter any letters from other aggrieved colleagues for real proof, stripped of all emotion or prejudice.

Those physicians who assume the defense expert's role are also obligated to ascertain that whatever actions the defendant took were within the standard of care and that the untoward results were totally beyond human control.

Those physicians asked to act as plaintiff's witness need not uniformly refuse to participate on the basis of fear or possible damage to their ego. This responsibility, however, assumes a much higher priority: to separate fact from fiction, to know with certainty that the act is one that was plainly outside the standard of care, to consider all extenuating circumstances, and to reject compensation for services as an expert as the principal motivation for agreeing to be a witness. Most importantly, the expert must consider whether the same event might have happened had the case been under his control. Then, and only then, can the candidate expert witness decide in the loneliness of his mind whether the totality of the situation outweighs the constraints of the heart. ¹²

Dr. Gorney is a plastic surgeon and is affiliated with The Doctors' Company, Napa, CA.





**ACS Health Policy
Steering Committee
*sets the course for surgery***

by
Cynthia A. Brown, Director,
Division of Advocacy and Health Policy,
and
Josef E. Fischer, MD, FACS,
Boston, MA

As various entities that affect surgical practice continue to expand and extend their influence in new and intrusive ways, the College, like other national health care organizations, has sometimes struggled to keep pace. As a result, the College's limited resources often have been consumed by efforts aimed at solving the problems created by others. Such reactive posturing has been a source of frustration to the Fellowship, as well as to College leaders and staff, because it has interfered with our ability to generate and pursue new ideas of our own that stand to benefit the surgical profession and its patients.

Purposes

The Health Policy Steering Committee was created by the Board of Regents to help address this situation. As a resource to the Division of Advocacy and Health Policy, the panel's work complements efforts that have long been conducted by the Patient Safety and Professional Liability Committee and the General Surgery Coding and Reimbursement Committee.

The Board of Regents approved a plan to establish the Health Policy Steering Committee in January 2001 to help identify, prioritize, and develop action plans for public policy issues affecting surgeons and their practices. In more practical terms, the committee provides the College with a formal structure to:

- Analyze emerging socioeconomic trends and develop policies and proposals to either capitalize on those circumstances or mitigate problems in a proactive way.
- Sort through and prioritize the many issues that compete for a share of the College's financial and staff resources.
- Serve as a stable of individuals with diverse talents who can be called upon as a "rapid response team" when guidance is needed on new proposals that are on the legislative or regulatory "fast track."

Strength in diversity

The committee is composed of a diverse group of surgeons who are broadly representative in terms of specialty, geography, and practice type.

This diversity, combined with the members' policy expertise, allows us to consider issues that pertain generally to the surgical profession and to surgical patients. (See table, p. 17, for list of members.) The advantages of this approach go beyond developing appropriate responses to far-reaching and rather obvious issues of concern, such as cuts in Medicare reimbursement and patient access to specialty care. For example, it is not unusual for new and troublesome developments to affect one specialty before spreading to others. Such issues may be raised by a representative of the affected specialty and assessed by the entire group so that an appropriate response may be developed before the situations get out of hand. Further, the committee's heterogeneity helps the College put into practice a theme that is emphasized frequently by the leadership and by Executive Director Thomas R. Russell, MD, FACS—that the College is an all-inclusive organization engaged in matters that are important to all surgical specialties, as well as to general surgery.

Work groups

To further develop the expertise of its membership so that more thoughtful and innovative policies may be developed, the committee itself divided into five work groups that meet frequently by telephone conference call. These groups address the following topics: (1) health system reform; (2) physician reimbursement; (3) quality and safety; (4) surgical workforce; and (5) regulatory reform.

Currently, the *health system reform work group* (composed of Drs. Fischer, Eddy, McAninch, Miller, and Oblath) is reviewing the complexities of the nation's health care delivery and financing mechanisms and creating a vision for how the system might ultimately be improved. Essentially, the members of this panel seek an answer to the question, "What do we want the health care system of the future to look like?" In the process, the group is identifying the incremental policy steps that may lead us toward the goal of a rational and equitable system. While the proposal is a work in progress that must ultimately be reviewed by the Regents, some general principles that now guide the group's deliberations include the following:

- The money and resources currently in the system are probably adequate to meet our population's health care *needs*, if not all its *wants*.

- Money that is now being wasted or diverted to the extraordinarily high profits of some payors and industries could be put to good use in providing necessary health care services. Reliance on evidence-based medicine to make benefit and coverage decisions is one of the central components of an efficient and equitable health care system. Medical liability reform is another essential component.

- The notion of individual responsibility for health care choices and health care financing must be incorporated into the system.

The *quality and safety work group* (comprising Drs. McGinnis, Browner, Gardner, Mathes, Miller, Muraszko, Rodgers, and Schild) has been reviewing and providing input into the many quality measurement, reporting, and improvement efforts under way in the public and private sectors. Private sector groups involved in quality assessment include the Leapfrog Group, the National Quality Forum, and others, while federal agencies include the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality. The work group is coordinating its efforts with the College's Division of Research and Optimal Patient Care. More recently, the group began working with the *reimbursement work group* (composed of Drs. Opelka, Gardner, Oblath, and Rodgers) to assess various "pay for performance" options that are being proposed by policymakers in all these arenas.

Patient access to care is a central theme in many of the College's advocacy efforts, and the *surgical workforce work group* (Oblath, Browner, Gardner, Opelka, and Warshaw) is examining the issue from the perspective of how current socioeconomic trends are affecting the demand for and supply of surgeons and the consequences for patient access to care. And, finally, the *regulatory reform work group* (Drs. Warshaw, Browner, and Eddy) is charged with helping the Washington Office assess the burdens imposed on surgeons and their patients due to regulations, such as the Emergency Medical Treatment and Active Labor Act.

Health Policy Steering Committee Roster

CHAIR: Josef E. Fischer, MD, FACS, *Boston, MA*
General surgery

VICE-CHAIR: LaMar McGinnis, Jr., MD, FACS,
Atlanta, GA
General surgery

L.D. Britt, MD, FACS, *Norfolk, VA*
General surgery

Bruce Browner, MD, FACS, *Farmington, CT*
Orthopaedic surgery

A. Craig Eddy, MD, JD, FACS, *Missoula, MT*
General surgery

Timothy J. Gardner, MD, FACS, *Philadelphia, PA*
Thoracic surgery

Stephen Mathes, MD, FACS, *San Francisco, CA*
Plastic surgery

Jack McAninch, MD, FACS, *San Francisco, CA*
Urology

Robert Miller, MD, FACS, *New Orleans, LA*
Otolaryngology

Karin Muraszko, MD, FACS, *Ann Arbor, MI*
Neurosurgery

Robert Oblath, MD, FACS, *Encino, CA*
Vascular surgery

Frank Opelka, MD, FACS, *Boston, MA*
Colon and rectal surgery

William Rich III, MD, FACS, *Falls Church, VA*
Ophthalmic surgery

Bradley Rodgers, MD, FACS, *Charlottesville, VA*
Pediatric surgery

A. Frederick Schild, MD, FACS, *Miami, FL*
General surgery

Andrew Warshaw, MD, FACS, *Boston, MA*
General surgery

EX-OFFICIO:
James S. Allan, MD, FACS, *Cambridge, MA*


Other activities

In addition to these ongoing efforts, the committee has brought forth a number of recommendations that the Board of Regents has approved and that have had a significant effect on the way the College conducts its advocacy programs. For example, subsequent to a recommendation made by the committee, the College's efforts in state advocacy were expanded considerably, with the addition of staff and implementation of a Web-based advocacy tool sponsored jointly with more than a dozen surgical specialty societies. The College also has joined the National Quality Forum and is participating actively in reviewing its attempts to develop quality measurement tools.

