2004: the year of the RESIDENT
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The College’s President, Claude H. Organ, Jr., MD, FACS, has declared that he wants his tenure in that post to be remembered as “the year of the resident.” In this month’s cover story (p. 12), Dr. Organ explains what that phrase means to him and discusses why it is so important for the College to be responsive to the changing needs and concerns of an increasingly diverse pool of surgical residents.

Thomas R. Russell, MD, FACS, Executive Director of the College, devotes his column this month (p. 3) to this topic and explains why he thinks Dr. Organ “has an understanding of the issues affecting the future of this profession.” Cover photo © Punchstock.
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From my perspective

The current President of the American College of Surgeons, Claude H. Organ, Jr., MD, FACS, wants his presidency to be remembered as ‘the year of the resident.’

The current President of the American College of Surgeons, Claude H. Organ, Jr., MD, FACS, is deeply concerned about the surgical profession’s ability to continually attract the best and brightest residents. As a result, he wants his presidency to be remembered as “the year of the resident.” In an article on page 12, Dr. Organ shares his views about this topic, and I encourage you to read this piece.

I believe Dr. Organ is being incredibly forward thinking by dedicating his tenure as ACS President to the needs and interests of this critically important group of young men and women. Surgery is undergoing a period of great change, not only with respect to the way we practice surgery, but with regard to the way we train people to become surgeons as well. Hence, all of us who are in surgical practice and who have experienced both its joys and its frustrations must also be thinking about the times to come, rather than looking back and remembering the less complicated days we may cherish but will never see again. Looking in the rearview mirror and reflecting on the past is a futile exercise and does nothing to support those young people who are thinking about their future and evaluating whether they will find surgery to be the fulfilling and honorable profession they want to join.

Encouraging future surgeons

Instead of focusing on what might have been, we need to center our attention on the current realities of medical education, training, and practice. Gaining acceptance to American medical schools remains a significant challenge for many young men and women. A large number of students continue to apply to medical schools, and the competition for these coveted positions remains intense.

Similarly, many young people continue to vie for surgical residencies. Many disgruntled practicing surgeons allege that the caliber and number of residents have fallen precipitously. This portrayal is inaccurate. The fact of the matter is that the match rate for surgical residencies remains fairly high, with 90 percent of the positions being filled, mostly by graduates of U.S. medical schools.

In other words, we have a large pool of young people who consider surgery to be an attractive specialty. No doubt, part of their interest in surgery stems from the realization that surgical procedures will always be performed by trained surgeons. As a result, the members of our profession are less threatened by intrusion from allied health professionals than other physicians are.

Nonetheless, we certainly can do more to sustain and enhance the level of interest in and attractiveness of a surgical career. One of the greatest challenges for practicing surgeons is to act as strong role models for young people who express an interest in surgery. We must stress the positive aspects of our careers and not dwell on the day-to-day difficulties we perhaps have experienced. It helps to remember that our health care system most likely will be very different in the coming years, and that many of the current vicissitudes will disappear with time.

Professional organizations like the College often set an example for the individuals they represent. Hence, the College is working effectively to stand for the issues that this younger generation
has embraced and to encourage their participa-
tion in this organization.

For example, a few years ago, we created the
Candidate and Associate Society of the American
College of Surgeons (CAS-ACS). This group now
has more than 7,000 resident and young surgeon
members. The CAS-ACS has an active Web site
and publishes an electronic newsletter, which ad-
resses issues of specific concern to surgical resi-
dents. It has established a job bank to help resi-
dents find the type of gainful employment they
desire after completing a training program, and
its members develop and sponsor sessions at both
the Spring Meeting and the Clinical Congress.

In addition, opening up the College’s member-
ship to medical students is another tangible ex-
ample of how this organization is building a rela-
tionship with young people.

New expectations

Active dialogue is now occurring with respect to
the training paradigm for surgeons of the future.
By reexamining residents’ work hours, the effi-
ciency of the traditional training process, and the
amount of time residents spend in educational
versus noneducational activities, we have an op-
portunity to create a more inclusive training envi-
rionment. In the past, women and other
underrepresented populations may have been dis-
couraged from pursuing surgery as a career. For
example, restrictions on time away from the hos-
pital didn’t leave much room for starting a family
and, therefore, may have inhibited some women
from choosing a surgical career. I believe that new
approaches will help to make surgical training
more attractive to all young surgeons who want
to achieve a balance between their professional and
personal lives.

Furthermore, a number of challenges will face
young surgeons in the coming years. They will need
to be able to demonstrate competence, adhere to
new standards for maintenance of certification,
and live up to an evolving view of professionalism.
I believe that closer scrutiny of some of these is-
suess and innovative methods of responding to them
will actually help to alleviate some of the concerns
that surgeons have faced in recent years. For in-
stance, battles that many of us fought in the past
with respect to scope of practice and in defense of
our “turf” will be more adequately resolved by ex-
amining a surgeon’s training and competence,
rather than his or her specialty. We must ensure
that they will be appropriately trained, so that they
can meet these new expectations and avoid some
of the quarrels that have led to fragmentation
within the medical community.

Kudos to Dr. Organ

I applaud Dr. Organ for wanting his Presidency
to be remembered as “the year of the resident.”
He has a solid understanding of the issues affect-
ing the future of this profession. I agree with Dr.
Organ that now is the time to embrace the changes
that are taking place with regard to surgical edu-
cation, training, and practice. As we grow to ac-
cept these changes and determine how we can
make them work, we must be ever mindful of the
interests of medical students and residents and
how we can expand their opportunities to lead the
way into the future of surgery.

Disease processes and sick patients will remain
with us for the foreseeable future. We are obligated
to make certain that highly skilled, caring surgeons
will be available to provide the standard of treat-
ment that the American public deserves.

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.
LaSalle D. Leffall, Jr., MD, FACS

Fellow of the American College of Surgeons since 1964. Charles R. Drew Professor of Surgery at Howard University. Dedicated to the study of cancer. Past-President of the College, the American Cancer Society, and the Society of Surgical Oncology.

"Since I attended my first Clinical Congress as a surgical resident in 1955, I have been impressed by the College’s excellent educational programs, which help to ensure high-quality care for our patients. The College has played an integral role in my continuing surgical education.

"I would strongly urge contributions to the College because our profession could have no better advocate for surgeons and their patients. Further, some of the funds go to support scholarships for surgical research.

"The major benefits I have received from the College have been threefold: (1) being informed about the most recent advances and controversies in surgery; (2) having effective representation before Congress regarding major issues confronting surgeons; and (3) deriving special camaraderie and friendship with colleagues around the world."

Dr. Leffall 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.
With a 48-45 vote on February 24, the Senate failed to achieve the 60 votes necessary to allow further debate and passage of legislation that would provide medical liability relief for obstetrical services. Known as S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act provided the first of what is expected to be a series of Senate votes on medical liability reform this year.

Interestingly, the Senate voted 75–22 the following day to move legislation that would have prohibited civil liability actions from being brought or continued against manufacturers, distributors, dealers, or importers of firearms or ammunition for damages resulting from the misuse of their products. That legislation, which was ultimately withdrawn from consideration, gained support from 26 senators who declined to support similar liability protections for physicians and pregnant women.

Further education of these senators about the effect of the liability crisis on surgeons and patients clearly is needed. Surgeons are encouraged to participate in this effort through the College’s Legislative Action Center at http://capwiz.com/facs/mail/oneclick_compose/?alertid=2814386.

On February 23, Hugh Trout III, MD, FACS, testified before the Practicing Physicians’ Advisory Council, an advisory panel to the Centers for Medicare & Medicaid Services (CMS), on changes that should be included in the proposed Medicare fee schedule for 2005. Of particular note, the College proposed making two changes in calculating the sustainable growth rate—an expenditure target that is intended to control the growth in Medicare physician spending. Dr. Trout also spoke about the importance of the five-year review of malpractice relative value units, which will be undertaken this year. The full text of Dr. Trout’s testimony can be viewed at http://www.facs.org/ahp/testimony/ppac.html.

The College, together with Reps. James Greenwood (R-PA) and Sherrod Brown (D-OH), hosted a March 3 briefing on Capitol Hill for members of Congress and their staff titled, “Saving Lives When Minutes Count: Preparing for Terrorism, Natural Disasters and Everyday Injuries.” The briefing was designed to educate legislators about trauma systems and why they are important, what role they can play in terrorism preparedness, and how they are lacking in many areas of the U.S.

Moderated by ACS Committee on Trauma Chair J. Wayne Meredith, MD, FACS, the briefing featured presentations by Kurt Newman, MD, FACS, of Children’s National Medical Center, Washington, DC; David Hoyt, MD, FACS, of the University of California-San Diego and ACS Trauma Medical Director; and N. Clay Mann, PhD, of the University of Utah School of Medicine and the Intermountain Injury Control Research Center.

The Coalition for American Trauma Care, the National Foundation for Trauma Care, the American Trauma Society, and the American Association for the Surgery of Trauma co-sponsored the event.
CMS published an analysis in the January/February issue of Health Affairs that described health care spending in 2002. The report contains the following highlights:

- Health care spending totaled $1.6 trillion. The rate of growth in total health care spending was 9.3 percent, in contrast to an overall economic growth rate of 3.6 percent.
- Per capita health expenditures increased by $419 in 2002, to $5,440.
- Hospital spending was up 9.5 percent to $486.5 billion.
- The spending growth rate for physician services was 7.7 percent, down from 8.6 percent in 2001. Medicare physician spending growth was down from 9.6 percent in 2001 to 5.8 percent in 2002.
- Spending for prescription drugs was down slightly from 15.9 percent of all health care spending in 2001 to 15.3 percent in 2002.

On March 1, the Medicare Payment Advisory Commission (MedPAC) issued its 2004 Annual Report to Congress: Medicare Payment Policy. The report includes the commission’s recommendations on payment updates and policy improvements for physicians, hospitals, and other health care providers and systems. Of particular interest, MedPAC recommended that Congress update physician payments in 2005 by the projected Medicare inflation rate less a productivity factor of 0.9 percent. Under current cost estimates, that would produce a 2005 Medicare fee schedule update of approximately 2.6 percent. The full text of MedPAC’s annual report can be viewed at http://www.medpac.gov/publications/congressional_reports/Mar04_Entire_report.pdf.

Department of Health and Human Services Secretary Tommy Thompson recently announced that the Food and Drug Administration is issuing a final rule requiring bar codes on human drugs and biological products. Each bar code must include the medication’s national drug code number and may include the lot number and product expiration date. The rule also requires each blood product to contain symbols identifying the collecting facility, the lot number relating to the donor, the product code, and the donor’s blood group and type. These labels are already used in most blood establishments.

Identification information from the patient’s bracelet, information from the patient’s drug regimen, and the drug’s bar code are all compared by a computer to ensure the patient gets the right drug, at the right time, in the right dose, and by the correct route of administration. The rule was based on findings from a study of a bar code system installed at a Department of Veterans Affairs medical center, where 5.7 million doses were administered without any errors.

Existing medications and blood products will have to comply within two years. New medications will have to comply within 60 days of their approval. The rule applies to most drug manufacturers, repackers, relabelers, private label distributors, and blood establishments. Hospital adoption of information technology to take advantage of the new labels will be done voluntarily.

For a copy of the regulation, go to http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/04-4249.htm.
Editor’s note: On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act (MPPDIA), resulting in the largest expansion in the Medicare program’s history. Previous articles in the Bulletin have included detailed information on the physician-specific provisions of this legislation, such as its effects on the fee schedule conversion factor and geographic adjustments to physician payments.

This two-part series of articles attempts to answer some of the questions surgeons may have about the new prescription drug benefits, private plan options, and other aspects of this important new law. In Part I, which follows, the authors provide general information about the law’s impact on Medicare beneficiaries. Part II, which will be published in next month’s Bulletin, will focus more specifically on the act’s effects on surgeons and provide a more in-depth overview of certain aspects of the legislation.

What does the MPPDIMA do to help Medicare beneficiaries with the costs of their outpatient prescription drugs?

The MPPDIMA creates a new Medicare Part D outpatient prescription drug benefit beginning in 2006, which is described below. To help beneficiaries in the interim, the MPPDIMA established a discount card and transitional assistance program. Beginning in May 2004, Medicare beneficiaries will be able to sign up for a Medicare-endorsed discount drug card offered by private sector card sponsors. The card will entitle them to discounts on an array of prescriptions filled by participating retail and mail order pharmacies. The federal government will provide $600 per year in payments for drugs purchased using their discount cards in 2004 and 2005 to beneficiaries who have incomes of less than 135 percent of the poverty level and no other prescription drug coverage (except Medicare+Choice or Medigap).

What kind of outpatient prescription drug coverage will Medicare beneficiaries have?

The drug benefits available under the new Medicare Part D are limited and have a structure that is different than generally found in prescription drug coverage available to the non-Medicare population. In general, the benefit package offers some front-end coverage, after a deductible, and then no coverage until the catastrophic benefit level is reached.

Part D plan sponsors will have some latitude to offer different benefit packages that are of equivalent or greater value. The Part D drug benefits will first become available January 1, 2006. Beneficiaries will be given the opportunity to enroll in a Part D plan beginning in November 2005.

Specifically, the standard drug benefit will have a $250 annual deductible, and 25 percent coinsurance on the next $2,000 in drug spending. There will be a coverage gap, known as the “donut hole,” until the annual out-of-pocket limit of $3,600 ($5,100 in total drug spending) is reached. At that point, an enrollee will pay...
only the greater of 5 percent coinsurance or copayments of $2 for generics or $5 for brand-name drugs. All of these benefit thresholds apply in 2006; thereafter, they increase each year by the Part D per capita growth rate. Thus, it is estimated that in 2013 the deductible will be $445, the initial benefit cap will be $4,000, and the out-of-pocket limit will be $6,400 ($9,066 in drug spending).

The MPDIMA provides very generous drug benefits for low-income Part D enrollees, generally those in families with incomes under 135 percent of the poverty level (about $12,000 for an individual; $16,000 for a couple in 2003). Although the law provides for several different categories of eligibility as determined by income and assets, in general, qualified low-income enrollees will be exempt from paying premiums and deductibles, and their copayments will not exceed $2 for generics or $5 for nonpreferred brands. Qualified beneficiaries also will have no coverage gap and no copayments once drug costs reach the annual out-of-pocket threshold. Individuals with slightly higher incomes (up to 150% of poverty) and slightly more in assets may qualify for reduced premiums and reduced coinsurance.

Who will be eligible for Part D coverage?

All Medicare beneficiaries are eligible for the Part D drug benefit. Because the new benefit is voluntary in a manner similar to Part B, beneficiaries must decide whether to enroll. Current beneficiaries will have the opportunity to enroll between November 15, 2005, and May 15, 2006. Individuals who first become eligible for Medicare after November 15, 2005, will have the same seven-month period in which to make their initial enrollment decision as exists for Part B, with that period beginning three months before they first become eligible for Medicare. Special enrollment periods apply in certain circumstances; otherwise, enrollment outside of the allowed enrollment periods will result in the individual paying increased premiums for the drug benefit.

How will the Part D benefits be delivered?

The Part D drug benefits will be made available to beneficiaries through private drug-only insurance policies sold on an individual basis to Medicare beneficiaries—known as prescription drug plans (PDPs). Drug benefits also may be offered through private coordinated health plans (health maintenance organizations, preferred provider organizations, and so on)—so-called Medicare Advantage-Prescription Plans (MA-PDs) if one is offered in the geographic area in which a beneficiary resides. Beneficiaries will be able to choose a PDP or MA-PD plan located in their area each November during an “open enrollment” period. Plan sponsors will need insurance licenses, and although they will bear most of the financial risk, the government will share risk for high-cost enrollees. Beneficiaries who want to continue drug coverage from a former employer will be excluded from enrolling in Part D. However, employers who offer retiree plans that provide equivalent or better drug coverage will be eligible for government subsidies and favorable tax benefits. Finally, in any geographic region having less than two private drug plan options available, the government will contract with a “fallback” plan. Fallback plans (such as a pharmacy benefit management company) will provide drug benefits under arrangements where they are not at financial risk for the costs of covered drugs.

How will Part D beneficiary premiums be set?

The government will pay 74.5 percent of the average benefit costs for those Medicare benefi-
ciaries who are ineligible for the low-income subsi-
dies; the remaining 25.5 percent will be the enrollee’s responsibility. This provision applies
to the standard Part D drug benefit package or its actuarial equivalent. The Congressional Bud-
get Office projects that in 2006, the average Part D plan premium will be $35 per month (or $420 annually); by 2013 the average monthly pre-
mium will grow to $58 (or $696 annually). How-
ever, the actual amount that an enrollee pays will depend on the premium for the plan chosen. As noted above, low-income beneficiaries will qualify for premium subsidies, and genera-
ly those individuals who are fully eligible for both Medicaid and Medicare, or who have in-
comes below 135 percent of the federal poverty standard and limited resources, will be exempt from paying a premium for the standard drug benefit.

What kinds of tools will prescription drug plans be able to use to manage the cost of the new benefits?

Because most of the drug plan sponsors will bear substantial risk for paying claims, they will have a strong financial incentive to seek out dis-
counts from manufacturers and pharmacies and manage the drug use of their enrollees. The MPDIMA allows drug plan sponsors to use the same types of cost management tools and strategies that are used today in the private market by entities that administer prescription drug benefits for insurers and employer-sponsored health plans. These may include enrollee cost-sharing, such as tiered copayments that favor generic or certain branded drugs over other brand drugs, as well as pharmacy networks, prior authorization, generic substitution, and medication management. However, some con-
straints are imposed on a plan’s cost manage-
ment measures. For example, while a plan may require the enrollee to pay a deductible and copayments or coinsurance, it can only do so within certain parameters established within the definition of the standard benefit package or its actuarial equivalent.

The MPDIMA prohibits the government from “interfering” in any drug plan price negotiations or formulary determinations. This provision was controversial during the congressional debate on the legislation and remains so today. Those who advocate allowing the government to negotiate prices believe that in the absence of a govern-
ment role in negotiations, drug prices will sky-
rocket, increasing beneficiary out-of-pocket costs and jeopardizing the long-term sustainability of the Part D program. But permitting such a sig-
nificant expansion of government power in this area seems unlikely at this time. Government price controls applied to pharmaceuticals have consistently failed to muster broad support in Congress.

Can physicians ensure that patients will have access to non-formulary drugs when necessary?

PDPs and MA-PD plans may cover all FDA-
approved drugs and biological products (including insulin and vaccines) covered under the Medicaid program. Drugs also may be covered for any medically accepted indication as reflected in compendia recognized by the Secretary of the Department of Health and Human Services. Hence, items covered would include virtually all prescription medications currently on the mar-
et except certain types of products excluded from Medicaid, including “lifestyle,” fertility, barbiturate, weight-loss, and other drugs. How-
ever, plan formularies are only required to cover two drugs in each class and category of drugs. Thus, not all drugs in a particular class may be included in a plan formulary. Moreover, plans
may also design their cost-sharing policies to favor generic products and specific brand-name drugs, requiring the enrollee to pay more out-of-pocket for nonpreferred brand drugs.

Beneficiaries, not physicians, may appeal either the exclusion of a drug from a formulary (noncovered drugs) or to have a nonpreferred brand drug treated as a preferred drug for purposes of the beneficiary copayment. In the case of noncovered drugs, beneficiaries may appeal only if the prescribing physician determines that all other covered drugs on the formulary would be ineffective or have adverse effects. Similarly, if a beneficiary asks for a nonpreferred drug to be treated as preferred for cost-sharing purposes, the prescribing physician must also determine that the plan’s preferred drug would be less effective or would have adverse effects for the individual. Plans must have procedures for appeals, including reconsideration by the plan and opportunities for independent external review of decisions that adversely affect beneficiaries.

**Will physicians be required to file prescriptions electronically?**

No. Although this option was considered during the debate about the drug benefit, Congress ultimately decided to stop short of mandating electronic prescribing. Instead, the new law requires the establishment of federal standards for electronic prescription programs, and requires anyone who submits prescriptions electronically or who is expected to do so by a hospital or health plan to comply with these standards. The deadline for compliance with these standards is April 1, 2008. The law includes protection under the anti-kickback laws and the Stark physician self-referral law for the provision of non-monetary remuneration (in the form of hardware, software, and information technology and training services related to electronic prescribing) to physicians by hospitals, group practices, and private drug and health plans.

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**Ms. James** is a principal partner at Health Policy Alternatives, Inc.
The year of the RESIDENT

An interview with Claude H. Organ, Jr., MD, FACS
by Diane S. Schneidman, Senior Editor
You have indicated a desire to make your term as President of the College “the year of the resident.” Could you be a little more specific about what you mean?

Only about 4,070 current surgical residents hold appropriate membership in the College’s Candidate Group. Most residents do not know or appreciate the value of College membership and what it has to offer them. We need to make them aware of our interest in them and of these services.

Why do you think it is so important that the College place an emphasis on residents?

There are a number of reasons: (1) to encourage their participation in our multiple activities, both educational and professional; (2) to ensure that residents are seeing a broad view of ACS activities; (3) to bring them into the organization early in their careers and encourage their participation in ACS committees and programs; and (4) to resolve some of our concerns about declining membership in professional organizations.

What are your greatest concerns about surgical residency programs and surgical residents at this time?

My immediate concern is our decline in the national match rates for the last 10 years. Although many of the surgical specialties (even general surgery) have had respectable match rates recently, we are concerned that some excellent programs have had difficulty attracting new residents.

As Thomas R. Russell, MD, FACS, Executive Director of the College, has noted on many occasions, a number of factors prevent medical students from choosing a surgical career or finishing a residency program. Deterrents to the pursuit of surgical training include a lack of exposure to the practice of surgery and the rewards it offers to surgeons and patients, the lengthy hours that residents have had to work, the number of years of training, and the associated costs. Educators must be sensitive to the needs of medical students and residents.

We also must be very sensitive to residents’ concerns about quality of life. As difficult as it is for a minority of our colleagues who trained in other eras to accept, residents today want lives outside the hospital. Many medical graduates now have concerns about whether they will be able to start a family and enter a surgical career at the same time. Many also are reluctant to enter into the profession while deeply in debt only to receive a lower rate of reimbursement than they would have had 10 years ago.

The Accreditation Council on Graduate Medical Education (ACGME) and the College have recognized the need to improve the quality of resident life. On July 1, 2003, the ACGME implemented guidelines for an 80-hour workweek restriction for residents due to the increasing emphasis on lifestyle issues among residents and public concerns about the possible negative effects of resident fatigue on patient care. The College is working to address the new work-hour restrictions by informing program directors about the new mandates and to offer constructive ways to effectively utilize residents’ time in the hospital. Several sessions at the 2003 Clinical Congress focused on this topic. Discussion of these topics will be expanded at the 2004 Clinical Congress.

What can the College do to stimulate more interest in our organization and the profession?

We need to stress the expanding advocacy role of the College. Through our collaborative efforts with the federal government, the ACGME, and other parties to represent residents’ interests while they are in training and when they are in practice, we will increasingly make known our position on those policy issues.

We are making progress and will continue to offer programs at the Clinical Congress that address residents’ concerns. The 2003 Clinical Congress included a panel discussion on changing trends in surgical careers. Additionally, the Congress included two programs on the work-hours issue—one exploring the implications for medical students and one aimed at program directors who are responsible for implementing the new rules. We need to encourage more programming directed at residents and medical students with their active participation.
Residents should be made more aware of the scholarships and awards offered by the College. The Committee on Trauma, for example, sponsors a Residents Trauma Papers Competition. ACS scholarships awarded to young people include: (1) the Resident Research Scholarships, which are presented to residents planning to pursue careers in academic surgery ($30,000 for each of two years); and (2) the two-year Faculty Research Fellowships, which are for surgeons entering academic surgery and provide grants of $40,000. Other scholarships and awards are intended for surgeons already in practice. Residents and medical students must be aware that these programs are available to assist young surgeons in their career development after they enter practice. These awards include the Oweida Scholar, the ACS Japan Traveling Fellow, the Australia New Zealand Travelling Fellow, the International Guest Scholar, and the recently implemented ACS/Society of Thoracic Surgery Health Policy Scholarship.

Additionally, membership in the College has been expanded to include medical students, which allows us to bring physicians in training into the fold of this Fellowship at the earliest possible point in their professional maturation and expose them to the joys of surgery and the relevance of this organization.

The Candidate and Associate Society of the ACS (CAS-ACS) is also actively developing programs for residents. The July issue of the Bulletin will focus on this group, which is an increasingly important part of the College.

Which College committees and staff members are you working with to achieve this mission?

At this point, I am working with Dr. Russell and Paul Collicott, MD, FACS, Director of Member Services, to develop strategies for achieving this vision. Both are enthusiastic supporters. We have not yet formed any ad hoc committees devoted specifically to this subject, largely because existing committees and councils within the College already play significant roles in this area. For example, the Advisory Councils for the various specialties have been examining their match rates and discussing means of encouraging continued interest in attracting the best and the brightest to their respective fields.

The Committee on Education and its various subcommittees also are addressing residents’ needs. In fact, the committee has two subcommittees that focus exclusively on young people—the Subcommittee on Medical Student Education and the Subcommittee on Resident Education. These committees organized the sessions on work hours and trends in surgical careers mentioned previously.

What do you think the surgical residency of the future will look like?

L.D. Britt, MD, FACS, a College Regent, recently gave an excellent grand rounds presentation on this subject at the University of California, San Francisco. He noted that surgical training programs will need to be structured in a way that responds to the general competencies identified by the American Board of Medical Specialties and the ACGME. These organizations have indicated that surgeons must be able to demonstrate competency in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. As a result, surgeons in training will need to acquire more than the basic competencies of having a fund of knowledge, technical finesse, and clinical judgment.

"New" essential components of the "next generation" training program will give residents a grounding in the basic competencies just mentioned, as well as administrative management skills and clinical skills assessment tools. To meet administrative management demands, residents will need to understand practice management, financial accounting, compliance issues, legislative issues and advocacy, and alliance-building strategies. Clinical skills assessment tools will need to be scientifically and clinically valid and reproducible in other settings. Training programs, of course, now face the added challenge of teaching this broader range of skills and knowledge through a curriculum that is adaptable to 80-hour workweek restrictions and possibly even greater constraints in the future.

Factors that surgical educators will need to consider when crafting "the new look" for graduate medical education include work hour reform,
the general competencies, the use of simulators in training and transference of the skills acquired through this approach to the clinical setting, and assessment of technical skills. We also will need to monitor resident fatigue and stress levels, offer more Web-based education, and become more reliant on multiple evaluative tools.

I would add that in crafting the new surgical training models, it will be critically important that we seek and listen to input from the residents. We need to understand what is working for them and what needs improvement.

We also should form collegial alliances with organizations outside of the U.S. to learn from their experiences. For instance, we could stimulate a dialogue with organizations such as the Royal College of Surgeons to learn about the alternative and flexible programs in place in the U.K. to respond to their overlapping concerns, including their 56-hour workweek.

What are some other specific steps you would like the College to take toward achieving the broad goal of making this the year of the resident?

I have a list of about seven specific objectives. They are:

- Develop better data on the number and percentage of residents who are members of the Candidate Group. We need to analyze this information to help set goals and to determine which programs may need help in encouraging young surgeon involvement.
- The College needs to work closely with program directors and their efforts to redesign their training programs to better meet the needs of today’s residents. As part of this effort, Dr. Russell addressed the Association of Program Directors in Surgery at their annual meeting in March.
- We need to develop a letter that outlines what the ACS offers surgical residents and send it to the program directors to discuss these benefits with their trainees.
- The College should set a goal of 100 percent enrollment for residents in each program.
- A regular column in the Bulletin written by residents from different regions of the country and surgical specialties addressing their issues of concern.
- One issue of the Journal of the American College of Surgeons each year devoted to residents.
- Finally, we need to encourage our chapters to make their educational programs appealing to residents and medical students.

I want to thank the Bulletin for providing me with this opportunity to share my thoughts and vision with the College’s membership. I look forward to an exciting remainder of my term as President of this important surgical institution.
Understanding the latest changes in

EMTALA:

Our country’s emergency care safety net

by Thomas R. Russell, MD, FACS,
Chicago, IL
On April 7, 1986, President Ronald Reagan signed into law the Consolidated Omnibus Budget Reconciliation Act of 1985, which incorporated legislation known as the Emergency Medical Treatment and Active Labor Act (EMTALA) to address the problem of “patient dumping” by hospital emergency departments. While EMTALA was originally intended to serve as a safety net for emergency patients, the statute grew in both scope and complexity during the following two decades, leaving physicians and hospital administrators confused about their respective responsibilities under the law.

During the 1990s, this confusion, particularly with respect to physician on-call requirements, grew to such mammoth proportions that the affected parties began petitioning Congress and the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services (CMS), for clear and understandable guidance about EMTALA mandates. As part of this effort, physician and hospital groups also urged Congress and the agency to revise the regulations to better reflect the statute’s original intent.

These efforts paid off when CMS finally issued new EMTALA regulations that went into effect November 10, 2003. The new rules provide guidance that better clarifies physician and Medicare-participating hospital responsibilities under the law.

This article examines the main tenets of the revised EMTALA regulations and their positive impact on the future of surgical practice and emergency surgical care and highlights lingering issues that need to be addressed. Finally, the article considers new trends in the delivery of care that are influencing emergency care.

Obligations for hospitals

In January 1985, San Francisco General Hospital became the final destination for the triage and treatment of Eugene “Red” Barnes, a 32 year-old unemployed mechanic who had been fatally wounded when he was stabbed in an altercation outside an abandoned hotel in Richmond, CA. An investigation into the emergency care that Mr. Barnes received before arriving at San Francisco General revealed a number of weaknesses in our country’s emergency care safety net for the uninsured—primarily the lack of a federally mandated obligation for hospitals to examine, treat, and stabilize all patients with an emergency condition regardless of the patient’s insurance coverage.

Under EMTALA, this mandate is triggered when an individual comes to a hospital’s dedicated emergency department or presents on hospital property and requests an examination or treatment for a medical condition or a request is made on the individuals’ behalf. (The interpretation of what constitutes a “hospital emergency department” has expanded and contracted over the years. The current regulations state that a dedicated emergency department is defined as any department of the hospital, located on or off the main hospital campus, that is licensed by the state as an emergency department, is presented to the public as providing emergency services, or has provided at least one-third of its outpatient visits for treatment on an urgent basis during the previous year.) In the absence of such a patient request, EMTALA would also apply if a prudent layperson would believe that an individual needs examination or treatment for a medical condition. Exceptions to this rule are individuals who come to off-campus outpatient clinics that do not routinely provide emergency services or to those patients who have begun to receive scheduled, nonemergency outpatient services at the main campus of the hospital.

Once the hospital determines that the individual does indeed have an emergency medical condition, that hospital must stabilize the patient or, if it is unable to do so, must transfer the patient to a hospital that is capable of providing such treatment. The latter aspect of this requirement was included to ensure that patients with severe injuries or very complex medical conditions are examined and triaged to the appropriate acute care center as quickly as possible.

Physician obligations

Many surgeons complain about the numerous EMTALA obligations that the federal government has imposed on the physician community. In truth, the statute does not place any direct obligations or liabilities on physicians. EMTALA focuses its mandates on hospitals or “agents of the hospital” (for example, hospital medical staff or on-call physicians). It is when they fall into the latter group
that physicians come under the scrutiny of the law.

Close examination of EMTALA reveals that the statute maintains that the hospital, not its medical staff or individual physicians, is responsible for maintaining an on-call roster for the emergency department. However, when physicians join the medical staff of a hospital or agree to take call, they become a “responsible physician” under EMTALA by virtue of entering into a contract with the hospital to examine, treat, and/or transfer individuals who are covered by the law. In doing so, they become agents of the hospital and therefore share responsibility and liability with the hospital for providing EMTALA-related services, regardless of whether the contract references EMTALA responsibilities.

Because the final responsibility for maintaining on-call coverage falls on the hospitals, the medical staff bylaws for these institutions usually include language that requires physicians to comply with hospital policies and procedures as a condition of maintaining their clinical privileges at the hospital. This language, which is congruent with standards issued in the Joint Commission on Accreditation of Healthcare Organizations’ manual, encompasses the hospital’s policy for on-call coverage.

Although surgeons “voluntarily” accept their role as agents of the hospital when they secure privileges, many of them receive little training regarding the EMTALA guidelines and, thus, are often unsure of their responsibilities under the statute. This fact was illustrated in a past survey of hospital emergency departments conducted by the Department of Health and Human Services (HHS) Office of Inspector General (OIG). In a 2001 report, the OIG found that “training increases EMTALA awareness, and nearly two-thirds of emergency physicians, nurses, and registration staff receive training. However, only one-quarter of on-call specialists are trained in EMTALA guidelines.”

Since the inception of EMTALA, surgeons have found it difficult to distinguish between their responsibilities under the law versus “policy” developed by hospitals to comply with EMTALA. The following sections of this article examine the various issues that surgeons should be aware of when serving as an agent of the hospital, either on its medical staff or on an on-call panel.

Penalties, enforcement, and resolution of EMTALA violations

When CMS receives a report of an alleged EMTALA violation, the agency’s regional office sends state surveyors to conduct an investigation. Generally, in determining EMTALA compliance CMS will consider all relevant factors and look for specific patterns of care that could point to EMTALA infractions.

Hospitals that fail to comply with EMTALA-mandated responsibilities may have their Medicare participation terminated and may be subject to civil penalties of up to $50,000 per violation. If a physician serving as “an agent of the hospital” on its on-call panel is called by the hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable period of time, that physician may be in violation of EMTALA and could also face fines of up to $50,000 per violation. Patients who have suffered physical harm and hospitals that believe they have incurred a financial loss due to an inappropriate transfer also have a private right of action against hospitals that violate EMTALA.

In its January 2001 report, The Emergency Medical Treatment and Labor Act: The Enforcement Process (available at http://oig.hhs.gov/oei/reports/oei-09-98-00221.pdf), the HHS OIG recommended that CMS make certain that providers will not be terminated from the Medicare program for an EMTALA violation without peer review. Congress implemented that recommendation in the Medicare Prescription Drug, Improvement, and Modernization Act by requiring HHS to request a quality improvement organization review before making a compliance determination that would terminate a hospital’s Medicare privileges. An exception to this rule would be in the case when a delay would jeopardize the health and safety of the individual.

Also, in response to complaints from hospitals and physicians that they are kept in the dark as to whether an EMTALA investigation, once opened, is ongoing or has been resolved, the act also requires that a procedure be established to notify hospitals and physicians when an EMTALA investigation is closed.
On-call requirements

EMTALA requires that Medicare-participating hospitals maintain an on-call list of physicians to provide services to patients who seek care in hospital emergency departments. CMS has provided several memoranda and guidance documents since the original EMTALA regulations were released to help clarify various provisions of the act, including the on-call provisions. Despite the agency’s attempts to alleviate the ambiguity, it has remained a challenge for physicians to know what EMTALA mandates, whether hospital bylaws relating to emergency care are actually required by EMTALA, and how the law should be interpreted in specific circumstances.

The most onerous and perhaps most confusing aspect of EMTALA for surgeons and other physicians are the on-call requirements. Hospitals, often for fear of violating EMTALA, impose unrealistic on-call requirements on their physicians. It is not uncommon for a single specialist who covers multiple hospitals to be required, as a condition of joining a hospital’s staff, to be on-call 24 hours a day, seven days a week. In some cases, surgeons have been expected to leave their office practice activities, or even an operation, in order to respond to emergency department calls at the hospitals for which they have privileges. A “24-7” demand for on-call services creates such unrealistic schedules and unreasonable demands for surgeons and other specialists that a number of these physicians have altered their practices, often dropping privileges at a number of hospitals, in an effort to maintain viable practices and some semblance of quality of life.

Many areas of the country have an insufficient population base to support a large number of specialists in certain fields such as neurosurgery, cardiovascular services, pediatric surgery, obstetrics/gynecology, and orthopaedics. This situation is especially true in rural areas and in areas that have small hospitals providing care to populations spread out over a great distance. Being selective about the day or circumstance for providing on-call services in these areas is usually not an option for these high-risk specialties.

Recognizing this burden, CMS revised the on-call language to state that a hospital’s on-call list must be maintained in a manner that best meets the needs of the hospital’s patients who are receiving services required under EMTALA in accordance with the capability of the hospital, including the availability of on-call physicians. CMS intended this modification to provide more flexibility for hospitals and their medical staffs to determine how best to provide emergency medical care and respond to on-call needs. The agency states that these decisions can be made reasonably only at the individual hospital level through coordination between the hospitals and their staffs of physicians.

CMS issued this clarification in the latest regulations because of confusion over one of the most heavily perpetuated myths about EMTALA—the existence of the “rule of three,” which states that if a hospital has more than three physicians within a specialty, it must provide continuous emergency department coverage for that specialty. CMS makes it clear that no such rule exists; however, many hospitals have developed policies based on this principle, and physicians historically have been led to believe that it is mandated by EMTALA.

Some people have argued that EMTALA should require a minimum number of hours for individual physicians to be on call, the times for which physicians should be on call, or the number of physicians needed to fulfill on-call responsibilities at particular hospitals. CMS has rejected these proposals from a practical standpoint. The agency maintains that the wide variations with regard to medical staff size, specialty mix, and general capabilities that exist among institutions that participate in the Medicare program make it infeasible to mandate a particular minimum level of on-call coverage that must be maintained by all hospitals.