Further, the Regents themselves have come to rely on the committee as a sounding board for major policy proposals that come before the College. When the Board of Governors recommended that the necessary steps be taken to establish a political action committee to promote the profession's interests, the Regents referred the issue to the committee. Based on the committee's positive recommendation, the American College of Surgeons Professional Association (ACSPA) was formed about a year later and that affiliate was able, in turn, to take a significant step toward establishing a stronger presence for surgery in Washington by forming the ACSPA-SurgeonsPAC.

Finally, another goal of the committee is to foster greater interest and involvement in policy development among the Fellowship, particularly among younger surgeons. Last year, the College and the Society of Thoracic Surgeons jointly sponsored a scholarship program to enable one young surgeon each year to attend an intensive health care policy program that is administered by Harvard's Kennedy School of Government. The first recipient of this award, James Allen, MD, FACS, completed the program this year and was appointed to a one-year *ex officio* term on the Health Policy Steering Committee. Future scholarship winners will be given the same opportunity. In addition, this October, the College's Committee on Young Surgeons will appoint its first young surgeon liaison member to the panel.

The Health Policy Steering Committee is a di-

verse, dynamic, and committed group. The members truly seem to enjoy their role in helping to shape the College's involvement in policymaking and advocacy. The committee welcomes ideas from the Fellows about issues to address or proposals to develop. Written correspondence should be directed to the Washington Office at 1640 Wisconsin Avenue, NW, Washington, DC 20007, or by e-mail to ahp@facs.org. 

Dr. Fischer is chairman, department of surgery, and Mallinckrodt Professor of Surgery, Beth Israel Deaconess Medical Center, Boston, MA. He is a member of the College's Board of Regents and Chair, Health Policy Steering Committee.





The
American
College
of
Surgeons
at
90

by
C. Rollins Hanlon, MD, FACS,
Executive Consultant



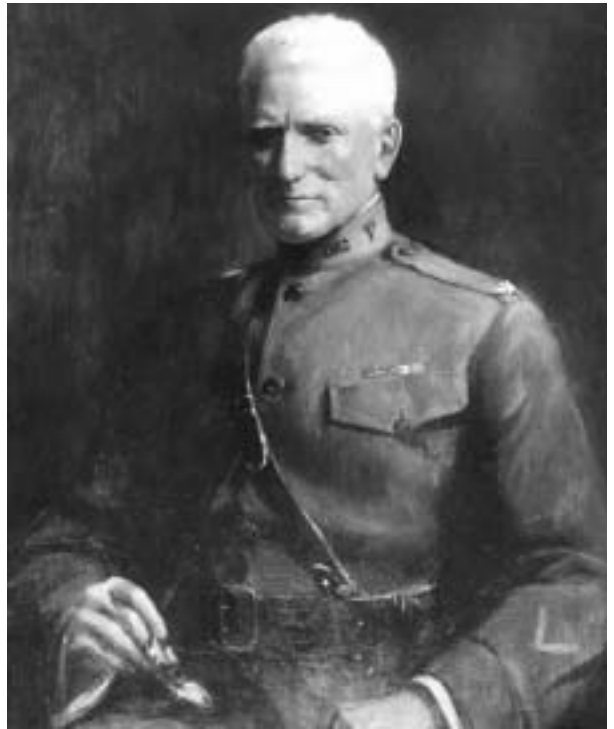
In May 8, 2003, the American College of Surgeons was 90 years old. The story of its first 75 years is well covered in two books, *Fellowship of Surgeons* by Loyal Davis, MD, FACS,¹ and *American College of Surgeons at 75* by George W. Stephenson, MD, FACS.²

At an informal 90th birthday staff luncheon in May 2003, a few vignettes of early College history were presented. These served to jog the memory of older employees and to introduce newer staff members to some of the events and personalities that defined the early days of the organization. At the suggestion of the *Bulletin* Editor, parts of that presentation are reproduced here.

Organizational beginnings in the field of medicine show a customary pattern, starting with common interests such as lesions of the skin or diseases of the eye. Individuals with such shared interests may establish a formal group to meet regularly for discussion of common problems. It is usual to memorialize their proceedings in published transactions or in specialty journals.

With the American College of Surgeons the process was reversed. First, in 1905 came the scientific journal, *Surgery, Gynecology and Obstetrics* (*SG&O*), which implemented Franklin Martin's (see photo, above right) cherished desire for an independent professional journal, written and managed by practicing surgeons, rather than one directed by commercial interests. Following the success of *SG&O*, Martin and his associates invited a group of journal subscribers to come to Chicago in 1910 for lectures and operating room demonstrations by leading Chicago surgeons. Prominent among them was the flamboyant John B. Murphy, MD, FACS, close friend and adviser of Martin, whose story is recounted in another Loyal Davis book, *J.B. Murphy, Stormy Petrel of Surgery*.

The 1910 assembly of surgeons, known as the Clinical Congress of Surgeons of North America, was the second successfully realized part of Martin's educational dream. At the time of the annual Clinical Congress in 1912, Martin proposed his third venture for a "college" modeled after the ancient colleges of the British Isles, whose advice and paternal blessings helped launch the Ameri-



Right: Dr. Franklin Martin and Isabelle Hollister (Martin).



Maj. Gen. Gorgas



Executive Committee of the General Medical Board. Seated, left to right: R. Adm. William C. Braisted, Maj. Gen. Gorgas, Surgeon General Rupert Blue, U.S.P.H.S, and Dr. Martin. Standing, left to right: Dr. Frank F. Simpson; Dr. Victor C. Vaughan, Dr. William H. Welch. Insets, upper right: R. Adm. Cary T. Grayson, and Dr. William J. Mayo. Lower left: Dr. Charles H. Mayo, and Brig. Gen. Jefferson R. Kean.

can College of Surgeons in May 1913. After some bitter resistance, the new College in 1917 absorbed the Clinical Congress, maintaining it as the College's premier annual educational meeting, a relationship that persists to the present.

Dr. Martin's early origin as a Wisconsin farm boy might seem an unlikely source for a successful performer on the national and international medical stage. But his inherent talent was buttressed by remarkable associates.

In addition to enlisting a group of professional colleagues who furthered his plans, he successfully wooed a cultured, discriminating, and vigorous woman, Isabelle Hollister (see photo, p. 20). Isabelle was the daughter of one of Martin's medical school professors, the domineering John H. Hollister. Hollister and his wife stubbornly and rather contemptuously resisted the idea of Martin as a suitable husband for their only daughter, and Martin never forgot the humiliation of his in-

terview with the older physician. Hollister's own failed venture into surgical publishing was a strong factor in Isabelle's early, ineffectual opposition to the founding of *SG&O*. Thereafter her unwavering support and uncommon discernment were vital factors in Martin's later enterprises, including his 1916 organization of the Committee of American Physicians for Medical Preparedness.

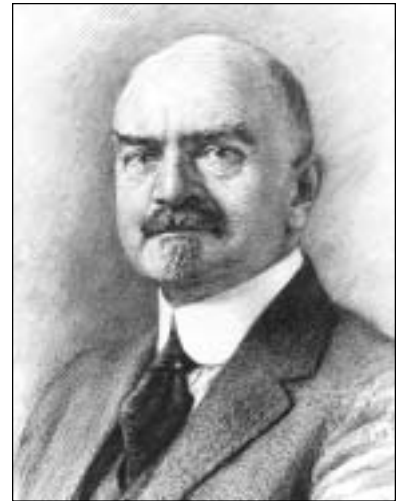
This 38-person committee included 10 ex-officio members drawn from the Surgeons General of the armed forces, the Red Cross, the American Surgical Association, and the American College of Surgeons. It was a remarkable organization, conceived and birthed by Martin at the suggestion of another distinguished gynecologist, Frank F. Simpson, MD, of Pittsburgh. Simpson was a tornado of activity and his behind-the-scenes recommendations resulted in Martin's rapid rise to the highest levels of influence in the preparation of resources for our entry into the Great War. Af-



Dr. Codman



Dr. Scudder



Dr. Cullen

ter Martin's visit to U.S. Army Surgeon General William C. Gorgas, MD (see photo, p. 21), and the enthusiastic approval of President Woodrow Wilson, the medical preparedness committee was launched as a governmentally sponsored entity. It secured the enlistment of 2,000 Medical Reserve officers from a list provided to General Gorgas. Moreover, the committee surveyed the capacities of some 1,700 medical institutions for possible involvement in the coming war effort.

When a Council of National Defense was established by law in August of 1916, the Committee of American Physicians was placed under an Advisory Commission of the Council composed of seven civilian Presidential appointees drawn from academe, industry, finance, labor, and medicine, with Martin as a startled member of this redoubtable group. He describes these variegated activities in Chapter 33 of his autobiography, *Fifty Years of Medicine and Surgery*.³

The interlocking work of all these bodies with practicing surgeons, nurses, medical school deans, and other parts of the health care enterprise was instrumental in coordinating the civilian and military resources of the nation. Eventually there

came into being a General Medical Board of 87 active and four honorary members with Martin as Chairman (see photo, p. 21). His prominence as a specialist in this overarching effort so troubled the AMA president that he vigorously solicited President Wilson to remove Martin from the chairmanship but without avail.

Following the Allied victory in 1918, Martin was once more able to devote his full energies to building up the multiple projects of the College. In this work he relied heavily on many individuals whose enthusiasm and expertise he guided into productive channels. There was Ernest A. Codman, MD, FACS (see photo, above left), who originated the Bone Sarcoma Registry and pioneered the concept of end-result reporting, which he espoused so vigorously and undiplomatically that he was rejected by organized medicine in his home state of Massachusetts. Not until long after his death was he properly appreciated as the stimulus for the Commission on Professional and Hospital Activities (CPHA). This autonomous body, with multiple sponsors, was established in 1956 to collect hospital case records for machine analysis to determine the incidence of diseases in hospitals, the fre-



HAROLD GUTHMAN

Dr. Davis



Dr. Stephenson



Ms. Grimm

quency of surgical procedures, and other valuable data to allow comparison of individual performance with national norms.

Codman had also proposed at the 1912 Clinical Congress the concept of hospital standardization, which became a functioning program in 1918. Ultimately in 1952 this led to the Joint Commission on Accreditation of Hospitals (JCAH, later modified as the Joint Commission on Accreditation of Healthcare Organizations, JCAHO). At that same Clinical Congress, Martin had proposed his plan for the “standardization of surgeons,” which led to the formation of the American College of Surgeons in 1913. Codman’s story was featured in the *ACS Bulletin* in 1999⁴ and is exhaustively covered in the JCAHO publication that reproduces Codman’s 1917 book on results of care in his private hospital.⁵

Then there was Charles L. Scudder, MD, FACS (see photo, p. 22), whose 1923 ACS committee on “Treatment of Fractures” evolved into a nationwide program with area chairmen and hundreds of participating Fellows. Concern over poor care for industrial injuries led to College-sponsored standards for clinics in industry and to a Board of

Traumatic Surgery. Ultimately the treatment of fractures and other traumas blended into the Trauma Committee, which went on to become a vast program. One aspect of the College’s work in trauma is the internationally renowned Advanced Trauma Life Support® (ATLS®) program, which has been adopted and copied worldwide.

Thomas S. Cullen, MD, FACS (pictured on page 22 in a sketch by the famous medical artist Max Brödel), a professor of gynecology at Johns Hopkins, stimulated the formation in the College of an interest in gynecologic cancer, leading to the American Society for the Control of Cancer. This became the American Cancer Society, working closely with the College on cancer initiatives under various organizational entities. The correlation of work by thousands of physicians and support personnel is managed by the College’s Commission on Cancer, supervising education, standard setting, guidelines for management and follow-up, as well as many other aspects in the wide realm of malignancy. (Cf. Web site at <http://www.facs.org/dept/cancer/coc/cocar.html>.)

Franklin Martin’s genius was complemented by the host of individuals described by Loyal Davis



Dr. and Mrs. Martin (center) and the staff of the American College of Surgeons and *Surgery, Gynecology & Obstetrics*.

(see photo, p. 23) as a group “...brought together and stimulated by a man with imagination, a dreamer, an enthusiast, a driver whose mark on American surgery has been made by the organization which he conceived.” We have presented a brief glance at several individuals who worked with Martin on projects not directly related to the College structure. We omit discussion of Allen B. Kanavel, MD, FACS, unassuming workhorse of the early *SG&O*, or of Nicholas Senn, MD, FACS, the more famous initial editor of Martin’s journal. Nor is there specific note of the vital role of the Mayo brothers, or the reluctant, magisterial John M.T. Finney, MD, FACS, as first President, and the even more reluctant sixth President, Harvey Cushing, MD, FACS. George Crile, MD, FACS, of Cleveland, OH, is not mentioned; he functioned as chair of the Board of Regents for years before the office was officially established. The Canadian surgeons, such as George E. Armstrong, MD, FACS, of Montreal, QC, played a vital role in the initiation and continuing functioning of the College as a body looking beyond the borders of the U.S. to its ultimate worldwide character, especially in Latin America.

In the preface to his book George Stephenson (see photo, p. 23) notes that all activities of the College depend on the thousands of Fellows who serve on committees, commissions, and councils throughout the world. Truly, he says, *they are*

“the College.” But there is another aspect of the organization, less prominent and at times unappreciated. This consists of the College staff, some of whom serve individually for many decades to preserve the organizational goals and to adapt them to changing circumstances.

Emblematic of such individuals was Miss Eleanor K. Grimm (see photo, p. 23), who rose from secretarial status to Secretary of the Board of Regents and Editor of both the *Bulletin* and the *Yearbook*. She served as well on the Administrative Board that managed the College from the time of Franklin Martin’s death in 1935 to the coming of Paul R. Hawley, MD, FACS(Hon), as the Director in 1950. Her complete, meticulous notes, assembled before her 1952 retirement, constituted the background for *Fellowship of Surgeons* by Loyal Davis, as he graciously acknowledged.

The ninetieth birthday luncheon saluted the invaluable services of the headquarters staff, now increased by a factor of four from the group pictured above with Dr. and Mrs. Martin some seven decades ago. *SG&O* has developed enormously, changed its name to *Journal of the American College of Surgeons*, and sharply reduced the number of its in-house staff by virtue of outsourcing many publishing functions.