The latest changes to EMTALA provide other specific clarifications regarding on-call requirements that are aimed at allowing hospitals and their medical staffs to develop more realistic policies and procedures to achieve the goals of EMTALA and to address critical issues that have long concerned surgeons and other physicians with regard to the regulations.

Of course, many surgeons hold privileges at several hospitals, particularly in areas where shortages of certain specialties exist. CMS has only recently established that it is in the best interests of patients and hospital emergency departments that physicians be permitted to be on-call at more than one hospital simultaneously. In updating its policy,
the agency recommends that hospitals notify each other when a physician is on-call at more than one hospital simultaneously and that each facility be aware of the physician’s on-call schedule. Furthermore, hospitals must have in place written policies and procedures for when a physician is on-call at another hospital and is unable to respond. Such policies and procedures could include arranging for a back-up on-call physician or executing an appropriate transfer.1 Performing elective surgery while on call has become another issue that surgeons struggle with in order to maintain their regular busy practice while fulfilling EMTALA requirements. In the past, CMS has made conflicting statements in guidelines regarding whether physicians who cannot respond to an emergency call because they are performing elective surgery have violated EMTALA. In the current regulations, the agency states that EMTALA does not prohibit surgeons from performing elective surgery while on call. This is welcome news to many surgeons who are on call for days or weeks at a time.

Scope of privilege

“Many physicians limit their scope of practice to well-defined subspecialty areas, even though they are often credentialed by their hospitals to perform all surgery for the broader specialty for which they are board-certified.”1 For example, a neurosurgeon with limited privileges for spine surgery would argue that he or she is not required to take call for head trauma. Surgeons should be aware that CMS addresses this issue in the current regulations, and hospitals may soon begin to move toward defining core privileges for a number of specialties.

CMS states that “a physician who is in a narrow specialty may, in fact, be medically competent in his or her general specialty, and in particular may be able to promptly contribute to the individual’s care by bringing to bear skills and expertise that are not available to the emergency physician or other qualified medical personnel at the hospital.”1 CMS also stresses that while the emergency physician and the on-call specialist may need to discuss the patient’s best treatment options, the agency believes any disagreement between the two regarding the need for the on-call physician to come to the hospital and examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual.1

Although the new EMTALA regulations clarify that on-call coverage determinations are to be made jointly by the hospital and the physicians on its on-call roster, the hospitals are in the position of ensuring that policies and procedures are in place to provide coverage of emergency department services. In turn, physicians practice at hospitals under privileges extended to them by those institutions. If a physician refuses to assume on-call responsibilities or to carry out the responsibilities he or she has assumed, the hospital could suspend, curtail, or even revoke the offending physician’s privileges.

Hence, hospitals retain a tremendous amount of leverage in the development of on-call policies and schedules. Despite this fact, surgeons should take solace in knowing that they now have more concrete knowledge of EMTALA’s requirements—an invaluable asset when negotiating privileges with hospitals, working to maintain a viable practice, and striving to provide comprehensive emergency care in their communities.

Some individuals may argue that CMS’s most recent actions “relax” EMTALA standards and endanger the safety net established by the law. Physicians believe that the EMTALA clarifications promise to have a positive effect on a situation that has been, up to now, increasingly unsustainable.

Managed care reimbursement

Managed care plans often require preauthorization for services delivered in the emergency room. Under EMTALA, though, Medicare-participating hospitals or physicians are barred from seeking preauthorization before providing medical treatment unless such activities do not delay required screening and stabilization services. Thus, hospitals and physicians often wind up in a financial quandary when treating managed care patients in the emergency room—either forgoing payment or risking the imposition of EMTALA fines.

A key provision in the new Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA), which was signed into law December 8, 2003, addresses the issue of managed care plans making retrospective denials for emergency screen-
ing and stabilization services. Under MPDIMA, medical necessity determinations for EMTALA services must be made “on the basis of the information available to the treating physician or practitioner (including the patient’s presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient’s principal diagnosis).”¹

Many experts in the medical community and in Congress have long advocated requiring managed care plans to pay for justifiable screening and treatment services provided under EMTALA. Hopefully, this key reform in the Medicare prescription drug law will resolve many of the disputes that hospitals and physicians often encounter with the managed care community’s approach to reimbursement for emergency care services.

Technical Advisory Group

Another key provision of MPDIMA establishes a new EMTALA Technical Advisory Group “to review issues related to EMTALA and its implementation.” Membership in the advisory group will consist of 19 individuals, including the Administrator of CMS and the OIG. Seven slots on the advisory group are reserved for representatives from the physician community in the areas of emergency medicine, cardiology or cardiothoracic surgery, orthopaedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry.¹ The physician and hospital communities are optimistic that this new group will help CMS in its future deliberations on implementing changes in EMTALA regulations.

Issues remain

While the federal government has come a long way in addressing the concerns of the medical community regarding the scope of EMTALA, a number of issues remain that will continue to affect access to emergency surgical care. These issues include: managed care reimbursement policies and emergency room overcrowding; proliferation of single-specialty hospitals; lack of liability protections for EMTALA-related services; and growing burdens on trauma centers and community hospitals.

General responsibilities of EMTALA Technical Advisory Group

1. Review EMTALA regulations.
2. Provide advice and recommendations to the HHS Secretary with respect to those regulations and their application to hospitals and physicians.
3. Solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations.
4. Disseminate information on the application of such regulations to hospitals, physicians, and the public.

While Congress has now addressed the issue of managed care reimbursement for EMTALA-related services, a number of other practices used by this industry continue to place stress on the emergency care safety net. One such pressure revolves around patients’ inability to receive timely access to specialty care in the nonhospital setting. More often than not, managed care plan enrollees, some of whom are knowledgeable about EMTALA requirements, may use the emergency room when they cannot get an appointment with their regular specialist or primary care physician. Add to this number the more than 40 million uninsured who view the ER as their primary source of health care, and the result is massive overcrowding. This kind of nonemergent saturation of emergency room departments across the country, particularly in urban areas, is resulting in numerous injured patients being unnecessarily diverted—causing critical delays for individuals requiring acute care.

Furthermore, while many physicians are heralding the recent changes in EMTALA’s on-call requirements, others, particularly in the trauma community, are worried that these changes will further exacerbate the financial difficulties facing trauma centers and community hospitals. Under EMTALA, hospitals are now only required to maintain an on-call list “in a manner that best meets the needs of the hospital’s patients in accordance with the capability of the hospital, including the availability of on-call physicians.”¹
Many trauma professionals believe that this change in the regulation will provide hospitals, particularly for-profit entities, with the ability to shield themselves from caring for severely injured patients by limiting on-call schedules. For example, some hospitals may only provide on-call coverage until 9:00 pm every night—leaving the local trauma center as the provider of last resort.

One trend that will likely grow as a result of this change will be the increased demands by specialists for hospitals to provide on-call compensation or stipends for emergency room coverage. The trauma community views this situation as yet another financial burden that trauma centers and community hospitals will have to bear in order to maintain their trauma designation or keep the doors of their emergency room open.

Some other factors that will likely influence the viability of trauma centers in the future include lack of medical liability protections for EMTALA-related services and the exploding growth of specialty hospitals in areas such as cardiac and orthopaedic care. Congress is examining both of these issues. In terms of medical liability protection, some legislators are calling for a narrow approach to medical liability reform that would focus solely on providing caps on noneconomic damages for EMTALA and ob-gyn services. With regard to the growth of specialty hospitals, Congress has imposed an 18-month moratorium on physician investments in specialty hospitals through mid-2005 in order to study the impact of this growing trend in care delivery on patient access to specialty services, particularly in the emergency room environment.

Suggestions from surgeons

In drafting this article, I reached out to a broad array of surgeons from all parts of the country—physicians who are on the frontlines of providing emergency surgical care. Without exception, all of them applauded the recent changes in EMTALA. Some of them also had very good suggestions regarding aspects of the law that should be addressed to better enhance timely patient access to specialized emergency care. These suggestions include better hospital triage and transfer policies, more flexibility regarding on-call response time, and evaluation of hospital staff cutbacks and recent implementation of the 80-hour resident workweek on hospital capacity.

While greatly abbreviated, the preceding comments were all presented to me with one goal in mind—improving care for the emergency patient. Surgical schedules and caseloads are increasing, reimbursement is declining, and liability insurance premiums are skyrocketing. In the twenty-first century, these trends have led many surgeons to alter their practices in ways that would have seemed unimaginable a decade ago—limiting scope of privileges, dropping participation in hospital medical staffs, and requesting stipends for providing on-call coverage.

While many individuals outside the profession mistakenly view these changes in surgical practice as selfish and self-serving, surgeons know that these modifications have often become necessary to maintain a viable practice where they may continue treating patients, albeit for a reduced range of services. Despite this fact, surgeons with whom I have spoken say that they still view the provision of charity care as an integral part of why they became physicians and that they anticipate being able to continue to provide these services to the local community.

It is a shame that the last 20 years of government involvement in strengthening the emergency care safety net may have inadvertently weakened it to the breaking point. Surgeons, in general, say that to mend this safety net our country and government must recognize the public good that emergency medical and trauma systems provide to continued on page 67
Restoring palliative care as a surgical tradition

Geoffrey P. Dunn, MD, FACS, Erie, PA
The term palliative care was first coined in the mid-1970s by Balfour Mount, MD, a Canadian urologic surgeon and pioneer of hospice and palliative care, to describe a comprehensive, patient-centered, symptom-treatment approach to caring for patients with advanced illness. The modern origins of this philosophy stem from the work of Dame Cicely Saunders, OM, OBE, FRCS, of Great Britain and her seminal efforts to develop hospice care during the 1950s and 1960s.

One of Dr. Mount’s many contributions to the field was his introduction of the hospice concept to the milieu of an acute care multispecialty hospital. Dr. Saunders’s hospice model of care not only lent itself to successful application in different settings but also in the management of illnesses other than cancer. Significantly, it was recognized that this approach to care was compatible with ongoing disease-directed therapy. Surgeons were among the earliest and most steady referral sources to Mount’s palliative care unit at Montreal’s (QC) Royal Victoria Hospital.

In 1990, the World Health Organization (WHO) defined palliative care as “the active total care of patients whose disease is not responsive to curative treatment.” By then it was widely appreciated that the palliative model of care could be applied earlier in the course of illness and in conjunction with disease-directed therapy, and the WHO’s definition specified this application. Palliative medicine had already been designated a medical specialty in Great Britain in 1987, and recently in the U.S. a plurality of the medical subspecialties not traditionally active in palliative care practice and research, including surgery, have endorsed the principles of palliative care.

The “total care” referenced in the WHO definition can be understood as the caring response to the four domains of human pain or suffering: the physical, psychological (emotional), social (economic), and spiritual. Dr. Saunders defined distress in all four domains as “total pain.” An enduring iconographic image of total pain is seen in Montegna’s fifteenth century masterpiece St. Sebastian, in which a nearly naked man, lashed to a pillar of stone and with numerous crossbow bolts in his torso and extremities (reminiscent of a laparoscopic procedure gone haywire) averts his eyes heavenward with a look of profound existential suffering (see image on page 23). In the background, completing the picture of isolation and abandonment, are two distant figures (family? consultants? insurers?) walking away from the sufferer.

In palliative care, no specific therapy is discounted. At the heart of palliative care is the agreement between physician and patient that the expected outcome is relief from distressing symptoms, easing of pain, and improvement in quality of life. The decision to intervene is based on the ability of the treatment to meet the agreed upon goals rather than its effect on the underlying disease. The three foundations of palliative care are: (1) pain and non-pain symptom management; (2) communication between patients, families, and care providers; and (3) continuity of care across a range of clinical settings and services.

Other hallmarks of palliative care include team-based care planning that involves the patient and his or her family with attention to their spiritual, psychosocial, and bereavement issues. Team members who provided care for the deceased may also require this type of support. It cannot be emphasized enough that the indications for palliative care are based on need, not prognosis. Terminally ill patients and actively dying patients are only subsets of patients treatable using a palliative approach.

New to surgery?

Is palliative care really new to surgery or has it always been an integral part of the surgical tradition but applied under a different name? Until the twentieth century, when the full impact of Descartes and Newton became visible in clinical medicine and its underpinnings and practice became increasingly the result of scientific methodology, the vast majority of medical and surgical interventions were, in fact, palliative measures. These interventions were noteworthy—or notorious—more for reducing symptom burden than for curing disease. Many of these procedures exchanged an imminent demise for a chronic illness. Theodor Billroth’s first successful gastrectomy for an advanced, ob-
structing cancer of the pylorus exchanged an imminent demise of the patient from dehydration and starvation for a more peaceful death from anorexia and cachexia from liver metastases several months later. More than a century later, his reflections on this case offer us good guidance on the rules of engagement for surgical palliative care: “Our next care...must be to determine the indications, and to develop the technique to suit all kinds of cases. I hope we have taken another good step towards securing unfortunate people hitherto regarded as incurable or, if there should be recurrences of cancer, at least alleviating their suffering for a time.”

W. S. Halsted, MD, FACS, completed the initial series of radical mastectomies not for the mammographically detected lesions of today, but for individuals who were undergoing enough symptom burden to “have nothing to lose” by submitting to what was an enormous surgical undertaking by the standards of his day. More recently, Alan O. Whipple, MD, stated in his 1942 writings about his series of pancreaticoduodenectomies, “the considerable risk (that is, operative mortality) of 30 percent to 35 percent is justified if they (the patients) can be made comfortable for a year or two.” These examples of oncologic treatment proved that prolonged survival and cure ultimately were possible following a pattern seen as well beyond the field of cancer care. There is abundant evidence in the history of surgery to show that the relief of suffering as the first priority of surgical care has never undermined the goals of prolongation of life or cure: on the contrary, it has made them possible. More subtle and lasting variations of this theme are evident today in the surgical management of vascular disease and end-stage organ failure.

Recent voices in surgery remind us that the core principle of palliative care, nonabandonment, is intuitive to us and not an exotic import from the primary care specialties or medical oncology. Nonabandonment should not be interpreted in the strict and literal sense of continuous, scheduled follow-up visits, but as an attitude of willingness to stay engaged in whatever way would be helpful. Examples include facilitating contact or referrals with other health care professionals, paying “social” visits to a patient now hospitalized under another specialist’s care, or making a house call to a bed-bound patient.

**Burn care**

For surgeons, the most riveting and well-developed paradigm for surgical palliative care is found in burn care. It is more than a coincidence that some of the most eloquent speakers on palliative care, hospice care, and medical ethics in general have had experience with burns, possibly because these individuals have witnessed the intensity of the suffering (or the totality of the threat to a person’s wholeness) associated with burns. Burn patients suffer pain at the highest degree, no matter which parameter is used to measure it—physical injury to the body, neuronal injury and the complications thereof, or transformation of an individual’s lifestyle, social status, psyche, and spirituality. Burn care has taught us that the first step toward salvaging a patient involves attending to pain control. Burn experience has taught us to respect, not fear, morphine in a way that has ultimately benefited countless individuals suffering from other painful conditions, such as cancer. The threat of physical mortality is only a part of the existential threat resulting from devastating injury because we also exist in social and spiritual contexts. Nowhere else in the practice of surgery is it so obvious as in burn care that existential salvation for patient and caregivers alike begins with the response to suffering.

**Barriers**

If we all agree that the concept of palliation is deeply rooted in the surgical tradition, that the need for the palliation of illness is widespread, and that fertile areas for growth and application of this idea await, then what are the barriers to implementing a comprehensive approach to palliation in surgical care? As it turns out, there are quite a few. The impediments work at the cognitive, psychological, social, and spiritual levels, making them reflective of the four dimensions of pain identified with suffering.

As surgeons trained extensively in the natural sciences, we highly value information and rea-
soning. The philosophical background of our current cognitive framework is revealing when searching for the reasons for the visceral sense of awkwardness we feel when the boundaries of life and death are obscured, and we are haunted by questions of meaning. The separation of mind and body at the heart of Descartes’ philosophy, so influential in modern scientific thinking with its implicit emphasis on the physical, has often blinded us to nonphysical suffering. Intriguing discoveries in physics and the neurosciences increasingly tell us that the Cartesian separation of mind and body was an arbitrary and ultimately doomed conceptualization. The irony here is that Descartes’ philosophy evolved as an attempt to accommodate the study of anatomy within the existing doctrine of the Roman Church, and it is the current study of anatomy that is contradicting his philosophy.

In the largely agrarian society that existed before the twentieth century, even lifesaving measures such as amputation were more morbid from a socioeconomic and psychological point of view than from a physical perspective. Yet success in therapy since then has increasingly become a measure of its impact on the individual’s physical domain to the exclusion of all other domains. As our understanding of the natural sciences deepened, we were increasingly ready to harness this knowledge to solve physical problems encountered at the bedside, while the other domains were assigned a subordinate status because they were somehow “less real.”

Our current deficiencies of language and knowledge to discuss and provide palliative care in the context of surgery is one of the results of scientific materialism, despite the bounty of useful physical interventions we have received as a result of this world view. McCahill and others have shown that formal education or training in palliative care for surgeons is limited, even within a population of medical professionals who have frequently encountered these problems. Several reviews of surgical textbooks and articles show little attention, if any, is paid to death and dying or palliative techniques or approaches, using a systematic and interdisciplinary approach.

Language problems pose another cognitive barrier to full integration of a palliative philosophy. We lack the words and phrases to adequately account for the newer thinking and insights that are rapidly accruing. “Surgical palliative care” is not “palliative surgery,” although “palliative surgery” certainly is a subset of “surgical palliative care.” Widespread inconsistencies in the use of the words “palliative” and “palliation” exist in the surgical literature. In some cases the word is used to describe tumor positive histologic margins, in other words, a “failed” curative operation; in other instances these terms are appropriately used to describe symptom control, through the eyes of the beholder (the surgeon) but not through those of patient. McCahill’s survey demonstrated the extent to which palliation is examined from the surgeon’s perspective: 43 percent of surgeons surveyed defined palliative surgery on the basis of the surgeon’s preoperative intent, 27 percent defined it on the basis of postoperative findings, and 30 percent defined it based on individual prognosis.

Even with the best intentions, the current inconsistencies of language defining palliation allow a dangerous gap between the surgeon’s and the patient’s perception of a given experience. It is genuinely tragic whenever a surgeon, justifiably proud of his or her skill and commitment, discovers a procedure has completely missed the mark of the patient’s personal goals.

Other cognitive barriers consist of scarcities and deficiencies in the quality-of-life data in the literature of surgery and surgical oncology. Much work needs to be done, although the field is already in a robust phase of development, leading to the design of better instruments and interpretation of quality-of-life outcomes.

The psychological barriers to palliative care may be more formidable than the cognitive obstructions. Many surgeons, including those who have performed brilliantly and successfully in terms of relieving suffering, still express a fear of “taking away hope” when discussing palliative treatments, especially during direct disclosure of a terminal disease to a patient. These fears often have more to do with the surgeon’s own psyche than with the possibility that the patient might actually lose hope when told a truth they have consented to hear. It may seem counterintuitive to some surgeons that disclosure of bad news, if given gently, honestly, and empathetically, can actually engender the renewed trust necessary for rekindling and redirecting hope.