The three Erie Street properties, pictured on page 25 in the second decade after the founding of the College, have also been profoundly altered




EXECUTIVE OFFICES, AMERICAN
COLLEGE OF SURGEONS

JOHN B. MURPHY MEMORIAL

OFFICES, "SURGERY, GYNECOLOGY
AND OBSTETRICS"

The College's Erie St. properties in the late 1920s.

in form and function as the main College headquarters have been moved to more modern facilities. The internally upgraded and reconfigured Murphy Memorial Building will serve as a center for renewed activities in patient safety, together with proper preservation and management of our records and artifacts under supervision of a professional archivist.

Other initiatives proceeding under the recently established four divisions of the reorganized College structure promise to confront effectively the new external and internal challenges posed by an evolving health care situation. But the loyalty and effectiveness of the staff, as shown by nine decades of "serving all with skill and fidelity," will continue as the College moves confidently forward in its centennial decade. 

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Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

This month, *ACS Surgery: Principles and Practice* unveils a new organizational structure online at www.acssurgery.com. The table of contents now features an intuitive "system approach" plus a new section, "Elements of Contemporary Practice," which covers such key topics as patient safety, patient risk assessment, and malpractice. The following are highlights from the newest additions to *ACS Surgery*, the practic-

ing surgeon's first and only Web-based and continually updated surgical reference.

1. Basic surgical and perioperative considerations

1. Preparation of the operating room. Rene Lafrenière, MD, CM, FACS; Ramon Berguer, MD, FACS; Patricia C. Seifert, RN; Michael Belkin, MD, FACS; Stuart Roth, MD, PhD; Karen S. Williams, MD; Eric J. De Maria, MD, FACS; and Lena M. Napolitano, MD, FACS, for the American College of Surgeons' Committee on periOperative Care. The authors discuss the following topics: the general principles of operating room (OR) design and construction; environmental and safety issues in the OR, including infection control; endovascular and laparoscopic ORs; and OR data management.

The OR presents a number of environmental hazards to both surgical personnel and patients. Chemical hazards exist from the use of trace anesthetic gases, flammable anesthetic agents, various detergents and antimicrobial solutions, medications, and latex products. Other ever-present physical hazards include electrical shock and burns, exposure to radiation from X-ray equipment, and injuries caused by lasers. (In addition to causing injury directly, the use of lasers can expose OR personnel to papillomavirus in smoke plumes.) Hazards that are less often considered include noise pollution and light hazards from high-intensity illumination. The most effective way to minimize the particular hazards in an OR is to have an active in-hospital surveillance program run by a multidisciplinary team that includes surgeons. Subscribers to *ACS Surgery* may view the full text of "Preparation of the operating room" at www.acssurgery.com.

4. Vascular system

1. Stroke and transient ischemic attack. Thomas S. Maldonado, MD, and Thomas S. Riles, MD, FACS. In their new chapter, Drs. Maldonado and

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Riles discuss the incidence, risk factors, and clinical evaluation of stroke, including imaging and laboratory approaches to diagnosis and the timing of therapy for stroke. They also review the differentiation of hemorrhagic and ischemic strokes, as well as the key issue of timing and aggressiveness of therapy.

Patients presenting with sizable intracerebral hemorrhage (ICH) often rely on a marked compensatory elevation of blood pressure to maintain a pressure gradient in the setting of acute increases in intracranial pressure. It is vital to resist the impulse to lower blood pressure aggressively in these patients: a rapid drop in blood pressure may induce brain ischemia. Short-acting antihypertensives should be administered only when the systolic blood pressure is persistently higher than 180 to 200 mm Hg or when there is evidence of active bleeding or an enlarging hematoma. Other medical treatment of hemorrhagic stroke from ICH includes reversal of coagulopathies with transfusions of fresh frozen plasma and platelets when appropriate. Subscribers to *ACS Surgery* may view the full text of "Stroke and transient ischemic attack" at www.acssurgery.com.

6. Critical care

2. Acute cardiac dysrhythmia. Caesar Ursic, MD, and Alden H. Harken, MD, FACS. The authors discuss the pathophysiology of cardiac arrhythmias and the five classes of antidysrhythmic agents, including unclassified agents. They outline the approach to the patient with an apparent acute cardiac dysrhythmia; describe approaches to the control of ventricular rate and the maintenance of a normal sinus rhythm in the patient who is hemodynamically unstable; and present approaches to the management of the hemodynamically stable patient whose ventricular rate is either slow or fast. Cardiac dysrhythmias during pregnancy are also reviewed.

Verapamil (or another calcium channel blocker), lidocaine, and adenosine are the only drugs essential for the acute treatment of cardiac dysrhythmias. Because patients may already be taking oral agents for chronic dysrhythmias, however, it is important to be aware of the actions and side effects of these drugs when treating an individual with an acute dysrhythmia.

Antidysrhythmic drugs have been classified on the basis of their dominant electrophysiologic effect; this classification has been reviewed and placed in a clinical context. Adenosine has a unique receptor that modulates cyclic adenosine monophosphate (cAMP), resulting in cholinergic activity. It is not similar to other antidysrhythmic agents and is therefore unclassified. Subscribers to *ACS Surgery* may view the full text of "Acute cardiac dysrhythmia" at www.acssurgery.com.

6. Critical Care

8. Disorders of water and sodium balance. Richard H. Sterns, MD. The author discusses the following topics: body fluid homeostasis; the diagnosis and management of disorders of water excess (hyponatremia), water deficiency (hypernatremia), saltwater excess (edematous states), and saltwater deficiency (volume depletion); and the pathogenesis, diagnosis, and treatment of neurogenic diabetes insipidus.

Volume depletion occurs when saltwater is lost from the extracellular fluid at a rate that exceeds intake. Saltwater can be lost from the gastrointestinal tract, kidney, or skin, or due to extravascular sequestration (third-space losses) in the abdominal cavity or in traumatized tissues. Underfilling of the arterial circulation triggers a cascade of physiologic responses that preserve blood flow to vital organs. Volume receptors and baroreceptors activate the sympathetic nervous system and the renin-angiotensin-aldosterone system. Except when renal salt wasting is the cause, these responses reduce urinary sodium excretion so that nearly all ingested salt is retained. Volume-depleted persons also become thirsty; ingested water is retained because vasopressin, released in response to volume depletion, concentrates the urine, decreasing water excretion. The plasma sodium concentration may be high, normal, or low in volume-depleted persons, depending on electrolyte-free water intake and excretion. Vasoconstriction maintains the systemic blood pressure and also reduces renal blood flow. Initially, efferent arteriolar resistance, mediated by angiotensin II, predominates, sustaining intraglomerular pressure

continued on page 40

Mr. Kelly is editor, *What's New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

Socioeconomic tips of the month

Common coding hotline questions

by the Division of Advocacy and Health Policy

One of the many benefits that the ACS provides to Fellows is access to a coding hotline (800/ACS-7911). ACS Fellows are entitled to 10 consultation units (CUs) in one 12-month period. If your office has coding questions, please contact the hotline between 8:00 am and 6:00 pm central standard time, holidays excluded. The following are frequently asked questions that may provide some insight for your practice.

Q. **How do I code when a physician's assistant, nurse practitioner, or surgical technician is assisting at surgery?**

A. Medicare's guidelines state that physician's assistants (PAs), nurse practitioners (NPs), and certified clinical nurse specialists (CNSs) must have their own provider identification number (PIN) in order for a surgeon to report their services as assistants-at-surgery. In coding for their services, append health care common procedure coding system (HCPCS) modifier -AS to the Current Procedural Terminology (CPT) code used to report the procedure. Medicare does not recognize surgical technicians as providers and, therefore, CPT codes cannot be used to report their services. If the payor is a private insurer, check with the insurer to determine how the service should be reported.

Q. **Our surgeon performed the PEG portion of an EGD during the same session that the gastroenterologist performed the EGD. I have looked at code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube*, code 43235, *Upper***

Around the corner

November

- The 90-day implementation period during which Medicare will allow claims to be submitted with the 2002 and 2003 versions of ICD-9-CM diagnosis codes continues until December 31, 2003. After that only the 2004 version will be accepted.
- CPT 2004 available.
- Economedix teleconferences scheduled as follows: Diagnosis Coding for Surgeons...ICD-9 (Oct. 29 and Nov. 1); Building Employee Superstars: Evaluations and Appraisals (Nov. 5 and 8); and Creating a Strategic Business/Marketing Plan for 2004 (Nov. 12 and 15). For more information and to register, go to <http://yourmedpractice.com/ACS-Teleconference>.

gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure), and code 43750, Percutaneous placement of gastrostomy tube. Should each physician report their own service with the gastroenterologist reporting code 43235 and the surgeon reporting code 43750, or do they both report 43246 with modifier -62?

A. Either option would be acceptable. If the surgeons want to report the same code, they should report code 43246 and append modifier -62. Each physician should dictate a separate note describing his/her portion of the service.

Q. **How do I code when the physician did a colonoscopy with tattooing?**

Current Procedural Terminology©2003 American Medical Association. All rights reserved.

A. Report code 45381, *Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance*. This code is new in CPT for 2003

Q. **We billed code 36870, *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)*, to Medicare, and it was reduced because of the place of service (POS). Why?**

A. The Medicare fee schedule contains both a facility and a nonfacility RVU for code 36870. The facility relative value unit (RVU) for this code is 7.78; the nonfacility RVU is 47.71. If the fee reported was based on the nonfacility RVU and the service was performed in a facility, this would be the reason for the reduction in reimbursement. When a procedure is performed in a facility, the physician is reimbursed solely for the work involved in the service because the other costs involved in providing the procedure (operating room, equipment, staff, and so on) are borne by the facility and separately reimbursed to the facility. It is important to remember to include the POS code on the submitted claim. You can find a list of current Medicare POS codes at <http://www.cms.gov/states/posdata.pdf>.

Q. **If there is not a code for a laparoscopic procedure, how should it be coded? Do we report a diagnostic laparoscopic code and the open code?**

A. If there is no specific code for the laparoscopic procedure, look for the appropriate unlisted laparoscopic code for the body site. If no laparoscopic code is listed for the body site, use the unlisted open code. Do not report both the laparoscopic and open code for the service. For example, for a ventral hernia repaired laparoscopically, report code 49659, *Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy*. Set the fee based on a reference code that describes a similar amount of physician work. Include a cover letter explaining why the fee was set based on that reference code and the operative notes.

Q. **How do I code for a secondary closure of abdominal wall dehiscence with fibrin glue?**

A. Either code 12020, *Treatment of superficial wound dehiscence; simple closure*, or code 13160, *Secondary closure of surgical wound or dehiscence, extensive or complicated*, would be acceptable, depending upon complexity and size.

Q. **If the physician saw a patient two years ago and the patient is coming back to the office now for a different diagnosis, is it appropriate to code a new patient E/M encounter?**

A. New patient status is not diagnosis-driven. CPT defines a new patient as “one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.” Because the surgeon saw the patient two years ago, established patient codes should be used regardless of the diagnosis. Also consider whether the encounter meets the criteria for a consultation (an opinion requested, the request documented, a written report made and placed in the common medical record or sent to the requesting physician). If this is the case, then the appropriate consultation codes should be used, regardless of whether the patient is new or established.

Q. **What code should be used when the patient already had a mastectomy due to breast cancer and now is having a recurrent cancer removed from the chest wall? Remember the patient no longer has a breast so this is from the muscle of the chest wall.**

A. You can use code 21556, *Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular*.

Q. **What codes should be used when the physician is called into the nursing home for a consultation?**

A. The CPT definition of an Initial Inpatient Consultation states, "The following codes are used to report physician consultation provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting." Report the appropriate level of service in the code series 99251-99255.

Q. **What code is used when the surgeon changes antibiotic beads in a wound?**

A. *CPT Changes 2002* states: "Three new codes were added to describe insertion/removal/removal with reinsertion of a nonbiodegradable drug delivery implant. You will note the type of drug is not listed in the descriptors of codes 11981-11983, as various types of medications (such as hormones and antibiotic) for various indications can be administered using this type of implant." Code 11983, *Removal with reinsertion, nonbiodegradable drug delivery implant*, can be reported.

Q. **Which codes may be used to bill for placement of BIOBRANE?**

A. BIOBRANE, a brand name product for temporary skin substitute, consists of a custom-knitted nylon fabric mechanically bonded to an ultra-thin silicon membrane. It is used as a temporary skin substitute for the management of excised burn wounds and is applied to cover a meshed autograft for the purpose of diminishing healing and closing time of the mesh and improving graft take. Because BIOBRANE is used over the autograft, it would be considered a part of the dressing. You would report the appropriate autograft code found in the free skin graft series 15050-15261.

Q. **How do I code for resection of the cecum?**

A. Because the cecum is considered apart of the colon, use code 44140, *Colectomy, partial; with anastomosis*.


Q. **How do we code for an excision of a skin lesion of the stoma site?**

A. Report the appropriate code in either series 11400-11406, *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs;...or* series 11600-11606, *Excision, malignant lesion including margins, trunk, arms, or legs*, based on the pathology report.

Correction

A typographical error appeared in the April 2003 issue of this column that resulted in incorrect coding advice. The question and answer should have read:

Q. **How do we code when the physician uses fibrin glue to repair an anal fistula?**

A. Use code 46706, repair of anal fistula with fibrin glue. This code is new in CPT for 2003. 

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

Fiscal Affairs Committee proposes long-term dues strategy

In 2001, the Fiscal Affairs Committee on the Board of Governors approved a long-term dues strategy tied to inflationary increases, which was presented to the Board of Governors in

2002. However, the recommendation was not approved at that time.

In recent months, the Fiscal Affairs Committee, the Finance Committee of the Board of Re-

gents, and the Board itself have subsequently discussed a long-term dues strategy for the College.

The College's Fiscal Affairs Committee, chaired by Julie A. Freischlag, MD, FACS, met August 7, 2003. The committee reviewed the 2004 budget and business plans approved or discussed by the Board of Regents and the Finance Committee. The Fiscal Affairs Committee reviewed a proposed long-term dues strategy for the College.

The working draft of the long-term dues strategy is as follows:

- Management must demonstrate that resources are needed for dues-supported programs.
- Leadership evaluates, with input by members, the value of dues-supported programs to the membership.
- If resources are needed, dues should be set to keep pace with economic conditions—an increase during times of inflation and a decrease in times of deflation. An increase may be less than the rate of inflation, depending on the funding needed to support the proposed program.
- Small annual incremental increases during periods of inflation are preferred over large periodic lump sum dues adjustments.