Another potential psychological barrier for sur-
geons is the fear that lack of disease control is lack of all control, or, that they are “losing” or, worse, “giving up.” The inevitable reactions (denial, anger, resistance, despair, stoic acceptance, humor, and so on) that accompany any loss of control can profoundly color the outcome for surgeon and patient. As part of examining psychological barriers to palliative caring, the long-held doctrine that the surgeon is the “captain of the ship” in the course of care of the patient will invite ongoing scrutiny. Does being the captain of the ship mean the surgeon is the ultimate undisputed authority on all matters, or, will it come to mean guiding the patient with a lighter hand on the tiller, capable of quickly adjusting to the needs of any particular moment?

One critical prerequisite for skilled palliative care is the capacity for self-reflection or introspection, so that one can differentiate one’s own thoughts and emotions from those observed in patients. This may be more difficult for surgeons than for other physicians because of the nature of surgical disease and the settings (trauma centers, operating rooms) in which it is provided. The acuity and intensity of crisis often do not allow for much reflection, and may provoke a more drastic psychic defense mechanism. Krizek wrote of the phenomenon of “doubling” by surgeons. This process involves a behavioral description first described by Robert Jay Lifton, who wrote about Nazi concentration camp guards who could do murderous things by day and then go home and be kind and loving husbands and fathers. Although the comparison is not a flattering one, it does demonstrate that people have a basic ability to split emotion from behavior when dealing with extreme circumstances such as murder or saving lives. (In the case of the camp guards and others engaged in activity that would provoke an extreme visceral reaction, this behavior was only one of a series of psychological adjustments that ultimately led to profound mental illness and distress later in life.)

Krizek warned of the psychological morbidity to surgeons maturing in a culture that does not offer the necessary support for emotional self-awareness. More mundane counsel related to psychological preparedness for the frequently arduous work of palliative care can be found in many commercial in-flight information cards describing the use of oxygen masks: “Take care of your own needs.
before attending to your child.” Surgeons comprise a culture; that is to say, “an institution in which attitudes, beliefs, customs, traditions, art, and achievements of a society...are passed on from generation to generation.” Any reorientation of perspective, especially if related to basic concerns such as quality of life, will inevitably encounter social or cultural barriers.

The surgical culture in the U.S. and Canada is predominately hierarchical, male, and caucasian. To fulfill its basic mandate of addressing the four dimensions of pain and suffering, palliative care requires a consensual, interdisciplinary, and patient-centered process that is gender and culturally sensitive. Fortunately, the innate response to suffering shared by all surgeons can do much to overcome these differences when they present barriers to effective palliative care.

Other potential social barriers to palliative care include the perception held by many of our nonsurgical colleagues that surgeons are aloof or inaccessible. One of our other cultural institutions, mortality and morbidity (M&M) rounds, will need redirection toward enhancing palliative care. A disincentive remains to operate on patients near death even if another procedure would greatly enhance comfort and function when that patient, due to the stage of illness, is predestined to appear on the M&M list.

Financial and referral considerations also may prevent worthwhile interventions and encourage futile ones. An internist who is unaware of the danger and futility of placing a feeding gastrostomy in a patient with end-stage cancer cachexia syndrome will press the surgeon to perform this procedure, invoking the distress of the individual’s family. It will require more than the surgeon’s principles to exit this type of no-win situation. He or she will need prospective data, support from peers, and, most importantly, the patient’s understanding. The surgeon will need to show that he is protecting the patient’s realistic wishes and not the desires of the referring physician.

The spiritual barriers to palliative care in surgical practice stem from the tension between the most physical and mechanistic of the medical arts and the nature of spirituality, the capacity for transcendent yearning and connection. Evidence shows that patients welcome our interest in this aspect of their lives, though there is a potential barrier in recognizing these needs if the surgeon cannot distinguish religion from spirituality and his own beliefs from the patient’s.

The College’s role

Although palliative care always has been part of surgery, it was not until the late 1990s that it was recognized as a specific philosophy of care with principles in consensus with other medical specialties in the U.S. and abroad. In 1998, the College endorsed the “Statement on Principles Guiding Care at the End of Life,” marking the first specific institutional step in the direction of promoting better understanding of palliative care.

In October 2002, the Task Force on Surgical Palliative Care was organized in the Division of Education of the College. The purpose of the task force is to facilitate introduction of the precepts and techniques of palliative care to surgical practice and education in the U.S. and Canada by bringing together surgeons with demonstrated interest in palliative care to share resources, strategies, and expertise, and in so doing, to act as a catalyst for change.

In October 2003, the task force published its Recommendations to the Field Summary with funding from the Robert Wood Johnson Foundation. Members of the task force have been contributing to an ongoing series of articles, “The Surgeon and Palliative Care,” in the Journal of the American College of Surgeons. In addition, the panel has presented symposia on palliative care issues at College meetings. The task force has proposed a revision of the College’s 1998 “Statement on Principles Guiding Care at the End of Life” that would adapt them to the broader spectrum of chronic illness as an effort to break down the current dichotomy that exists between care for patients at the end of life and all other patients. Future projects of the task force include surveying surgeons about their beliefs and concerns about palliative care, creation of teaching materials, ongoing conference presentations, and participation in other activities of the College. The task force hopes to inspire and assist the College to use its credibility and influence to provide re-
search opportunities and public education in this rapidly expanding and deeply rewarding field, in which the very best of our past becomes a light in our future.

Dr. Dunn is a general surgeon in private practice in Erie, PA, and is a member of the College’s Board of Governors.

References


Dr. Dunn is a general surgeon in private practice in Erie, PA, and is a member of the College’s Board of Governors.
A “PRINCIPLED” APPROACH TO SURGICAL PATIENT SAFETY IN THE OFFICE SETTING

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

On October 19, 2003, the American College of Surgeons’ (ACS) Board of Regents approved a set of 10 fundamental patient safety principles that physicians should adhere to when performing office-based surgery (OBS) that uses moderate or deep sedation or general anesthesia (see statement on page 32). The board’s action last fall was the culmination of a year-long consensus-building process that was led by the College.

The following article summarizes the efforts of many individuals in the specialty society community who joined forces with the College to develop and shape a comprehensive package of patient safety. The standards address proper patient selection and informed consent criteria, facility accreditation, emergency transfer protocols, physician training and competency, and guidelines for both physician and medical personnel regarding training in emergency resuscitative techniques.

Call for action
Over the past few years, the number of invasive procedures performed in the office setting has increased noticeably. Recognizing that many states still hadn’t issued patient safety guidelines in this area, and understanding that a collaborative effort on the part of medicine was needed, the College took the lead role in advancing a solution to this issue by sponsoring a resolution passed at the American Medical Association’s (AMA’s) December 2002 Interim Meeting of its House of Delegates (HOD). In brief, the resolution called on the AMA to work with the College in “convening a work group of interested specialty societies and state medical associations to identify specific requirements for optimal office-based procedures and utilize those requirements to develop guidelines and model state legislation for use by state regulatory authorities to assure quality of office-based procedures.”

On February 5, 2003, the ACS convened at its headquarters in Chicago, IL, a meeting of interested surgical specialty societies to discuss the surgical community’s perspective on this issue. In addition, the College invited representatives from the American Society of Anesthesiologists (ASA) to provide information and guidance regarding
ASA’s anesthesia guidelines. As a result of this meeting, most of the surgical community reached consensus on a set of 10 core principles that states should examine when moving to regulate office-based procedures.

**Office-based surgery summit**

Having observed the College’s catalytic efforts in this area, the AMA quickly followed suit with a March 17, 2003, meeting of interested parties including: surgical and medical specialty societies; state medical associations; the National Committee on Quality Assurance; and the major accrediting organizations for ambulatory and office-based surgery—the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities, Inc. (AAAASF), and American Osteopathic Association (AOA). The AMA meeting, held in consultation with the ACS, used the 10 principles from the College’s meeting as the foundation for discussion and debate.

The AMA meeting was co-chaired by LaMar S. McGinnis, Jr., MD, FACS, and Clair Callan, MD, of the AMA. The discussion focused on a walk-through of the principles document that the College and the specialty societies developed, with the work group debating the merits of each principle. After a few minor changes, the members of the panel unanimously approved the revised set of 10 principles.

**Bump in the road**

With the success of this collaborative process under its belt, the AMA Board of Trustees presented a report to the organization’s HOD at the June 2003 annual meeting asking for adoption of the principles. When a few organizations raised some concerns about some of the principles, two negotiating sessions were convened to iron out differences of opinion. Due to the sheer importance of patient safety, the desire by the College and others to set the highest possible standards, and the complexity of the issue, the delegates agreed that the principles needed to be referred back to the trustees for further discussion and definitive action.

Following the HOD meeting, the surgical community remained united in its view that the AMA trustees should maintain the basic integrity of the principles in the March 17 document. After the College engaged in considerable dialogue and advocacy with the AMA Board of Trustees, including a special appearance by Thomas R. Russell, MD, FACS, Executive Director of the College, during a meeting of the Board of Trustees, the AMA decided to adopt the principles with only a few clarifying changes. These principles were then distributed for information to the December 2003 interim meeting of the HOD.

**Unified front**

Dr. Russell applauded the AMA for joining the College in adopting a unified message on patient safety for surgical care in the office setting. The principles exist because of the widespread cooperation and support from many members of the surgical and medical communities, particularly the American Society of Plastic Surgeons, American Society of Anesthesiologists, and major accrediting organizations.

Chapters are encouraged to use these patient safety principles in their respective states to educate policymakers on the issue and to advocate for legislation or regulations that reflect the intent of the principles. Chapters seeking assistance in these activities are encouraged to contact the College’s State Affairs staff. 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.
The following statement was approved by the ACS Board of Regents at its October 2003 meeting.

Over the past few years, there has been a noticeable increase in the number of invasive procedures being performed in the office setting. Recognizing that many states still haven’t issued patient safety guidelines in this area, the American College of Surgeons (ACS) sponsored a resolution, which was passed at the American Medical Association’s (AMA’s) December 2002 Interim Meeting of its House of Delegates. In brief, the resolution called on the AMA to work with the ACS in “convening a work group of interested specialty societies and state medical associations to identify specific requirements for optimal office-based procedures and utilize those requirements to develop guidelines and model state legislation for use by state regulatory authorities to assure quality of office-based procedures.”

On February 5, 2003, the ACS convened a meeting of interested surgical specialty societies to discuss the surgical community’s perspective on this issue. In addition, the College invited representatives from the American Society of Anesthesiologists (ASA) to provide information and guidance regarding ASA’s anesthesia guidelines. As a result of this meeting, a majority of the surgical community reached consensus on a set of 10 core principles that states should examine when moving to regulate office-based procedures.

Having observed the College’s catalytic efforts in this area, the AMA quickly followed suit with a March 17, 2003, meeting of interested parties including: surgical and medical specialty societies; state medical associations; the National Committee on Quality Assurance; and the major accrediting organizations for ambulatory and office-based surgery (Joint Commission on Accreditation of Healthcare Organizations [JCAHO], Accreditation Association for Ambulatory Health Care, Inc. [AAAHC], American Association for Accreditation of Ambulatory Surgical Facilities, Inc. [AAAASF], and the American Osteopathic Association [AOA]). The March meeting, which was held in consultation with the ACS,
used the 10 principles from the College’s meeting as the foundation for discussion and debate.

The AMA meeting was co-chaired by LaMar S. McGinnis, Jr., MD, FACS, of the ACS and Clair Callan, MD, of the AMA. The discussion focused on a walk-through of the College’s principle document with the work group debating the merits of each principle. After a few minor changes, the members of the work group unanimously approved the revised set of 10 principles.

The following principles were based on a document that was unanimously agreed to by the following groups during a March 17, 2003, ACS/AMA coordinated consensus meeting on office-based surgery:


- **Core Principle #1** – Guidelines or regulations should be developed by states for office-based surgery according to levels of anesthesia defined by the American Society of Anesthesiologists’ (ASA’s) “Continuum of Depth of Sedation” statement dated October 13, 1999, excluding local anesthesia or minimal sedation.¹

- **Core Principle #2** – Physicians should select patients by criteria including the ASA patient selection Physical Status Classification System² and so document.

- **Core Principle #3** – Physicians who perform office-based surgery should have their facilities accredited by the JCAHO, AAAHC, AAAASF, AOA, or by a state-recognized entity such as the Institute for Medical Quality, or be state licensed and/or Medicare-certified.

- **Core Principle #4** – Physicians performing office-based surgery must have admitting privileges at a nearby hospital, a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

- **Core Principle #5** – States should follow the guidelines outlined by the Federation
of State Medical Boards (FSMB) regarding informed consent.\(^3\)

- **Core Principle #6** – States should consider legally privileged adverse incident reporting requirements as recommended by the FSMB\(^3\) and accompanied by periodic peer review and a program of Continuous Quality Improvement.

- **Core Principle #7** – Physicians performing office-based surgery must obtain and maintain board certification from one of the boards recognized by the American Board of Medical Specialties, AOA, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

- **Core Principle #8** – Physicians performing office-based surgery may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

- **Core Principle #9** – At least one physician, who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (Advanced Trauma Life Support\(^\circ\), Advanced Cardiac Life Support, or Pediatric Advanced Life Support), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in basic life support.

- **Core Principle #10** – Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.

**References**

Patients and health care workers (HCWs) have great concerns about potential transmission of blood-borne pathogens, either from health care worker to patient, or from patient to health care worker. Much of this concern has been prompted by the epidemic of human immunodeficiency virus (HIV). Experience indicates that the actual risk of HIV transmission in health care settings is extremely small. The concern over HIV also focused attention on transmission of other blood-borne pathogens. As a result, there is increased awareness of the consequences to surgeons, other health care workers, and patients from the hepatitis viruses (B and C), which are transmitted by blood contact.

Hepatitis B virus (HBV) and hepatitis C virus (HCV) are more efficiently transmitted blood-borne pathogens than HIV in the health care setting. An estimated 1.25 million people in the U.S. have chronic HBV infection, and more than 4 million have chronic HCV infection. Transmission of these infections to health care workers continues to occur, and approximately 250 health care workers die annually from chronic HBV infection alone.

**Hepatitis B**

HBV infection is detected by serologic testing for HBV antibodies. Chronic, or persistent, infection is documented by the continued presence in serum of the HBV surface antigen. In some cases of persistent infection, the hepatitis “e”-antigen, which indicates the presence of very high viral concentrations in the patient’s blood, is present and is indicative of high risk of disease transmission through blood exposure. In many centers, detection of the e-antigen has been replaced by actual counts of the number of viral units in the infected patient’s blood. High viral concentrations indicate increased risks for transmission.

Prevention of HBV infection is possible through immunization. The introduction of safe and effective vaccines for immunization against HBV, and the general
acceptance by the professional community of the wisdom of immunization, has reduced the incidence of new cases. Immunization against HBV is effective, with more than 90 percent of vaccine recipients becoming immune after the initial inoculation series. However, many surgeons in practice remain without immunization and at risk for HBV infection. While younger surgeons have been routinely immunized, an estimated 25 to 30 percent of surgeons in practice for greater than 10 to 15 years remain at risk for infection.

The risk of exposure to HBV (and all blood-borne pathogens, including HCV) begins early in a surgeon’s career and is greater than the risk to most HCWs during the entire professional life of a surgeon. The risk of transmission of HBV from a patient to a surgeon is much greater than the risk of transmission from an infected surgeon to a patient. It is worth emphasizing that an immune surgeon cannot contract or transmit HBV infection. All but one of the reported series of HBV transmissions involved surgeons who were e-antigen positive. It is known that disease transmission and infection occur in 30 percent of hollow needlestick exposures to hepatitis e-antigen-positive blood.

Because HBV acute infection is often asymptomatic (70% of cases), there may be some surgeons who are unknowingly positive for hepatitis e-antigen and some patients doubtlessly exist whose HBV infection from exposure in the clinical setting was not detected or reported. Thus, the actual number of clusters of surgeon-to-patient transmissions is greater than the number reported in the literature. The risk of transmitting HBV from an e-antigen-positive surgeon to a patient during an invasive procedure varies with the particular procedure, the particular surgeon, and the character of the exposure event (such as puncture or cut). The actual number of surgeons who have tested positive for the e-antigen is unknown. The risk of transmission to patients is estimated from theoretical models that cover only sporadic transmission. Thus, the estimated risks are much smaller than the attack rates noted in the clusters of HBV infections that have been completely investigated. Nonetheless, these estimated risks appear to be significantly greater than the individual risks of anesthesia-associated mortality, HIV infection after transfusion of screened blood, or mortality from penicillin anaphylaxis. Because most individuals infected with HBV do not develop chronic or persistent infection, the risk of death from HBV is likely to be less than that from anesthesia, transfusion, or penicillin anaphylaxis. It stands to reason that surgeons should know their HBV immune status and be vaccinated if not already immune. Surgeons who have contracted HBV infection and are at risk for being e-antigen positive should obtain expert medical advice for their own care and take appropriate measures to prevent disease transmission to patients.

The exact mechanism of transmission from surgeon to patient is unknown, but has been thought to be from contact with the surgeon’s blood. Blood exposure from the surgeon to the patient could occur when the surgeon sustains an intraoperative injury (such as needlestick or cut), which allows the surgeon’s blood to directly touch the patient’s open tissues. Existing evidence demonstrates that prolonged knot tying or other shear injury may allow the surgeon’s virus to be transmitted to the patient.
Thus, surgeon-to-patient transmission of HBV might occur even without gross blood contact. Current information about mechanisms of transmission is insufficient to know whether modifying surgical technique might prevent surgeon-to-patient transmission.

**Hepatitis C**

HCV is responsible for 80 percent of infections that were formerly known as non-A, non-B hepatitis. It is mainly transmitted through exposure to the blood of an infected individual. Intravenous drug abusers, patients receiving blood transfusions before 1991, hemophiliacs, and patients on hemodialysis are at increased risk for harboring HCV infection. Prevalence of HCV infection varies according to individual risk factors of patient populations, but is now greater than 1.5 percent of the U.S. population. HCV infection is a significant blood-borne pathogen that poses an occupational risk to surgeons.

Acute HCV infection is commonly asymptomatic (70%). Infection with HCV is detected by the identification of specific antibodies to the virus in serum. About 60 to 70 percent of acute HCV infections result in chronic, persistent infection. Patients fortunate enough to recover from an acute infection remain at risk for subsequent reinfection. Prevention of HCV infection is possible through the rigorous practice of infection control, the use of universal precautions, the use of personal protective barriers to prevent contact with potentially infected blood, and the consistent practice of behaviors to prevent needlestick and sharp instrument injury both within and outside the operating room. There is currently no immunization to prevent infection with HCV.

Only two reported instances of transmission of HCV virus from surgeon to patient are known. Currently, there is no indication for surgeons to take special measures to protect their patients except during acute, symptomatic HCV infection. It is prudent for surgeons known to be infected with chronic HCV infection to obtain ongoing expert medical advice so that treatment can be undertaken. Currently, treatment with interferon-alfa and Ribavirin has effectively treated the infection in 50 percent of chronically infected patients. Ongoing expert medical advice will also keep the infected surgeon abreast of developments in this area of new treatment research.

**Recommendations**

Based upon current data and recommendations issued by the Centers for Disease Control and Prevention, the College makes the following recommendations regarding hepatitis infection:

1. **Relevant to all blood-borne pathogens:** Surgeons should continue to use the highest standards of infection control, involving the most effective known sterile barriers, universal precautions, and scientifically accepted measures to prevent blood exposure. This practice should extend to all sites where surgical care is rendered and should include safe handling practices for needles and sharp instruments. During every operation, maximum effort should be exerted to prevent patients’ exposure to the blood of members of the surgical team and to protect the surgical team from exposure to the blood of patients.

2. **Relevant to all potentially infected patients:** Surgeons have the same ethical ob-
ligation to render care to hepatitis-infected patients as they have to care for other patients.

3. Relevant to hepatitis B (HBV): Surgeons should know their HBV immunization and antibody status. Surgeons with acquired antibody from successful immunization are protected from future infection and are not infectious to their patients. Surgeons with natural antibodies to HBV have had previous infection and should know whether they are positive for the antigen of HBV. If they are negative for the HBV-surface antigen, then they do not have chronic infection and they cannot transmit the infection to patients. If they are positive for the HBV-surface antigen but are negative for the e-antigen, then they can continue medical practice but should consult expert medical advice for their own personal health. If the chronically infected HBV surgeon is positive for e-antigen or has high viral counts in his or her blood, then an expert panel should be convened to make recommendations about the continuation of clinical practice. Such a panel should consist of infectious disease specialists and surgeons who are knowledgeable in blood-borne transmission of viruses. The e-antigen-positive surgeon and the panel should discuss and agree on a strategy for protecting patients who are at risk for disease transmission. Current clinical investigation into possible antiviral therapies for chronic HBV infection may result in effective treatments in the immediate future. Chronic HBV-infected surgeons should have expert medical advice on evolving treatments for purposes of their own health.

4. Relevant to hepatitis B (HBV): Surgeons who have not been immunized and have not had previous infection with HBV (that is, no antibodies to HBV), should be immunized for HBV. Documentation of seroconversion to a positive antibody test for the surface antibody for HBV should be obtained one month after completion of the immunization process. Failure to seroconvert should result in a second attempt at immunization. Failure to respond should be known to surgeons so that full use of strategies to prevent blood exposure may be employed to avoid future blood contact.

5. Relevant to hepatitis C (HCV): Surgeons should know their antibody status for HCV infection. Surgeons who are negative for HCV antibodies are at risk for HCV infection and should employ all strategies to prevent blood exposure for the future. Surgeons who have chronic HCV infection have no reason to alter their practice based upon current information. They should seek expert medical advice because current medical therapy with interferon-alfa and ribavirin can successfully treat this infection in some patients.

6. Relevant to postexposure responses and questions: Call the National Clinicians’ Postexposure Prophylaxis Hotline at 1-888/448-4911, or e-mail http://www@ucsf.edu/hivcntr.

Summary

Immunization against HBV infection appears to be the most effective method of preventing transmission of HBV from patients to members of the surgical team, and surgeons, therefore, should be immunized against HBV. Such immunization is also the most effective way to reduce the risk of transmission of HBV from surgeons to patients. New therapies may result
in treatment for the HBV-infected surgeon. Prevention of HCV infection is currently only possible through prevention of blood exposure. Surgeons should know their infection status for HCV infection so that effective therapy may be undertaken. The HBV and HCV infection status of the surgeon is personal health information and is confidential. The American College of Surgeons and its appropriate committees will continue to monitor the data and update these recommendations in the interests of protecting public safety and of protecting surgeons.

Bibliography

Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the Bulletin to keep Fellows and other interested readers abreast of any changes in the procedures of the various boards.

The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the Bulletin will feature the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Orthopaedic Surgery, the American Board of Surgery, and the American Board of Thoracic Surgery.

The March issue of the Bulletin contained reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Plastic Surgery, and the American Board of Urology.
The American Board of Colon and Rectal Surgery

The American Board of Colon and Rectal Surgery (ABCRS) held its most recent annual meeting September 21, 2003, and its most recent interim meeting March 23, 2003, in Chicago, IL. Future meetings will be held at the Omni Hotel in Chicago through 2006. The schedule is as follows:


Officers/members of the board

The board is composed of 14 members. Nominations to fill vacancies are from the board and five other sponsoring organizations. The American Board of Colon and Rectal Surgery (ABCRS) nominates four members; the American Society of Colon & Rectal Surgeons (ASCRS) nominates four; the American College of Surgeons (ACS) nominates two; the American Medical Association (AMA) nominates one; the Association of Program Directors for Colon and Rectal Surgery (APDCRS) nominates two; and the American Board of Surgery (ABS) nominates one. Board members normally serve two four-year terms—a total of eight years.

The board’s current officers are: James W. Fleshman, MD, FACS, president; Alan G. Thorson, MD, FACS, vice-president; and Herand Abcarian, MD, FACS, executive director (at pleasure of the board). Current members of the board are: Richard P. Billingham, MD, FACS; Terry C. Hicks, MD, FACS; Vendie H. Hooks, MD, FACS; Ian C. Lavery, MD, FACS; Martin A. Luchtefeld, MD, FACS; Robert D. Madoff, MD, FACS; Patricia L. Roberts, MD, FACS; John P. Roe, MD, FACS; Marshall M. Urist, MD, FACS; Bruce G. Wolff, MD, FACS; and W. Douglas Wong, MD, FACS.

Examination committee activities

The board’s examination committee is chaired by Dr. Fleshman. It is divided into three working groups consisting of the oral, written, and recertification subcommittees; each is directed by a separate chairman. A summary of the subcommittee activities follows.

Oral examination. The ABCRS oral examination committee, under the direction of Dr. Hicks, continues to focus its attention on standardizing the oral examination process. Early in 2002 the committee began this task by editing existing oral case scenarios, making all the options clear, focused, and consistent. Thirty-eight cases were preselected for the September 2002 oral exam, and all examiners were instructed to test on the same material and gather responses in key elements from each candidate. In January 2003, committee members met to review the 2002 oral examination. The most and least missed questions were evaluated. Some were deleted, but most were kept and modified. Committee members were assigned specific topics and wrote new cases for the 2003 oral examination and for the oral case pool. New cases were preselected, and the 2003 oral examination was constructed.

The committee’s goal is to change the oral examination from one that merely tests candidates’ recall ability to one that tests their cognitive knowledge. It is predicted that these changes will make the oral process more objective and provide a mechanism that will better identify the areas in which candidates fail.

Written examination. At the March 23, 2003, board meeting, Dr. Wolff, chair of the written examination committee, made a proposal to combine the radiology and pathology sections of the written examination into one visual diagnostic examination. The current radiology pool will be reviewed and categorized. Poor-quality cases will be deleted and new high-quality cases will be added. Additions will include not only endoscopic examples, but also examples of gross pathology, such as prolapsed hemorrhoids, rectal prolapse, and fissures. Cases with corresponding photos that incorporate findings on visual and physical examination, as well as various diagnostic tests, includ-
ing manometry, MRI, CT, and histology on biopsy will be used. Eventually, the pathology and radiology examinations will be combined into one digitalized diagnostic exam.

Dr. Wolff said he believes these changes will make the examination more specialty-relevant. The images and corresponding cases will more closely resemble “real life” scenarios and authentic practice settings germane to colon and rectal surgery. Also, the examination will be projected using contemporary digital equipment, which will facilitate the interpretation of material. Ultimately, the changes will make the examination more current, uniform, and streamlined.

Recertification examination. The last recertification examination was given June 21, 2003, in New Orleans, LA. Forty-eight diplomates participated; 46 passed and two failed. The results and statistical summaries for the last 13 years are provided in Table 1 on page 43.

Transition to MOC

At the board’s March 23, 2003, interim meeting, the recertification committee was officially renamed the maintenance of certification (MOC) committee, and is chaired by Dr. Hooks (previously the recertification committee chairman). Under his direction, the ABCRS is making a transition from recertification to the new MOC program as requested by the American Board of Medical Specialties (ABMS).

In March 2003, the ABMS tentatively approved the ABCRS application for the first three components of MOC, including: (1) professional standing; (2) lifelong learning and self-assessment; and (3) cognitive expertise. The board’s next project will be to address the part four requirement—assessment of practice performance. This component will be the most difficult to develop because it requires that boards establish a process for assessing physician practice performance.

Beginning January 1, 2004, the Colon and Rectal Surgery Educational Program (CARSEP) requirements became effective for all diplomates who hold time-limited certificates. The board’s MOC plan requires a 10-year interval between initial certification and completion of requirements to maintain certification for the first time and for each subsequent 10-year interval. Specific requirements to prove professional standing, lifelong learning, and self-assessment include:

- Completion of CARSEP at least twice during the 10-year MOC interval.
- Approximately 30 Category 1 CME credits will be granted for each program.
- Accumulation of 100 Category 1 CME credit hours will be required two years before MOC application.
- Documentation of active state medical license without restrictions.
- Documentation of local institutional privileges as a “physician/colon and rectal surgeon” in “good standing.”

To fulfill requirements for cognitive expertise, a diplomate must pass a secure written examination covering all areas of colon and rectal surgery. The ABCRS administers a secure written examination every 10 years for all its diplomates certified since 1990 as the “recertification” process. Diplomates now holding unlimited certificates will have access to the board’s MOC programs and are encouraged to participate; however, participation is not necessary to retain the original certification.

Examination results

The most recent written examination (Part I) was given March 22, 2003; 67 candidates were examined. The most recent oral examination (Part II) was given September 20, 2003; 71 candidates were examined. The pass/fail rates are shown in Table 2 on page 43.

Examination fees increased

At its March 23, 2003, meeting, the ABCRS voted to raise its examination fees. Notably, the board has been able to keep examination fees at the same level for more than 15 years; however, escalating examination expenses necessitated the increase. The new fee schedule, effective as of March 2003, is:

- Application fee: A nonrefundable fee of $400 (previously $300) must accompany the application.
- Written examination fee (Part I): A fee of $500 (previously $400) is due and payable when the candidate is notified of approval to take the written examination.
- Oral examination fee (Part II): A fee of $700 (previously $500) is due and payable when the candidate is notified of approval to take the oral examination.
### Table 1: ABCRS recertification performance - 1991-2003

<table>
<thead>
<tr>
<th>Year</th>
<th>Participants</th>
<th>Passed</th>
<th>Percent</th>
<th>Failed</th>
<th>Percent</th>
<th>Maximum</th>
<th>Minimum</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>48</td>
<td>46</td>
<td>96%</td>
<td>2</td>
<td>4%</td>
<td>92%</td>
<td>66%</td>
<td>82%</td>
</tr>
<tr>
<td>2002</td>
<td>43</td>
<td>42</td>
<td>98%</td>
<td>1</td>
<td>2%</td>
<td>94%</td>
<td>59%</td>
<td>82%</td>
</tr>
<tr>
<td>2001</td>
<td>24</td>
<td>23</td>
<td>96%</td>
<td>1</td>
<td>4%</td>
<td>90%</td>
<td>69%</td>
<td>81%</td>
</tr>
<tr>
<td>2000</td>
<td>16</td>
<td>13</td>
<td>81%</td>
<td>3</td>
<td>19%</td>
<td>90%</td>
<td>59%</td>
<td>80%</td>
</tr>
<tr>
<td>1999</td>
<td>68</td>
<td>62</td>
<td>91%</td>
<td>6</td>
<td>9%</td>
<td>94%</td>
<td>61%</td>
<td>82%</td>
</tr>
<tr>
<td>1998</td>
<td>46</td>
<td>44</td>
<td>96%</td>
<td>2</td>
<td>4%</td>
<td>93%</td>
<td>57%</td>
<td>81%</td>
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<td>1997</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>97%</td>
<td>72%</td>
<td>87%</td>
</tr>
<tr>
<td>1996</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>94%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>1995</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>98%</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>1994</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>96%</td>
<td>78%</td>
<td>90%</td>
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<tr>
<td>1993</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>97%</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td>1992</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>98%</td>
<td>57%</td>
<td>86%</td>
</tr>
<tr>
<td>1991</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>98%</td>
<td>57%</td>
<td>86%</td>
</tr>
<tr>
<td>Total</td>
<td>257</td>
<td>244</td>
<td>95%</td>
<td>15</td>
<td>5%</td>
<td>98%</td>
<td>57%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Passing score: 70 percent

### Table 2: Examination results: Pass/fail rates

<table>
<thead>
<tr>
<th></th>
<th>Written exam - March 22, 2003 (67 candidates)</th>
<th>Oral exam - September 20, 2003 (71 candidates)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fail rates</td>
<td>Pass rates</td>
</tr>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Total candidates</td>
<td>67</td>
<td>11/67 16%</td>
</tr>
<tr>
<td>First-time takers</td>
<td>61</td>
<td>8/61 13%</td>
</tr>
<tr>
<td>Repeat candidates</td>
<td>6</td>
<td>3/6 50%</td>
</tr>
</tbody>
</table>

### Table 3: Geographic/gender distribution

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>%</th>
<th>Female</th>
<th>%</th>
<th>All</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total current diplomates</td>
<td>1,444</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active U.S.</td>
<td>1,055</td>
<td>73.06%</td>
<td>117</td>
<td>8.10%</td>
<td>1,172</td>
<td>81.16%</td>
</tr>
<tr>
<td>Active international</td>
<td>67</td>
<td>4.64%</td>
<td>5</td>
<td>0.35%</td>
<td>72</td>
<td>4.99%</td>
</tr>
<tr>
<td>Retired U.S.</td>
<td>185</td>
<td>12.81%</td>
<td>2</td>
<td>0.14%</td>
<td>187</td>
<td>12.95%</td>
</tr>
<tr>
<td>Retired international</td>
<td>5</td>
<td>0.35%</td>
<td>0</td>
<td>0.00%</td>
<td>5</td>
<td>0.35%</td>
</tr>
<tr>
<td>Status/address unknown</td>
<td>5</td>
<td>0.35%</td>
<td>0</td>
<td>0.00%</td>
<td>5</td>
<td>0.35%</td>
</tr>
<tr>
<td>Expired certificate holders</td>
<td>3</td>
<td>0.21%</td>
<td>0</td>
<td>0.00%</td>
<td>3</td>
<td>0.21%</td>
</tr>
<tr>
<td>Total</td>
<td>1,320</td>
<td>91.41%</td>
<td>124</td>
<td>8.59%</td>
<td>1,444*</td>
<td>100%</td>
</tr>
</tbody>
</table>

*This figure excludes diplomates who are deceased
Reexamination fee: Fees for reexamination are the same as shown above for each examination.

Withdrawal from examination: A candidate who fails to appear for examination or who withdraws without giving at least 10 days notice will forfeit $200 (previously $100) of the designated examination fee and will have to resubmit the forfeited amount before being admitted to the next scheduled examination.

Late applications: Late applications are those that are postmarked from July 16 through August 15 each year. There is a nonrefundable late application fee of $200 (was $100), bringing the total processing fee of a late application to $600. No applications will be accepted postmarked after August 15.

Late examination fees: All examination fees are subject to a late (or past due) assessment of $200.

Geographic/gender distribution
As of September 2003, the board has a total of 1,444 diplomates: 1,244 in active practice and 200 retired/inactive, three of which have expired certificates. Table 3 on page 43 provides the male/female and international distributions.

The American Board of Obstetrics and Gynecology
by Norman F. Gant, M D, Dallas, TX

No “board eligible” status
The phrase “old myths die hard” has never been more accurate than today when applied to the term “board eligible.” The American Board of Obstetrics and Gynecology (ABOG) last used the term in 1976. Despite this change that was made almost three decades ago, the term is still in common use.

In order to relegate this myth to posterity and to update our diplomates, a listing of current types of board status is outlined herewith. It also must be stressed that all other 23 member boards of the American Board of Medical Specialties (ABMS) have discarded the use of a “board eligible” status. The term is now meaningless. Today, any licensed physician who has completed an Accreditation Council on Graduate Medical Education-approved residency in obstetrics and gynecology is eligible to apply for ABOG examinations leading to certification. The types of board status follow:

Registered graduate. Individuals are registered graduates with the board when, upon application, the board rules that they have fulfilled the requirements to take the written examination.

Active candidate. Individuals achieve active candidate status by passing the written examination. To maintain active candidate status, candidates must fulfill all requirements for admission to the oral examination and must not have exceeded the limitations to admissibility for the oral examination (six years since passing the written examination or three attempts). Active candidate status that has expired may be regained by repeating and passing the board’s written examination.

Diplomate. Individuals become diplomates of the board when the written and oral examinations have been satisfactorily completed and the board’s certifying diplomas have been awarded. Certificates have a limited duration of validity (six years).

Expired certificate. Individuals have an expired certificate status when they have failed to complete successfully a maintenance of certification process prior to the expiration date printed on their time-limited certifying diploma. Individuals in this category are no longer diplomates of the ABOG. Former diplomates whose time-limited certificates have expired may regain diplomate status by successfully completing an ABOG maintenance of certification process.

Retired diplomate. Individuals have retired from clinical practice at a time when they were still diplomates. Individuals in this category are retired diplomates. If they return to active practice after their time-limited certificate has expired, they must complete an ABOG maintenance of certification program in order to reactivate their diplomate status. Individuals choosing to be retired diplomates must notify the board. Failure to take this
action will result in an expired certificate status.

Exam results

The principal written examination was administered June 24, 2002, at multiple sites. A total of 1,643 candidates applied for the exam. Of them, 1,209 were new applicants, 1,105 were U. S. medical school graduates (USMGs), 88 were international medical school graduates (IMGs), and 434 were reapplying. Of those persons reapplying, 310 were USMGs and 124 were IMGs. Pass/fail results are listed in Table 1 on this page.

The principal oral examination was administered November and December 2002 and January 2003 in Dallas, TX. A total of 1,433 candidates applied for the oral exam: six were disapproved ad hoc; 21 were disapproved based on case list; 74 turned in incomplete-no fee applications; four were no-shows; 43 withdrew from the exam; and 1,285 took the exam. Pass/fail results are listed in Table 2, this page.

Exam trends. For U.S. graduates of American medical schools taking the examination for the first time, the pass rate has ranged between 87 and 95 percent. For the entire examination, the pass rate has ranged between 66 and 76 percent. The number of applicants for the written examination peaked in the mid-1990s. Since 1997, however, the number of applicants has decreased through the year 2002. The major decrease has occurred in reapplicants.