The long-term dues strategy will be presented to the Board of Governors for discussion at the October 2003 meeting.



Dr. Russell and Dr. Foster attend state legislatures conference

Thomas R. Russell, MD, FACS, ACS Executive Director (left), dropped by the recent annual meeting of the National Conference of State Legislatures (NCSL) in San Francisco, CA, to get an update on the organization's medical liability reform efforts from West Virginia House Member Daniel Foster, MD, FACS. In addition to serving in the West Virginia Legislature and on the NCSL's Health Committee, Dr. Foster has proven to be a valuable resource to the College's Patient Safety and Professional Liability Committee.

NTDB™ data points

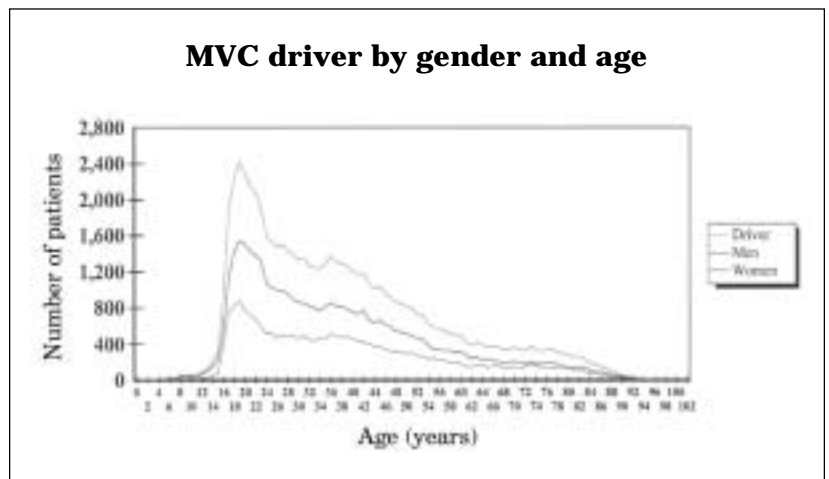
The driving force behind injury

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

What clearly has developed over time as a rite of passage is the day a teenager gets his or her first driver's license. While the teenager already knows every thing there is to know at that age, it is apparent that avoiding motor vehicle crashes is not part of their knowledge base. Depicted in the graph at right, we see a dramatic rise to a high peak in motor vehicle driver-related injuries during the teen years. This peak coincides with the early years of a teenager's driving independence.

There is a recognized increase in crash rate, injury rate, death rate, and cost among new teenage drivers. Just ask any parent with teenagers who has to pay a car insurance premium. Going along with this increased cost is the unfortunate rise in death rate for this group of drivers. These data contained in the second *Annual Report* of the National Trauma Data Bank™ (NTDB) support addressing the issue of teen driving and the related increased injury risk. Recognition of the problem is the first step. Prevention is the next.

Several states have started to implement graduated driver's license programs to try and minimize motor vehicle-related injuries in this age group. Decreasing distractions by limiting the number of passengers under 21 years of age in the vehicle, im-



Number of patients injured in motor vehicle crashes who were drivers for both men and women at each age from 0 to 105. Total N = 64,968.

posing restricted driving hours, and enforcing an after-dark curfew on new drivers are a few of the restrictions being placed on new teenage drivers. There have also been efforts to raise the driving age to 18. This action would coincide with an increased maturity level that would foster a better understanding of this newfound responsibility. However, these efforts have met with significant opposition from many groups. It is imperative that we do whatever we can to reduce teenage driving fatalities. Our children are our future.

Hopefully, as more and more states adopt a graduated driver's

license program, we will see a decrease in the teenage peak of motor vehicle driver-related injuries in future NTDB annual reports.

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/trauma/ntdb/annualreport2002.pdf>. If you are interested in submitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB at mneal@facs.org.

Profiles in Leadership

Frank T. Padberg, MD, FACS

Fellow of the American College of Surgeons since 1954. Neurological surgeon. Director of ACS Fellowship and Graduate Education Departments. Distinguished Service Awardee 1988.



“When I was in surgical practice, I participated in the educational activities of the College; later I served the College on staff administering the Fellowship Department and Graduate Education Programs. I determined then that a personal, designated financial contribution from me to the ACS would help to continue the activities of the College that I found so important and enjoyable.”

“The College Fellowship encompasses all the surgical specialties and provides broad educational, ethical, social, and political projects and events that are available to the medical community. I believe that personal gifts are more important than ever to help the College to continue its active involvement in promoting and continuing these projects—each of which is directed at improving the care of the surgical patient.”

“The ACS provided me with a broad ‘second career’ that was demanding, most enjoyable, and, I believe, productive and contributory to the field of surgery after a long active surgical practice. It is a pleasure for me to ‘give back.’”

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

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



**We invite you to consider
joining Dr. Frank T. Padberg
in the Fellows Leadership
Society of the American
College of Surgeons.**



The following comments were received in the mail or via e-mail regarding recent articles published in the *Bulletin* and the "From my perspective" columns written by Executive Director Thomas R. Russell, MD, FACS.

Professional liability

Complying with Dr. Russell's request for thoughts about what can be done about the prohibitive cost of malpractice insurance, I would like to suggest that physicians create an "American Board of Malpractice Arbitration."

We physicians have neglected to protect the public from the practice of bad medicine. As a result, the lawyers have found a gold mine "protecting the public" from the "ravages" of bad medicine. Now we physicians are paying for our lack of involvement. The board would review liability cases and present opinions based on a critical review of the physician's care of the patient. If the evidence indicates that the physician harmed the patient, the Malpractice Arbitration Board could make that determination. Similarly, if the physician is not guilty of malpractice, the Malpractice Arbitration Board could attest to that innocence. This information would be made available for judges, juries, defense, and plaintiff attorneys to study.

The board could also provide opinions based on a review of available scientific evidence about the efficacy of various drugs, medical practices, and the potential harm caused by environmental substances. Too often, we doctors have remained silent while others have allowed pseudoscience, such as the unproved harm of breast implants, to be used in courtrooms.

This litigious atmosphere is stifling the practice of medicine, and only physicians can do anything about it. A new organization such as the one I am suggesting could

solve many problems, including the policing of the quality of the practice of medicine, removing incompetent physicians, and helping to eliminate worthless lawsuits.

Jay L. Ankeney MD, FACS

I enjoyed Dr. Russell's recent comments in the July *Bulletin* regarding professional liability and applaud his sense to communicate with the surgeons at this time. The malpractice crisis is an extraordinarily complex problem.

A patient or family member who has suffered tragedy as the result of a medical error will justifiably be angry. In our society, this usually means a lawsuit and millions of dollars at issue. The public, however, is unaware that hernia pays under \$500 and an emergent laparotomy at 2:00 am under \$1,200. If they knew that our fees were fixed by the government and 95 percent of all insurance companies, then maybe my \$82,000 malpractice bill for \$500k per occurrence would clearly seem unreasonable to the public. To put it simply—maybe people would accept a \$250,000 cap on pain and suffering if they knew the doctor only makes about \$80 per hour.

This problem has strong advocates on both sides but, clearly, the predicament of the general surgeon with fixed low fees in combination with high risk and high malpractice premiums will force something to crack.