The pass rates for all candidates for the principal oral examination in obstetrics and gynecology have varied from 83 to 87 percent for the past decade. The number of applicants for the principal oral examination was constant between 1996 and 1999 (range 1,650-1,686). This number dropped abruptly by more than 100 to 1,543 in the year 2000, 1,469 in 2001, and to 1,433 in 2002. This likely reflects the decreasing total number of applicants for the principal written examination noted in the years 1998 and 1999.

Subspecialty exams

The written examinations in oncology were administered June 24, 2002, at multiple sites. Of the 83 individuals taking the exam, 68 (82%) passed, and 15 (18%) failed.

Subspecialty oral examinations were administered April 15-17, 2002. In the subspecialty of reproductive endocrinology/infertility (REI), 44 individuals took the oral exam, and 34 (77%) of them passed. A total of 886 physicians are board-certified in REI to date. In the subspecialty of maternal-fetal medicine (MFM), 48 individuals took the oral exam, and 38 (79%) passed. A total of 1,457 physicians are board-certified in MFM to date. In the subspecialty of gynecologic oncology (GO), 39 individuals took the oral exam, and 35 (90%) passed. A total of 725 physicians are board-certified in GO to date.

Trends/written exams. The number of applications, those approved to take the examinations, and the actual number who took the subspecialty written examinations in MFM and REI have de-

---

**Table 1:**

<table>
<thead>
<tr>
<th>Passed</th>
<th>Failed</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>(%)</td>
</tr>
<tr>
<td>Took exam</td>
<td>1,154 (76)</td>
</tr>
<tr>
<td>USMGs</td>
<td>1,066 (80)</td>
</tr>
<tr>
<td>IMGs</td>
<td>88 (47)</td>
</tr>
<tr>
<td>First-time takers</td>
<td>1,037 (89)</td>
</tr>
<tr>
<td>USMG first-time takers</td>
<td>957 (89)</td>
</tr>
<tr>
<td>Reapplications</td>
<td>117 (34)</td>
</tr>
</tbody>
</table>

**Table 2:**

<table>
<thead>
<tr>
<th>Passed</th>
<th>Failed</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>(%)</td>
</tr>
<tr>
<td>Took exam</td>
<td>1,119 (87)</td>
</tr>
<tr>
<td>U.S. graduates</td>
<td>1,055 (88)</td>
</tr>
<tr>
<td>International graduates</td>
<td>64 (80)</td>
</tr>
<tr>
<td>U.S. graduates/first-time takers</td>
<td>954 (89)</td>
</tr>
</tbody>
</table>

The number of active diplomates is 34,000 (approximate).
clined for the past two years. This finding likely reflects the marked decrease in applicants for these fellowship positions first noted three years ago. The marked decrease this year was likely due to the increase in duration of fellowships from two to three years. The pass rate for the written examination in GO has remained stable since the mid-1990s, between 70 and 82 percent.

Trends/oral exams. The pass-fail percentage rates for the subspecialty oral examinations are listed by year from 1990 to 2002 in Table 3, this page.

A total of 3,068 diplomates have been issued subspecialty certificates (GO, MFM, REI) of whom approximately 2,421 are currently in practice. This represents approximately 7.1 percent of the total of 34,000 actively practicing diplomates.

Maintenance of certification
Certificate renewal/voluntary recertification written exams were administered June 24, 2002, at multiple sites. Of those physicians seeking to renew their certificates in obstetrics/gynecology (ob-gyn), 117 (97%) passed and four (3%) failed. Of those physicians seeking to renew their certificates in ob-gyn and GO, four (100%) passed. Of those physicians seeking to renew their certificates in ob-gyn and MFM, eight (100%) passed. Of those physicians seeking to renew their certificates in ob-gyn and REI, seven (100%) passed.

A total of 6,259 individuals applied for annual board certificate (ABC) renewal and voluntary recertification for 2002 in the areas of ob-gyn, oncology, MFM, and REI. A total of 6,239 applications were approved in these subspecialties, seven were disapproved, 13 applications were withdrawn, and 200 were incomplete. Pass-fail numbers and percentages of diplomates who started the ABC process are listed in Table 4, this page.

Analysis of ABC, first five years. For the obstetrics and gynecology portion of the ABC process several points are worthy of note. Approval of applications in the years 1998, 1999, 2000, and 2001 was 97.5, 99.8, 99.7, 99.6, and 99.7 percent, respectively. The number of applications in 1999 (3,292) decreased from 1998 (4,098). This 20 percent decrease likely is explained by individuals who did not complete the process in 1998 and did not apply in 1999, plus the attrition of those individuals who simply did not want to continue the process for a variety of reasons. The increase back to 4,092 in 2000, 4,808 in 2001, and 5,742 in 2002 almost certainly represents the influx of another group of diplomates with time-limited certificates choosing this method of certification maintenance. The percentage of diplomates who did not complete the process decreased from 30 percent in 1998 to 11 percent in 1999. In 2000, this number had decreased to 8 percent, and in 2001 this number was 5 percent. In 2002, this was slightly less than 3 percent. This improvement likely represents the loss of those who failed to complete the process in

### Table 3: Subspecialty oral examinations:
**Pass-fail percentage rates 1990-2002**

<table>
<thead>
<tr>
<th>Year</th>
<th>GO Pass</th>
<th>GO Fail</th>
<th>MFM Pass</th>
<th>MFM Fail</th>
<th>REI Pass</th>
<th>REI Fail</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>71</td>
<td>29</td>
<td>78</td>
<td>22</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>1991</td>
<td>61</td>
<td>39</td>
<td>79</td>
<td>21</td>
<td>63</td>
<td>37</td>
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<tr>
<td>1992</td>
<td>78</td>
<td>22</td>
<td>83</td>
<td>17</td>
<td>55</td>
<td>45</td>
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<tr>
<td>1994</td>
<td>85</td>
<td>15</td>
<td>80</td>
<td>20</td>
<td>69</td>
<td>31</td>
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<tr>
<td>1995</td>
<td>77</td>
<td>23</td>
<td>81</td>
<td>19</td>
<td>75</td>
<td>25</td>
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<td>1996</td>
<td>85</td>
<td>15</td>
<td>79</td>
<td>21</td>
<td>73</td>
<td>27</td>
</tr>
<tr>
<td>1997</td>
<td>79</td>
<td>21</td>
<td>82</td>
<td>18</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>1998</td>
<td>86</td>
<td>14</td>
<td>81</td>
<td>19</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>1999</td>
<td>89</td>
<td>11</td>
<td>78</td>
<td>22</td>
<td>76</td>
<td>24</td>
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<tr>
<td>2000</td>
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<td>89</td>
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<td>31</td>
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<tr>
<td>2001</td>
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<td>15</td>
<td>86</td>
<td>14</td>
<td>73</td>
<td>27</td>
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<tr>
<td>2002</td>
<td>90</td>
<td>10</td>
<td>79</td>
<td>21</td>
<td>77</td>
<td>23</td>
</tr>
</tbody>
</table>

### Table 4. Pass-fail numbers/percentages of diplomates who started ABC process

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>Approved</th>
<th>Pass</th>
<th>Fail</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td># (%)</td>
<td># (%)</td>
<td></td>
</tr>
<tr>
<td>Ob-gyn</td>
<td>5,456</td>
<td>5,265 (96)</td>
<td>191 (4)</td>
</tr>
<tr>
<td>ONC</td>
<td>139</td>
<td>130 (94)</td>
<td>9 (6)</td>
</tr>
<tr>
<td>MFM</td>
<td>435</td>
<td>409 (94)</td>
<td>26 (6)</td>
</tr>
<tr>
<td>REI</td>
<td>209</td>
<td>197 (94)</td>
<td>12 (6)</td>
</tr>
<tr>
<td>Totals</td>
<td>6,239</td>
<td>6,001 (96)</td>
<td>238 (4)</td>
</tr>
</tbody>
</table>
1998. Also, this number likely includes a new group of diplomates with time-limited certificates and a better understanding of the process. More than 70 percent of diplomates using the ABC process in 1998 and 1999 did so voluntarily. This percentage fell in 2000 to 57 percent and in 2001 this number was 50 percent. The 2002 value was 38 percent. This decline was expected due to the entry of more diplomates with time-limited certificates.

Analysis of the subspecialties after four years reveals several similarities to the ABC process in obstetrics and gynecology. Approvals of applications have been 100 percent and 98.5 percent in 1999 and 2000 respectively. This was 99 percent in 2001 and 99.5 percent in 2002.

Since 1999, those failing and/or not completing the subspecialty ABC process appear to have bottomed at approximately 6 to 7 percent.

The subspecialists, using the ABC process in obstetrics and gynecology, have changed from voluntary to certificate renewal. The 1999 voluntary rate was 77 percent, the 2000 voluntary rate decreased moderately to 61 percent, and in 2001 this rate was 55 percent. The voluntary rate in 2002 was 30 percent.

**Officers and directors**

The ABOG officers for the year ending June 30, 2003, were: Philip J. DiSaia, MD, FACS, president; Kenneth L. Noller, MD, vice-president; Larry C. Gilstrap III, MD, treasurer; Gerson Weiss, MD, chairman of the board; Norman F. Gant, MD, executive director; and William Droegemueller, MD, director of evaluation. Directors included Haywood L. Brown, MD; Mary C. Ciotti, MD; Larry J. Copeland, MD, FACS; Alan H. DeCherney, MD, FACS; Sherman Elias, MD, FACS; Wesley C. Fowler, Jr., MD, FACS; David Gershenson, MD, FACS; Ronald S. Gibbs, MD; Frank W. Ling, MD; Michael T. Mennuti, MD; Roy T. Nakayama, MD; Valerie M. Parisi, MD; Nanette F. Santoro, MD; Robert S. Schenken, MD; Russell R. Snyder, MD; Michael L. Socol, MD; and Morton A. Stenchever, MD.

In addition, the following individuals served as the directors and representatives of the subspecialty divisions: Dr. Gershenson, division of GO; Dr. Socol, division of MFM; Dr. Schenken, division of REI. Dr. Stenchever is the director and representative for female pelvic medicine and reconstructive surgery.

**The American Board of Orthopaedic Surgery**

by Richard E. Grant, MD, FACS, Washington, DC

During the past four-and-one-half years, the American Board of Medical Specialties (ABMS) has pursued a major revision of policy focusing on physician competence. Accordingly, the American Board of Orthopaedic Surgery (ABOS) has responded to these mandates by developing programs relevant to maintenance of competency.

In addition, the ABOS has recently instituted a new standing committee in order to allow for more effective communication with the American Academy of Orthopaedic Surgery, diplomats of the American Board of Orthopaedic Surgery, and residents who are also facing the challenges of adjusting to the ABMS push for maintenance of certification and enhancement of professionalism.

Additionally, our recertification examination committee, chaired by Randy Rosier, MD, has been evaluating a practice profile examination, which has been offered for several years. The last addition to the practice profile series was the spine surgery examination that came on line in 1999. The practice profile recertification examinations currently offered include adult reconstructive surgery, sports medicine, and spine surgery. The committee has found that approximately 40 percent of the questions presented on the practice profile recertification examination are basic science and general orthopaedic questions. The general written recertification examination was given on February 7, 2003, at the annual meeting of the ABOS.
in New Orleans, LA. The oral recertification examination was administered July 8, 2003, in Chicago, IL, and the computerized recertification examination for the general category, adult reconstruction, and sports medicine and spine surgery was made available to diplomates during March and April of 2003. These examinations are administered throughout the country at specified Prometric testing centers. The computerized examination for the certificate of added qualification (CAQ) of hand recertification pathway was reevaluated and reinstituted in mid-August and mid-September 2003, to be administered at the Prometric testing centers. The written examination for CAQ hand recertification has been discontinued.

In 2002, a total of 72 candidates took the general written examination and 70 passed. Of 299 candidates who chose the computerized general written examination pathway, 294 passed. Fifty-one candidates took the adult reconstructive surgery examination, and all 51 passed. There were 106 candidates who chose to take the sports medicine examination, and all of these examinees passed. Of the 58 candidates who took the spine surgery examination, 57 passed. Of the 47 candidates who took the CAQ hand pathway, 46 passed.

Finally, of the 50 candidates who chose the oral recertification examination, 42 passed. Of the overall 683 candidates examined in 2002, 666 passed, for a passage rate of 98 percent. The results for the 2003 examination are pending.

Maintenance of certification

The current committee is headed by James Luck, MD, FACS, of Los Angeles, CA. The ABOS has developed an ad hoc committee in conjunction with the American Academy of Orthopaedic Surgery to explore the issues of maintenance of certification. Currently, the ABOS evaluation includes continuing medical education (CME) credits, evaluation of practice performance, and one of the following secure exams:

1. Written general examination.
3. Computer-based practice profile examination in adult reconstruction, spine, and sports medicine.
4. Practice-based oral examination based on a six-month case collection from the candidate's practice as with the Part II oral examination.
5. Certificate of added qualification for hand surgery, now administered at the Prometric center.

The ABOS committee addressing the issues of maintenance of certification has responded to the ongoing concerns from public and private constituents. The ABMS created a task force on physician competency in 1998. The ABMS task force focused on methods to evaluate specialists after completion of initial certification. The information forwarded from the ABMS program has generated a new program for maintenance of certification. The task force identified four essential components of maintenance of certification—ongoing evidence of professional standing, commitment to lifelong learning and periodic self-assessment, cognitive expertise, and evaluation of practice performance.

In 2000, the ABOS and the American Academy of Orthopaedic Surgery established a task force with six members from each organization to address the complex question of how orthopaedic surgery could best respond to the maintenance of certification requirements as defined by the ABMS. In addition, the committee's task force also focused on addressing concerns and issues raised by the ABOS with respect to retesting after years of practice.

The American Academy of Orthopaedic Surgery's survey went out to 1,300 diplomates certified prior to 1992. Nine hundred and seventy-three, or 32 percent, responded. Sixty-seven percent of the respondents agreed that it was necessary to have a system that ensured "competence." Seventy percent of respondents agreed that it should be a documented system and that there was no clear position on the question, "Is the current system effective and fair?"

The ABMS requested that their individual specialty board submit plans for implementation of the first three components of maintenance of competency by February 2003. The ABOS has already submitted its report and that report has been favorably received.

The fourth element of maintenance of certification includes the program for evaluation of practice performance that is to be forwarded to the ABOS by 2004. The purpose of this compo-
ent is to demonstrate to patients, the public, and the profession that physicians provide safe, effective, patient-centered, timely, efficient, and equitable health care.

The goal of the maintenance of certification program is to stimulate continued education and improvement. The greatest challenge that the committee continues to face is the fourth component of the ABMS directive, evaluation of performance in practice.

CAQ/hand surgery

The committee on the certificate of added qualification in surgery of the hand, under the direction of Peter Stern, MD, FACS, provided testing for 75 examinees in 2002. The examinees included 57 registered by the ABOS, 17 examinees registered with the American Board of Plastic Surgery, and one with the American Board of Surgery. This compared favorably with 96 individuals who took the examination in 2001, 103 in 2000, and 75 in 1999. Overall, 24 percent of the examinees reported that their practice was devoted exclusively to hand surgery and 82 percent indicated that at least 75 percent was devoted to hand surgery. Sixty-nine percent had an annual case load of more than 250 hand cases. The passing score of 65 percent was chosen. Two of the three reexaminees failed and failure rates for the computer-administered and written examinations were comparable.

The CAQ in surgery of the hand report for recertification indicated that a total of 109 examinees took the recertification examination. Sixty-seven percent of the examinees were from the ABOS, 26 percent from the American Board of Plastic Surgery, and 13 percent from the American Board of Surgery. There was one reexaminee for recertification. Eighty-three percent of the examinees took the computer-administered examination at one of the local Prometric testing facilities and 17 percent took the written examination in Rosemont, IL.

Based on the equating study results and the 2002 certification examination passing score, a passing score of 63 percent was chosen. A total of 98 examinees passed and 11 failed, for an overall failure rate of 10.1 percent.

For 2003, both the certification and recertification examinations for CAQ of the hand will be entirely computer-based and will be administered by a local Prometric testing center. The paper and pencil written examination has been discontinued. By 2004, the ABOS diplomates who wish to recertify in orthopaedic surgery and continue to maintain a certificate of added certification will have to pass a combined computer-administered examination consisting of approximately 160 CAQ questions and 80 general orthopaedic surgery questions.

Research committee

The ABOS research committee is chaired by William E. Garrett, MD, FACS, in conjunction with Mark F. Swiontkowski, MD, FACS. The research committee continues to work on three separate projects. The ABOS began working on the development of a virtual reality model for simulation of knee arthroscopy. The ABOS has continued to work in conjunction with the American Academy of Orthopaedic Surgery and the Arthroscopy Association of North America to continue the development of a virtual knee arthroscopy simulator and psychomotor skills testing module.

The committee also continues to pursue methods of incorporating patient-derived outcome studies and data into the certification process. Dr. Swiontkowski and Dr. Garrett have instituted pilot studies not dissimilar to the academy’s previous experiments with modems outcomes forms and short-form musculoskeletal functioning assessment forms. The research committee feels that the process can be linked to the patient list provided by ABOS candidates for the oral examination. This will allow the candidates to provide subjective patient data to be correlated with the candidate’s self report of their clinical outcomes and results.

A second pilot study utilizing patient-derived outcomes data has also been undertaken. Oral examination Part II applicants were offered the opportunity to enroll in the second phase pilot test.

Over the past three years, the ABOS research committee has collected data on the diagnosis and procedures for all cases completed by candidates presenting for Part II of the ABOS examination process. During 2002, there were 718 candidates who performed 92,307 cases in the
six months of data collection. The candidates reported an average of 129 cases. These data have been remarkably similar for the past four years of data collection. The top procedures include knee arthroscopy with partial meniscectomy, carpal tunnel surgery, removal of support implant, knee arthroplasty and chondral debridement, shoulder arthroscopy and decompression, total knee replacement, knee arthroscopy and anterior cruciate ligament reconstruction, repair of thigh fracture, and total hip replacement.

The research committee has also pointed out that the current data lend themselves to monitoring changes in a surgeon's practice over a period of years from immaturity to maturity. These data can help not only with design of the testing procedures for Part I and Part II of the ABOS examination but also in designing a resident education curriculum reflective of current profile trends.

The American Board of Orthopaedic Surgery Committee on Graduate Medical Education is chaired by Mark C. Gebhardt, MD, FACS, of Boston, MA. The residency review committee (RRC) met in South Carolina in conjunction with the proceedings of the American Orthopaedic Association in June 2003. During the meeting the RRC examined 38 orthopaedic residency programs. Two of those programs were placed on probation and one program had its accreditation withheld. Two programs received continued provisional accreditation and 23 attained continued full accreditation.

Thirty-eight fellowships were reviewed and one program in musculoskeletal oncology was placed on probation. There were five proposed adverse actions. Two programs had proposed withdrawal of accreditation, including a program with hand and sports medicine.