Either malpractice goes away or there should be more support for doctors organizing in order to increase reimbursement.

P.S.: The one thing that cannot be taken away is the privilege of surgical skill and the relationship with the patient who benefits.

Jonathan P. Yunis, MD, FACS

The "competitive surgeon"

I agree completely with Dr. Russell's comments in his column in the August *Bulletin* on the

"competitive surgeon," and thought they were most succinctly expressed. I am a surgeon of the past (retired 08/31/02); however, I would have loved to have gone through medical school and surgical residency with today's technology. How much fun it would have been to ultrasound a cadaver before seeing firsthand its innermost secrets, and compare the two. CTs would have made anatomy fun and much more practical. I personally think the ultrasound is the PCP and surgeons' next "stethoscope," and training should commence in medical school.

With regard to restrictions on resident hours, I guess I'm somewhat of a dinosaur in my thinking. I always thought that a surgical residency had some aspects of a military boot camp (if you can't stand the heat, then get out of the kitchen) in addition to instruction. I can now see that in regard to a patient's well-being, it might not be politically correct. However, I was never aware of any patient's safety being compromised as a result of a resident's long hours on duty.

Dr. Russell, keep up the good work—you seem to be perfectly attuned to the surgeon's problems and are guiding the College accordingly.

Robert J. Turner III, MD, FACS

Resident's workweek

In the June issue of the *Bulletin*, Dr. Russell expressed support, on behalf of the College, for the recommendation of the Bell Commission limiting the workweek of surgical residents in training to 80 hours. We are in disagreement with him on this issue, and we are equally disturbed by the strict restrictions on resident activities imposed by the Bell Commission. The reasons for our dissent are detailed in the

recent publication of the John Jones Surgical Society at Columbia, entitled *A Proud Heritage—An Informal History of Surgery at Columbia*.

We share Dr. Russell's concerns about the ability of overextended and fatigued residents to provide quality care, and agree that 120- to 130-hour workweeks are clearly excessive, particularly if much of that work is unrelated to training. As he points out, redundant activities, endless unproductive "rounds," senseless waiting for others to be available, disrespectful behavior by senior physicians, and doing work that ancillary help can expeditiously accomplish (such as transporting patients and drawing blood), must be eliminated. And the personal lives of the residents must be given appropriate consideration.

Given the public interest in recent years about "patients' rights," it is not inappropriate that federal and state governments intervened with legislation ostensibly designed to protect the patient from inexperienced hands in the operating room and faulty judgments at the bedside resulting from resident fatigue. We believe, however, that the Bell Commission overreacted to the widely publicized Zion incident, and succeeded in "throwing the baby out with the bath water." Their recommendations (in New York State) resulted in strict restrictions of resident work hours to 80 hours weekly, and mandated strictly enforced attending supervision of residents during all surgical procedures regardless of the resident's experience.

Unfortunately, these regulations have potentially serious consequences with regard to both the quality of patient care and the maturation of well-qualified surgeons for the future. Justified as these acts may appear in terms of patient protection, there are

dangers in their implementation. Continuity of care is essential to the delivery of safe patient care. For a resident to turn over the care of a sick patient to a colleague unfamiliar with the case, at a specified and mandated hour, invites trouble. We are all too familiar with mishaps resulting from faulty transfers of care. Adequate rest for the overworked resident is, of course, important, and restricting hospital duty to every third night is a reasonable step to take, the exceptions being those individuals working in emergency rooms or intensive care units where strict hours are required. But some compromise must be reached regarding the "changing of the guard" in surgical resident scheduling. The mandated time specifications must be relaxed if calamities are to be avoided.

By mandating attending supervision of virtually all resident activities, from decision making at the bedside to participation in operations, the Bell Commission regulations have also compromised the preparation of trainees for future clinical careers and have not improved the quality of patient care. The surgical programs of the past half-century, with which we are all familiar, allowed for progressive resident responsibility for patient care throughout the training period, and correspondingly less attending oversight as the experience of the resident widened. This committed and personalized resident attention not only benefitted the patient; it also promoted good habits for the future both in the care of the patient and in the application of surgical skills. Additionally, the resident learned that asking for help is not a sign of weakness or insecurity, but rather a badge of maturity and responsibility. This vitally important safeguard to patients would then also become a permanent component of the surgeon's armamentarium.

Finally, we take strong exception to Dr. Russell's suggestion that we "shift the emphasis from providing individual care to accentuation on working with teams." Although teamwork is frequently essential to effective care, the sharing of responsibility implied by "working with teams" can diffuse and weaken the relationship between surgeon and patient. It is all too evident that the surgeons of today are rapidly becoming skilled technicians rather than caring doctors. Although skill is desirable, even essential, the depersonalization of the profession is having a major impact on the quality of patient care, on resident recruitment, and on the very nature of our calling. Somehow we must regain what once was termed the "art" of surgery.

In view of the inherent dangers in the recommendations of the Bell Commission regarding surgical training and patient care, we urge the College to reconsider its support for these mandates, and to allow the debate to continue regarding approaches to resident training. The future of surgery deserves no less.

Frederic P. Herter, MD, FACS,
Emeritus Professor of Surgery
Alfred Jaretzki III, MD, FACS,
Associate Professor of
Clinical Surgery,
Department of Surgery,
College of Physicians & Surgeons,
Columbia University

Medicare

I would like to compliment Lawrence A. Danto, MD, FACS, on his excellent and perceptive article regarding Medicare published in the June issue of the *Bulletin* (p. 19). He has it all right.

Under the current Bush Administration, we are in a maelstrom of privatization of what were formerly considered to be government responsibilities. From its inception in 1965, Medicare was never conceived as

being supportable by anyone but the federal government. As a logical extension of the Social Security Act, passed in 1935 under FDR, both programs were considered to be *social contracts* with the sick and elderly. They were not designed to be “profit centers,” nor will they ever be.

Incidentally, Medicare is not a “free” service. With the deductions from Social Security checks, and the necessity for supplemental Medicare insurance, total cost to the individual can exceed \$2,000 per year, and that doesn’t include prescription drugs that can add thousands of dollars to the bottom line.

It is past time for both “organized medicine” and the U.S. government to recognize their responsibility and correct these defects. Bravo and hats off to those individuals like Dr. Danto who have the courage and foresight to speak out.

Jason I. Green, MD, FACS

Rural surgery

The development of a residency track to facilitate placement of general surgeons in rural areas is to be applauded (May *Bulletin*, p.

13). Broadening the scope of training to incorporate skills most general surgeons of previous generations possessed is practical both for rural surgical practitioners and their patients. This is particularly true in the western U.S. where vagaries of distance, weather, and patient status can make interhospital transfers not only costly but also, at times, dangerous.

Reading about this “generalist” general surgery training brings to mind another concept that may be worth exploring. As one who has intermittently traveled overseas to work in hospitals in the developing world, my experiences have paralleled those presented by many individuals in articles in the *Bulletin*. The scope of expectations is typically that as a general surgeon one is capable of managing problems in orthopaedics, urology, head and neck surgery, plastic surgery, and obstetrics and gynecology—as well as what we define as our usual limits of general surgery.

I would propose that consideration be given to formation of “fellowships in international surgery,” whereby formal rotations

in various surgical specialty areas could be undertaken with total training to last anywhere from six to 24 months, depending on individual needs. These fellowships could be used by trainees who are just finishing residency and want to practice overseas, or for established surgeons wishing to take a leave of absence or retire from practice in the U.S.