In addition to the review of orthopaedic programs and subspecialties, the RRC also tackled the very difficult challenge of reduced resident duty hours. The work group provided its report regarding the implementation of limitation of work hours (that is, 80 hours per week with the option of a 10 percent exception outside of New York State). The committee also discussed antitrust litigation directed toward the NRMP and ACGME.

Several concerns regarding graduate medical education have been identified by the orthopaedic RRC, including limited program director retention and acting chairmanships.

Written examination

The ABOS written examination committee reported the results of their examination process. In 2002, of the 805 examinees, 79 percent passed and 21 percent failed. Of the 623 examinees who were taking the examination for the first time, 89 percent passed and 11 percent failed.

The question writing in field task forces, the National Board of Medical Examiners, and the ABOS written examination committee are involved in the creation of the written examination. The process of developing the written examination requires the activities of 50 orthopaedic surgeons representing all subspecialties of orthopaedic surgery working for a period of at least two years.

The 2002 examination contained 321 items. Twenty-five items were identified as potentially defective by preliminary item analysis during the key validation process. The passing standard on the 2002 written certifying examination was 1.13 logits on the Rasch Bank scale. The 2002 examination standard was equivalent to a percent correct of 67.8 percent.

Credentials committee

During the 2002 meeting, the ABOS credentials committee reviewed 24 of the 700 recertification applicants and accepted 12 of those reviewed for the 2003 recertification examination process. Two were denied, five were deferred, and site visits were recommended for two applicants.

Recertification was adopted by the ABOS in 1972 and, beginning in 1986, all certificates issued by the ABOS were time limited to 10 years. The ABMS, of which the ABOS is a member, had endorsed maintenance of certification that will replace the concept of recertification.

The credentialing process is dependent upon the ABOS diplomates participating in the candidate evaluation process. The candidate has waived the right to take action for practice information provided in good faith. Additionally, state laws usually protect peer review information provided in good faith. ABOS liability insurance covers diplomates providing peer review
information that is factual, accurate, and given in good faith. The candidate evaluation process provides the basis for the ABOS evaluation of continued demonstration of the applicant’s professional competence and adherence to acceptable ethical professional standards.

During the credentials committee meeting in March 2002, 33 of 736 applicants for the Part II examination were reviewed. Twenty were allowed to sit for the examination, 13 were deferred, and 98 percent of the candidates were recommended to the board to sit for examination.

The recertification credentialing process is similar. Candidate evaluations are requested from certified orthopaedic surgeons who are familiar with the work of the applicant but not associates. The hospital administrator for each hospital where the applicant practices or has practiced must send a notarized letter verifying staff privileges and dates of practice. Continuing medical education Category 1 documentation for the prior three years must be provided by the candidate. In a manner similar to the credentialing process for Part II, the credentials committee provides recommendations to the board for admission to the recertification process. Adverse actions can include deferral or rejection of that application.

**Oral examination**

The ABOS oral examination committee is currently chaired by John J. Callahan, MD, of Iowa City, IA. The Part II oral examination administered in Chicago, IL, in July 2003 hosted well over 700 candidates who had previously passed the Part I examination.

The Part II oral examination is a practice-based examination. The candidate is asked to present 10 cases selected from his practice based upon a six-month computerized case list. The total number of operative cases for the 700-plus candidates was well over 100,000. The case list submitted to the board is reviewed by the directors of the board and selected oral examiners to identify 12 potential cases for examination. The ABOS now has an Internet-based selection system, Scribe. Scribe has been functioning well for the past four years and simplifies the selection of cases for the candidates.

The examination is a one-hour-and-45-minute practice survey divided into three 35-minute segments, with a five-minute break between each testing session. During each segment, the candidate is examined by two examiners who are matched to the candidate for areas of stated expertise. The examiners are provided the complete case list as well as a graphic analysis of the candidate’s practice profile and complications.

The decision with respect to passing or failing the candidate is based upon performance as assessed independently by six examiners without any caucus of the examiners. For each case presented, a candidate is graded on data gathering, diagnosis, treatment, planning, technical skills, outcomes, and ethics. At the conclusion of the examination process, each candidate has received approximately 100 to 130 grades that are statistically averaged and adjusted based upon the known severity or leniency of the examiner.

In contradistinction to Part I written examination, which tests exclusively orthopaedic knowledge, the Part II oral examination tests the application of that knowledge, diagnostic acumen, surgical techniques, outcomes, and ethics.

The oral examination committee has encouraged constructive debate to consider the most effective mechanism to measure the components of maintenance of competency for diplomates who have been in active practice. Consideration has been given to expansion of the oral examination process, review of practice generated case lists, and directed CME.
The following report summarizes the events of the 2002-2003 academic year, which has been a full one for the American Board of Surgery (ABS). A number of these issues should be of interest to the Fellows of the College.

**Initiation of early specialization program**

After 12 months of preparation and comment, the ABS, in January 2003, adopted the early specialization program for vascular and pediatric surgery. The program will allow residents in an institution with residencies in either of these specialties plus general surgery to have an integrated program in which they will enter specialty training after the PGY-4 year. The chief year of general surgery will be completed in the PGY-4 year, and the PGY-5 year, which will be the first year of specialty training, will also count as a fifth year of general surgery. The program will allow residents to complete training in six years and be eligible for both the general surgery and specialty certificates.

Initially the program will only be implemented in a single institution although, as experience is gained, it is envisioned that residents will be able to move between institutions for general surgery and specialty training. The program will be operating on a pilot basis initially, with outcome measures being maintenance of the number and diversity of total cases, as well as those in the defined categories of the residency review committee for surgery (RRC-S). Impact on those individuals entering the program, as well as other residents in the program, will be assessed and the ability of participants to maintain first-time pass rates on the qualifying and certifying examinations will also be monitored.

The program was reviewed by the RRC-S in February 2003 and approved. An oversight committee of representatives from the ABS and the RRC-S has been appointed under the chairmanship of J. David Richardson, MD, FACS, and is currently in the process of developing specific guidelines and implementing the program. It is envisioned that applications will be received by the RRC-S this fall, and the first residents may enter the program at the PGY-4 level in July 2004.

**Computer-based recertification exams**

The board moved progressively toward computer-based examinations for recertification, beginning in October 2003, with the specialty areas of vascular surgery, pediatric surgery, and surgical critical care. The surgery of the hand certification and recertification examinations have been given in computer-based formats since August of 2002. A vendor has been selected—Pearson Vue—which operates professional testing centers available throughout the country. There are a total of 200 professional centers so, from any given location, a diplomate taking the recertification examination will likely have to travel no more than 50 miles to locate a center.

In addition, the window during which the examination may be scheduled will extend over two weeks at the end of October, so that the diplomate may schedule more conveniently than before. Some of these centers will also be available on a Saturday schedule. The actual format of the examination—that is, multiple-choice questions with five possible answers—will remain the same as the paper and pencil version.

This change has been made to increase the convenience for diplomates in scheduling time for the examination and in decreasing travel costs and time away from home. It was well received by those taking the surgery of the hand examination last year, and we anticipate the same advantages for the larger group this year. In October of 2004, we anticipate extending this process to those diplomates who will be recertifying in surgery.

**IT/SBSE suspicious matches**

In the ABS report to the College last year, we highlighted a distressing finding that has occurred in the past few years. The ABS uses software that detects cheating on multiple-choice examinations by comparing the answers of all persons taking the examination with all others. The identifica-
tion of cheating occurs when two candidates have a high percentage of the same wrong answers to the questions. Since each question has four possible wrong answers, the likelihood of a substantial match between two candidates (>50% agreement) is unlikely by coincidence. The software allows the level of probability to be adjusted and, in the use of the software to monitor our examinations, it has been set at the p < .0000001 (1 in 1 million) level.

As we noted last year, there have been 30 to 50 episodes of cheating identified per year for the last four years, despite admonitions to program directors. In 2002, 38 episodes were identified, usually involving two persons, and occasionally three.

In 2003, the board printed the In-Training/Surgical Basic Science Examination (IT/SBSE) in two versions. Each had the same questions, but they were in different order in the two versions of the test booklet. Program directors were asked to hand alternate versions of the booklet to test takers seated next to each other, so that copying from one to the other would be difficult. With this modification, the incidence of cheating episodes dropped to 12 this year, but was not completely eliminated.

The board has notified all program directors of affected programs and has recommended specific measures to reduce the likelihood of cheating in the future. It has been found that the most effective measures are assigned rather than random seating, adequate spacing of candidates, and careful proctoring. The board has adopted specific policies for dealing with programs in the future when cheating episodes are identified in more than one year. After the first year, the program director and chief of surgery will be notified. If cheating occurs for a second year, the notification will go to the program director, chief of surgery, and the director of graduate medical education (GME) of the facility, with a requirement that the GME committee adopt specific measures to prevent future occurrences and report back to the board. If cheating occurs for a third year, use of the IT/SBSE will be withheld from the institution.

The same monitoring software has been applied to the qualifying examinations and the recertification examinations in all specialty areas and no cheating episodes have been detected in these venues.

**Maintenance of certification initiative**

The ABS has previously adopted the maintenance of certification (MOC) initiative of the American Board of Medical Specialties (ABMS), and is in the process of implementing its requirements, with the help of the ACS. The program has four basic components: (1) evidence of professional standing; (2) evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process; (3) evidence of cognitive expertise; and (4) evidence of evaluation of performance in practice.

The first of these is evaluated by the requirement of a full and unrestricted license in all jurisdictions where licenses are held by a diplomate, and by personal reference letters from the chief of surgery and the chair of the credentials committee in the hospitals where the diplomate practices.

The second requirement is met by demonstration of 100 hours of continuing medical education (CME) activities in the two years prior to submission of the recertification application, of which 60 hours must be Category 1.

The third requirement is met by taking and passing the recertification examination of the ABS.

The fourth requirement is met currently by the reference letters of the chief of surgery and the chair of the credentials committee, but it is felt that more objective criteria are needed, which specifically would address the practice experience of an individual diplomate. Currently, initiatives have been undertaken by the vascular surgery board of the ABS (VSB-ABS), the pediatric surgery board of the ABS (PSB-ABS), and the surgical oncology advisory council (SOAC), which are geared to obtaining outcomes measures that could be used in the MOC process. In 2003, for the first time, recertifying diplomates in vascular surgery are submitting reports of their outcomes with three operations: carotid endarterectomy, aortic aneurysmectomy, and infrainguinal bypass. Complication rates for each are being reported by all candidates as a condition of recertification. The reporting of complications is required with submission of the recertification application, but contains no identifiers and is separated from the basic application after it reaches the board office so that there is no way in which these records could be subject to discovery. As we gain experience in this area, we anticipate developing some norms of
reported experience and sending this information back to all diplomates for them to compare their own statistics so as to facilitate peer review at the local level.

We have not yet initiated such a program for recertification in surgery but are currently looking at various alternatives. The board feels it is essential for diplomates to begin some form of practice outcomes assessments for the more common procedures they do in order to meet the requirements of the fourth component of MOC.

The American College of Surgeons has been helping greatly with this process through the establishment of the task forces this past year to examine the various competencies, and we anticipate collaborative efforts with them in developing practical and workable measures. We anticipate that the ABMS will require implementation of all four components of MOC within the next one to two years.

Independent vascular surgery board

The American Board of Vascular Surgery (ABVS) applied for independent board status with the ABMS last year, and the application was heard by the Liaison Committee for Specialty Boards (LCSB) in December 2002. The LCSB denied the application, and the ABVS has decided to appeal the decision. A new committee will re-review the application and render a new judgment, but the timetable for that process has not yet been set.

Meanwhile, the VSB-ABS continues to work effectively to advance the interests of the vascular surgery community and to improve the certification process for vascular surgery. The VSB-ABS has complete responsibility for determining the requirements for vascular surgery certification and for developing the vascular surgery qualifying, certifying, and recertification examinations. The quality of the oral examinations has

<table>
<thead>
<tr>
<th>Examination</th>
<th># of Examinees</th>
<th>Pass rate</th>
<th>Diplomates to date</th>
</tr>
</thead>
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<td>Qualifying</td>
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<td>75%</td>
<td></td>
</tr>
<tr>
<td>Certifying</td>
<td>1,184</td>
<td>83%</td>
<td>48,355</td>
</tr>
<tr>
<td>Recertification</td>
<td>1,355</td>
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<td>13,736</td>
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<tr>
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<td>123</td>
<td>85%</td>
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<tr>
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<td>126</td>
<td>83%</td>
<td>2,259</td>
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<tr>
<td>Vascular surgery recertification</td>
<td>146</td>
<td>97%</td>
<td>1,214</td>
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<tr>
<td>Surgical critical care certification</td>
<td>78</td>
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<tr>
<td>Surgical critical care recertification</td>
<td>129</td>
<td>94%</td>
<td>808</td>
</tr>
<tr>
<td>Pediatric surgery qualifying</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Pediatric surgery certifying</td>
<td>--</td>
<td>--</td>
<td>877</td>
</tr>
<tr>
<td>Pediatric surgery recertification</td>
<td>--</td>
<td>--</td>
<td>498</td>
</tr>
<tr>
<td>Hand surgery certification</td>
<td>1</td>
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<td>224</td>
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<td>14</td>
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<td>7,323</td>
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</tr>
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</table>

Total 11,833*

N/A = Not applicable.

*4,441 examinees, excluding the IT/SBSE and pediatric surgery ITE.
been enhanced with the addition of objective visual and diagnostic material to nearly all prompter cases, and the oral examination process has been improved with the designation of a senior examiner group who will serve specific terms as vascular surgery examiners.

G. Patrick Clagett, MD, FACS, served as chair of the VSB-ABS from its inception until completion of his term on the ABS in June 2003, and has done an outstanding job of leading the vascular surgery board through its organization and initial work. He received the commendation of the full board for exemplary service during his six-year term. The chairmanship of the VSB-ABS has now been assumed by Frank W. LoGerfo, MD, FACS, of Boston, MA.

The ABS continues to oppose the designation of the ABVS as an independent board, and believes the VSB-ABS has done an outstanding job of representing vascular surgery. It is the belief of the board that vascular surgery represents an essential content area of general surgery and that the teaching of vascular surgery to general surgery residents remains crucial to their training, whether they choose to enter vascular surgery as a specialty area or not. Virtually all areas of general surgery and its specialties require a basic knowledge of vascular surgery, and the separation of this discipline from general surgery training would be a crucial error.

New and retiring members

The board would like to express its thanks for the dedicated service and excellent counsel of the following individuals who retired in 2003: (ABS directors) G. Patrick Clagett, MD, FACS; Thomas M. Krummel, MD, FACS; Mark A. Malangoni, MD, FACS; Bradley M. Rodgers, MD, FACS; Luis O. Vasconez, MD, FACS; (VSB-ABS) Bruce J. Brener, MD, FACS; and (SOAC) Peter W. T. Pisters, MD, FACS.

New appointees elected in April to replace the above individuals, and the appointing organizations, are the following:

ABS directors: E. Christopher Ellison, MD, FACS, American College of Surgeons; Carlos A. Pellegrini, MD, FACS, American Surgical Association; James A. Schulak, MD, FACS, American Society of Transplant Surgeons; Marshall Z. Schwartz, MD, FACS, American Pediatric Surgical Association; Thomas R. Stevenson, MD, FACS, American Board of Plastic Surgery; and Jonathan B. Towne, MD, FACS, Joint Committee for Vascular Surgery.

VSB-ABS: John J. Ricotta, MD, FACS, American Association for Vascular Surgery

SOAC: John M. Daly, MD, FACS, Society of Surgical Oncology.

We want to welcome all of them enthusiastically, and look forward to working with them. The board would also like to gratefully acknowledge the dedicated service of the following individual who will retire from active examiner status this year: David M. Heimbach, MD, FACS.

Necrology

It is with great regret that we report the deaths of the following individuals during the past year: Richard J. Cleveland, MD, FACS (June 11, 2002); Gustaf Lindskog, MD, FACS (August 4, 2002); Ronald A. Malt, MD, FACS (October 5, 2002); Marshall K. Bartlett, MD, FACS (December 14, 2002); David B. Skinner, MD, FACS (January 25, 2003); James D. Hardy, MD, FACS (February 19, 2003); William P. Longmire, Jr., MD, FACS (May 9, 2003); and James H. Foster, MD, FACS (June 17, 2003).
New inactive status
Diplomates holding a valid certificate from the American Board of Thoracic Surgery (ABTS) and who expect to be clinically inactive for a period of one year or more may apply for inactive status. Applications must be made in writing to the board, and approved before the granting of inactive status. Activities calling for such status might include, but are not limited to, academic sabbaticals, advanced studies, elected/appointed political offices, temporary disability from illness, or appointment to administrative positions in hospitals, medical schools, or health-related industries.

There is no limit to the length of time that a diplomate can remain on inactive status, but by applying for inactive status, the diplomate certifies that he/she will refrain from the clinical practice of thoracic surgery for the entire duration of the inactive status. For more information on the new inactive status policy, visit the board’s Web site at www.abts.org.

Recertification policies
In response to an initiative by the American Board of Medical Specialties, the ABTS, along with the other medical certifying boards, has begun the transition towards a Maintenance of Certification Program®. Beginning in 2001, the ABTS changed some of its recertification policies. All diplomates should be aware of the changes in the requirements in anticipation of renewing their own certificates. The board feels that recertification is important to the public and to each physician’s professional career.

A valid ABTS certificate is an absolute requirement for entering the recertification process. The only pathway for renewal of a lapsed certificate will be to take and pass the Part I (written) and the Part II (oral) certifying examinations. The ABTS will no longer publish the names of individuals who have not recertified.

The deadline for submitting recertification applications is now May 10 of each year. The change will now allow diplomates to include continuing medical education (CME) hours earned from attending medical meetings that are held in the spring. Additionally, diplomates need to be in compliance with the annual certification maintenance fee in order to enter the recertification process. The CME requirement is 70 Category 1 credits in either cardiothoracic surgery or general surgery earned during the two years prior to applying for recertification. Additional information concerning recertification requirements can be found in the annual Recertification Booklet of Information.

In 2002, 230 diplomates recertified, of which 126 did so for the first time and 104 for the second time. One hundred seventy-three diplomates used the SESATS computer version and 57 diplomates used the paper and pencil version (see table, page 57).

Background
Diplomates certified after 1975 must recertify within 10 years of the date of the original certification in order to maintain their certification. Diplomates with time-limited certificates may apply within three years of the expiration of their certificate.

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

The annual certification maintenance fee is required of all active diplomates, age 65 and under. The cumulative fee helps defray administrative expenses related to maintaining and using the diplomate information on the board’s computer system. The board will not respond to inquiries about the diplomate’s certification status until the fee is paid each year.