As in the rural surgery program in Oregon, this training could be based in community hospitals to avoid competition with other residents. An obvious difficulty would be funding. Perhaps the American College of Surgeons could partner with a source like the U.S. Agency for International Development to support salaries and program administration.

In an era when malpractice and managed care are often driving vital practitioners away from their surgical practices, this could be an avenue to facilitate exporting those same individuals to disadvantaged parts of the world where their skills would undoubtedly be greatly appreciated.

John P. Lawrence, MD, FACS

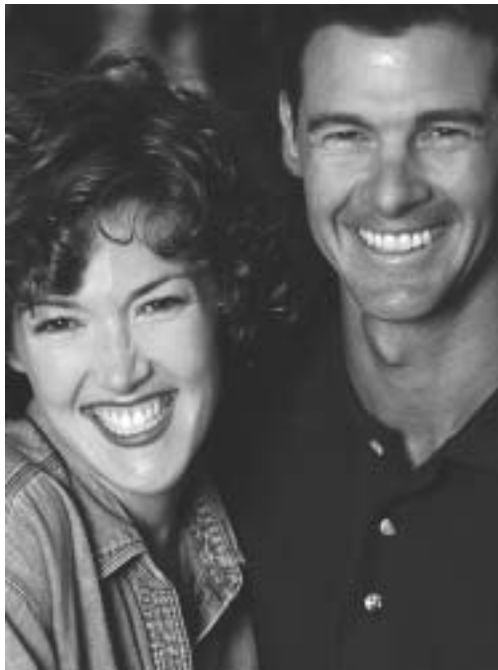


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Chapter news

by Rhonda Peebles, Chapter Services Manager, Division of Member Services

To report your chapter's news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

New award named for chapter executive

An award to recognize excellence in advocacy was presented at the 2003 Chapter Leadership Conference, which took place June 22-24, in Washington, DC. (For details, see the August 2003 issue of the *Bulletin*, p. 28.) The award was named for Arthur (Art) Ellenberger, the long-time Executive Director of the New Jersey Chapter. This new Arthur Ellenberger Award for Excellence in State Advocacy will be presented periodically to recognize a career of leadership and commitment to protecting patients' access to high-quality surgical care. Future recipients' names will be added to the plaque, which will be displayed prominently in the College's Washington Office.

New York Chapter hosts education program for residents

The New York Chapter will host a program for residents titled "Navigating the Passage from Residency to Private Practice," Saturday, October 25, at the New York Athletic Club, 180 Central Park South, New York, NY, 9:00 am-1:00 pm. For more information, call the New York Chapter at 518/433-0797.

Japan Chapter welcomes Traveling Fellow

In early June, the Japan Chapter and the Japan Surgical Society (JSS) welcomed Reid

B. Adams, MD, FACS, as the College's first ACS-JSS Traveling Fellow. Dr. Adams, who hails from Charlottesville, VA, presented a lecture during the JSS's 103rd annual meeting and toured several institutions.

This Traveling Fellowship was initiated in 2002 and is supported financially by the College, the Japan Chapter, and the JSS. In October, the College's International Relations Committee will welcome Masaki Miyamoto, MD, to the Clinical Congress.

Chapter anniversaries

Month	Chapter	Years
October	Alabama	52
	Belgium	4
	San Diego (California)	30
	Manitoba (Canada)	47
	Colombia	38
	Jacksonville (Florida)	46
	France	16
	Delaware	46
	Hong Kong	8
	India	10
	Kansas	52
	Jamaica	11
	Japan	16
	Federal District (Mexico)	43
	North Carolina	47
	Ohio	47
	Panama	6
	Metropolitan Philadelphia	17
	Saudi Arabia	12
	South Carolina	53
	Switzerland	4
	Tennessee	51
North Texas	33	
South Texas	33	
Thailand	6	
Utah	52	
Virginia	38	
Venezuela	37	
Vermont	53	



Officers of the Brooklyn-Long Island Chapter include (left to right): Michael O. Bernstein, MD, FACS; Anthony Tortolani, MD, FACS, Immediate Past-President; Robert F. D. Esposito, MD, FACS, President; Teresa Barzyz, Administrator; and James E. Turner, MD, FACS, Secretary-Treasurer.

Tennessee Chapter honors R. Benton Adkins, Jr., MD, FACS

During their annual meeting, the members of the Tennessee Chapter agreed to honor the late R. Benton Adkins, Jr., MD, FACS, by presenting an annual award in his name to a surgical resident. Dr. Adkins was a long-time supporter and friend of the Tennessee Chapter. In other business, the chapter agreed to examine the logistics for conducting state-house visits in Nashville and made a donation to the Tennessee Medical Foundation, which supports physicians with addiction or behavioral problems. In addition, the following officers were elected: George Eckles, MD, FACS, President; Laura Witherspoon, MD, FACS, President-Elect; and Ray Compton, MD, FACS, Vice-President. Gayle Minard, MD, FACS, will continue to serve as the chapter's Secretary.

Brooklyn-Long Island conducts annual meeting

The Brooklyn-Long Island Chapter conducted its annual meeting on June 5. Among other business, new officers were elected (see photo, left).

Applications sought for research award in academic vascular surgery

The Pacific Vascular Research Foundation (PVRF) is accepting applications for the 2004 Wylie Scholar Award in Academic Vascular Surgery. The award is intended to enhance the career development of academic vascular surgeons with an established research program in vascular disease, and is in the amount of \$50,000 per year for three years. Fund-

ing for the second and third years is subject to review of acceptable progress reports. The candidate must be a vascular surgeon who has completed an accredited residency in general surgery and who holds a full-time appointment at a medical school accredited by the Liaison Committee on Medical Educators in the U.S. or the Committee for the Accredita-

tion of Canadian Medical Schools in Canada.

February 1, 2004, is the deadline for submission of applications for the award, which will be granted July 1, 2004. For further information, contact the PVRF office at tel. 415/771-3451 or e-mail info@pvrf.org for an application.

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sure and the glomerular filtration rate; in more severe hypovolemia, renal blood flow is further reduced and glomerular filtration falls. Subscribers to *ACS Surgery* may view the full text of “Disorders of water and sodium balance” at www.acssurgery.com.

Looking ahead

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


- “Bleeding and transfusion,” by John T.

Owings, MD, FACS, and Robert C. Gosselin, MT.

- “Abdominal mass,” by Romano Delcore, MD, FACS, and Laurence Y. Cheung, MD, FACS.

- “Open repair of hernias of the abdominal wall,” by Robert J. Fitzgibbons, MD, FACS; Alan T. Richards, MD, FACS; and Thomas H. Quinn, PhD.

- “Repair of infrarenal aortic aneurysms,” by Frank R. Arko, MD, and Christopher K. Zarins, MD, FACS.

- “Multiple organ dysfunction syndrome,” by John C. Marshall, MD, FACS. 

Get month in *JACS*

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

Original Scientific Articles

- Radiofrequency Ablation for Hepatocellular Carcinoma
- Ipsilateral Synchronous Breast Cancers
- Access to and Assessment of Trauma Systems

Collective Review

- Genetics and Familial Endocrinopathies

Palliative Care

- Surgical Intensivist and End-of-Life Issues

What's New in Surgery

- General Surgery: Gastrointestinal Conditions
- Ophthalmic Surgery