Examinations
On November 24, 2002, the board administered its tenth criterion-referenced Part I (written) exam to 155 individuals. The pass rate for the examination was 86 percent. By using a criterion-referenced test, candidates are measured against a standard of knowledge predetermined by the board rather
than against each other, as in the case of a norm-
referenced examination.

The board administered its seventh criterion-
referenced Part II (oral) examination to 138 indi-
viduals on June 6-7, 2003. The pass rate for the
examination was 85 percent. By using a criterion-
referenced exam, the board applies statistical meth-
ods to equate the examination, so that alternative
forms of the examination are compared to a single
standard. The basic premise of a criterion-refer-
enced exam is that all candidates have a compa-
rable opportunity to pass since they are measured
against the same standard.

New pathways/requirements certification

On October 20, 2001, the ABTS approved the fol-
lowing resolutions regarding thoracic surgery cer-
tification. The exact timing of implementation for
some of the resolutions has yet to be determined.

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

2. One pathway to ABTS certification will con-
sist of successful completion of a full general sur-
gery residency approved by the Accreditation
Council on Graduate Medical Education (five
years) or the Royal College of Physicians and Sur-
geons of Canada, with or without ABS certifica-
tion, followed by successful completion of a two-
or three-year ACGME-approved thoracic surgery
residency. Individuals entering thoracic surgery
residencies in July 2003 or after will be eligible
under this pathway.

3. A second pathway to ABTS certification will
be a categorical-integrated six-year thoracic sur-
gery residency, to be developed by the Thoracic
Surgery Directors Association (TSDA). Residents

<table>
<thead>
<tr>
<th>Date of orig. cert.</th>
<th>Total # cert.</th>
<th>Total # recert. first time</th>
<th>% recert. first time</th>
<th>Total # recert. second time</th>
<th>% recert. second time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 1976</td>
<td>N/A</td>
<td>66</td>
<td>--</td>
<td>4</td>
<td>--</td>
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<tr>
<td>1976</td>
<td>160</td>
<td>142</td>
<td>89</td>
<td>128</td>
<td>80</td>
</tr>
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<td>1977</td>
<td>146</td>
<td>129</td>
<td>88</td>
<td>108</td>
<td>74</td>
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<td>1978</td>
<td>154</td>
<td>141</td>
<td>92</td>
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<td>1979</td>
<td>158</td>
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<td>91</td>
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<td>131</td>
<td>124</td>
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<td>111</td>
<td>85</td>
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<td>1982</td>
<td>159</td>
<td>147</td>
<td>92</td>
<td>126</td>
<td>79</td>
</tr>
<tr>
<td>1983</td>
<td>136</td>
<td>122</td>
<td>90</td>
<td>74</td>
<td>54</td>
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<td>135</td>
<td>125</td>
<td>93</td>
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<td>33</td>
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<td>119</td>
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<td>--</td>
<td>--</td>
</tr>
<tr>
<td>1994</td>
<td>156</td>
<td>57</td>
<td>37</td>
<td>--</td>
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</tr>
</tbody>
</table>
in these programs will be under the direction of the thoracic surgery program directors. Before this pathway is implemented, the residency review committee for thoracic surgery (RRC-TS) must first approve the standards and requirements for such programs. Individuals will match for such programs directly from medical school or at some later time. It is estimated that the first such programs would begin to accept residents in 2004 at the earliest.

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Time Required</th>
</tr>
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<tbody>
<tr>
<td>General surgery (including six months abdominal surgery and six months pediatric, oncology, and head and neck surgery)</td>
<td>12 months</td>
</tr>
<tr>
<td>Critical care</td>
<td>2 months</td>
</tr>
<tr>
<td>Transplantation and immunology</td>
<td>2 months</td>
</tr>
<tr>
<td>Trauma</td>
<td>2 months</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>3 months</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>3 months</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24 months</strong></td>
</tr>
</tbody>
</table>

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

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

6. The ABTS supports the following recommendations of the Joint Council for Thoracic Surgery Education (JCTSE):
   a. The JCTSE strongly encourages the RRC-TS as part of the special requirements for thoracic surgery residencies to require documentation of faculty participation in medical school curriculum.
   b. The JCTSE strongly encourages the ABS and Association of Program Directors in Surgery (APDS) to develop a shorter curriculum in "sur-

Applications

The deadline for submitting applications for certification is August 1 each year. The ABTS is no longer able to accept applications pending certification by the ABS. All requirements must be fulfilled at the time the application is submitted.

All residents who begin their training in 2001 or after must file their application and operative cases logs electronically through CTSNet. The board will allow residents who began their training in 2000 to file their cases through CTSNet (electronically) or by submitting a paper version. The board urges the program directors to help their residents in the application process by carefully reviewing the application before signing it.

Booklet of Information

Published annually, the Booklet of Information contains information about how the operative index case requirements should be recorded and tracked, which now has two components: surgical volume and index case distribution. All residents must perform an annual average of 125 major operative cases each year with a minimal number of 100 in any one year. Effective July 1, 2002, the board approved changes to the index of operative cases requirements for all candidates, which can be found in the latest Booklet of Information.
In-training examination
The 2003 in-training exam was held April 5 and April 12. A total of 353 individuals took the examination that was administered only online. The in-training examination consists of 80 general thoracic and 80 cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination. Score reports and comparative results were posted on the Internet for all test takers. The board encourages program directors and residents to use the in-training examination as an educational and self-evaluation tool.

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

New board members
At the 2002 fall board meeting, Valerie W. Rusch, MD, FACS, was elected to replace outgoing director William A. Baumgartner, MD, FACS, to represent the American Surgical Association on the board.
Virtual colonoscopy: What can we expect?
Abraham H. Dachman, MD, and Hiro Yoshida, MD, The University of Chicago Pritzker School of Medicine.

The exciting field of computed tomographic colonography, popularly known as virtual colonoscopy (VC), has progressed rapidly from the domain of research to clinical practice. Virtual colonoscopy is made possible by advances in computed tomography (CT) and computer technology that permit rapid, thin-slice acquisition of the entire abdomen and pelvis and real-time manipulation of volumetric images. VC typically uses CT to evaluate the colon for polyps or masses, although ongoing research using magnetic resonance imaging has had considerable success. A recently published multicenter trial generated renewed public interest because it was the first large clinical trial to conclude that VC was as good as optical colonoscopy for colorectal cancer screening and that it even detected some lesions missed on the initial optical colonoscopy.

There are two schools of thought regarding the best way to perform VC—either with or without the use of oral contrast for stool/fluid opacification. To date, the vast majority of studies have been done with an optimally cleansed colon and without having the patient ingest oral contrast. Radiologists prefer a “dry” prep, such as phosphosoda or magnesium citrate, rather than a colon lavage with polyethylene glycol, because large amounts of retained fluid can obscure polyps and masses. The colon is insufflated with air or carbon dioxide, either manually or with a mechanical pump, and scans are performed in both the supine and the prone positions. Changing from the supine to the prone position results in the movement of fluid and stool, thus facilitating a complete evaluation of the colonic mucosa and improving the radiologist’s ability to differentiate any retained stool from a polyp.

The alternative approach is to opacify residual fluid and stool with oral contrast. Ongoing research is evaluating the optimal method of opacification. The recently completed multicenter trial showed a by-patient sensitivity of 93.9 percent for patients with polyps 8 mm or larger. This trial employed a combination of oral barium and water-soluble contrast in conjunction with a unique software program that performed electronic subtraction of the high-density opacified stool and
fluid, resulting in a relatively “clean” colon. Images were evaluated with a 3D endoluminal fly-through of the colon with complementary 2D viewing that employed axial and multiplanar reconstructions. Most other investigators have used a more laborious viewing process for differentiating polyps from normal folds; in these studies, all the axial images were viewed as 3D images. There is controversy regarding whether 2D or 3D images enable optimal interpretation during the examination. This is important because most of the errors in VC are interpretive errors, with the polyps being visible in retrospect. This problem of interpretive errors, as well as problems associated with reader fatigue and time-efficient interpretation, may be solved through the use of computer-assisted interpretation of the images, in which a computer helps find the polyps (analogous to computer-aided diagnosis currently in use in mammography). The success of the trial published by Pickhardt and coworkers confirms the need for further research on stool opacification, electronic subtraction, and a comparison of 3D and 2D primary interpretation methods.

Controversies and advances aside, even before the recently published results became available, experts agreed that VC is the best test for patients whose optical colonoscopy is incomplete or who cannot undergo (or refuse to undergo) optical colonoscopy. It is also used to search for synchronous lesions in patients with an obstructing carcinoma. A VC and an infused CT for cancer staging can be done in one visit. A radiologist with proper training and expertise in interpreting the examination must be available. This requires considerable experience, and VC training opportunities for radiologists are still limited. The screening of asymptomatic patients with VC has been advocated, particularly in light of the fact that the vast majority of people in the U.S. have not been properly screened. VC has had a high degree of patient acceptance and preference because it is less invasive, does not require sedation, and can be done in an outpatient setting. Although mass screening with VC has not been advocated by experts, pending more published data, some academic centers and private practices now offer VC for colon cancer screening for patients who understand the limitations of CT compared with optical colonoscopy.

**Recommended reading**


**This month at ACS Surgery Online**

New and revised chapters are published each month online at www.acssurgery.com. This month, ACS Surgery Online features these new chapters:

- Health Care Costs: The Larger Context, by Charles L. Rice, MD, FACS, and Robert S. Rhodes, MD, FACS.
- Management of the Burn Wound, by David M. Heimbach, MD, FACS, and Nicole Gibran, MD, FACS.
- Parotidectomy, by Drew Ridge, MD, FACS, and Len Henry, MD.

whatsnew@webmd.net
Socioeconomic tips

New resource: ACS CodingToday
by the Division of Advocacy and Health Policy

During the summer of 2003, ACS Fellows received information about a new ACS-sponsored coding and reimbursement database, ACS CodingToday. The database was developed and is administered by Physician Reimbursement Systems (PRS), the same firm that provides the ACS Coding Hotline.

ACS CodingToday is designed to be a complete coding and billing tool for ACS Fellows. The database contains the following resources: all current Current Procedural Terminology codes with full descriptors; all ICD-9-CM diagnosis codes; the complete National Correct Coding Initiative (CCI) edits used by Medicare; and Medicare coding rules, including the fee schedule for each state and location, payment status of the code, modifier rules, and carrier-specific Medicare payment rules. In addition, the program offers researched advice on correct coding by code, when indicated, from the ACS’s General Surgery Coding and Reimbursement Committee. Using ACS CodingToday to determine proper coding and billing rules will assist surgeons in accurate and fraud-free reporting of their services for reimbursement.

ACS CodingToday is an Internet-based program. This delivery system was chosen by PRS because the firm believes the Internet is the best way to keep the Fellows informed of rules changes in a timely fashion. All information is housed in a safe, secure Web site and is updated immediately whenever any rules change.

To access the database, Fellows and their staff should go to www.ACSCodingToday.com. PRS suggests that viewers should initially download the database tutorial posted on the initial Web page in Adobe Acrobat (.pdf) format. Fellows should then register for a free trial period by clicking on the link, “Request a 10-day trial.” At this point, viewers will follow simple registration instructions to log onto the Web site as users.

Once logged in, users will find that ACS CodingToday is organized under five main tabs: CPT/HCPCS, ICD-9, Modifiers, Bundling, and ACS Notes. A snapshot of the Web page that displays bundling edits for an appendectomy is featured on page 63.

In the example shown, the highlighted main tab indicates that CPT/HCPCS information is displayed. Subtabs allow you to find more specific information about the procedure. Viewers can determine the Medicare fee schedule payments for the procedure in their geographic area, whether any CCI edits are associated with the procedure, which ICD-9-CM codes are recognized for the procedure, and whether there is any Medicare or private payor guidance currently available.

The illustration shows that you are viewing the bundling page under the CPT/HCPCS tab. Each code listed under the bundling tab is in hypertext. Users can click on a code once to view the CPT definition or click twice to view further the details. In the box titled “My Notes,” surgeons and their staffs may make any personal payor or coding notes pertaining to Medicare and private payors and re-
tain the notes for reference when they access the procedure code in the future.

In addition, a powerful search engine allows the user to search by partial word, partial number, or browse by topic as a reader would in the CPT book. The College anticipates that surgeons will find this new tool useful in carrying out their coding and billing activities.

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 e-mail HealthPolicyAdvocacy@facs.org.
Dr. Eberlein assumes leadership of JACS

Timothy J. Eberlein, MD, FACS, has been named Editor-in-Chief of the Journal of the American College of Surgeons (JACS). Dr. Eberlein succeeds Seymour I. Schwartz, MD, FACS, who will remain as Editor-in-Chief Emeritus. Wendy Husser will continue to serve as Executive Editor.

Dr. Eberlein is Bixby Professor and chairman, department of surgery, Washington University School of Medicine, St. Louis, MO. He is Spencer T. and Ann W. Olin Distinguished Professor and director, The Alvin J. Siteman Cancer Center, at Washington University. Dr. Eberlein also serves as surgeon-in-chief at Barnes-Jewish Hospital in St. Louis.

"It is a tremendous honor to assume the leadership of the Journal of the American College of Surgeons. JACS is approaching 100 years of publishing important findings that directly influence the science and art of surgery. The challenge for JACS, which represents the largest and most broadly based surgical organization, is to become even more meaningful for all our members and to do so in the context of the electronic age," Dr. Eberlein said.

Dr. Eberlein has been a Fellow of the College since 1988. He has served as a member of the Surgical Research and Education Committee since 1994 (Vice-Chair, 1998-2000; Chair, 2000-2002) and as a member of that committee’s Executive Committee, Corporate Research Roundtable (1994-2002). Dr. Eberlein has been a member of the Commission on Cancer since 1995, and of the ACS Committee for the Forum on Fundamental Surgical Problems since 1997 (Vice-Chair, 2000-present). He has served on the steering committee for the ACS Surgical Oncology Trials Group (1994-present) and is a member of the group’s Executive Committee. Since 1996 he has served as the College’s representative to the Inherited Susceptibility to Breast and Ovarian Cancer Task Force.

Dr. Eberlein obtained his medical degree in 1977 from the University of Pittsburgh (PA) School of Medicine. He was intern (1977-1978), and resident in surgery (1978-1979) at Peter Bent Brigham Hospital, Boston, MA. He was resident in surgery (1982-1983), senior resident in surgery (1983-1984), and chief resident (1984) at Brigham and Women’s Hospital, Boston.


On February 27-28, 2004, the American College of Surgeons hosted a summit on perioperative care, which was cosponsored by the American Society of Anesthesiologists and the Association of periOperative Registered Nurses. The purpose of the meeting was to bring together the leaders of organizations representing the members of the perioperative team to discuss the potential for organizational collaboration on issues of mutual concern as efforts are undertaken to ensure the safety of surgical patients. To that end, representatives from the American Association of Nurse Anesthetists, the American Association of Surgical Physician Assistants, the American Society of PeriAnesthesia Nurses, and the Association of Surgical Technologists were also invited to participate.

A number of shared themes emerged as a result of plenary and breakout sessions, which focused on public information and education, communication and teamwork, and coordination of guideline development. Issues related to these themes included public awareness, a shrinking skilled workforce and untrained personnel, the introduction of new technology and use of simulators, leadership development, and identifying preventable causes of errors along with close-call reporting. Dialogue will continue as the groups work together to improve communication and teamwork in the perioperative setting. For more information online, contact trussell@facs.org or bdean@facs.org.
ACS Insurance Program: Update on major medical products

The Trustees of the American College of Surgeons Insurance Program approved a rate increase for participants under age 65 and their dependents on the conventional major medical product and on the cost advantage major medical product of 25 percent and 30 percent, respectively, effective October 1, 2003, and 5 percent effective April 1, 2004. There will be no increase for members age 65 and over at this time. The premium rates for these products are based primarily on the actual claim experience of the ACS risk pool, which recently has not been favorable. The Trustees feel that New York Life Insurance Co., the insurer, and CBCA administrators, the plan administrator, provide quality services to our members. However, the approximate 850 plan participants is a relatively small risk pool and, as a result, the College’s products may not always be cost-competitive when compared to other products that have a much larger risk pool as a basis for their rate setting. If premium cost on your major medical coverage is a concern, the Trustees encourage you to compare the American College of Surgeons Insurance Program major medical cost with other products available to you in the market. Our members should make the appropriate decision that best suits their insurance needs.

If you have any questions, please contact the plan administrator at 1-800/433-1672.

EMTALA, CONTINUED FROM PAGE 22

Americans every day. As such, legitimate EMTALA services would then become a mandatory covered benefit under both Medicare and private health insurance plans, hospitals and physicians would receive reasonable liability protections for treating emergency and severely injured patients, and funding would be increased to help properly staff emergency rooms so that patients are evaluated and triaged quickly and appropriately.

Acknowledgement

I would like to thank the American College of Surgeons’ Committee on Trauma and members of the staff from the College’s Division of Advocacy and Health Policy for providing me with a wealth of background and resources. Their efforts greatly assisted me in writing this article.

References


Correction

The January issue of the Bulletin featured an article titled “The Swedish Patient Compensation System: A viable alternative to the U.S. tort system?” by Susan Hershberg Adelman, MD, FACS, and Li Westerlund, J D. The academic titles for Dr. Westerlund should have read “J D, LLM, PhD.” The editors regret the omission.
Announcing a new instructional CD-ROM

"I welcome the CD-ROM published this month by Dr. Buchwald and Dr. Ikramuddin, both international leaders in the field and faculty members at the University of Minnesota, the institution that has provided the most leadership in the development of this remarkable field. It provides excellent basic knowledge that can serve as an introduction for budding bariatric surgeons, as a review for those who are already in the field, as an overview for our nonsurgical colleagues."

— Walter J. Perry, MD, FACS

"Every general surgery training program, indeed, every general surgeon, has a need to be well-informed in bariatric surgery. This disk, presenting the very best of basic bariatric surgical knowledge, brings the viewer extremely close to the subject and provides him/her with a good intellectual grasp of the field. It is a must-have enduring educational gem."

— George S. Cousar, MD

by Henry Buchwald, MD, PhD, FACS
and Sayeed Ikramuddin, MD, FACS

Bariatric Surgery Primer

Course objectives:

- Describe the epidemiology, etiology, incidence, and demography of morbid obesity, and outline the energy metabolism and biochemistry of obesity, as well as the physiologic basis for bariatric surgery.
- Identify appropriate candidates for bariatric surgery and to discuss the pre-, intra-, and postoperative care of the bariatric patient, as well as patient selection, assessment, and preparation.
- Identify and clearly discuss the following bariatric procedures: laparoscopic adjustable gastric banding, vertical banded gastroplasty, gastric bypass, biliopancreatic diversion/duodenal switch, and gastric pacing.
- Describe the comorbid conditions of morbid obesity and the outcomes following bariatric surgery.
- Describe the training of the bariatric surgeon, the bariatric surgical and allied sciences team, and requisite hospital facilities, aspects of managed care, and liability issues in this field.
- Discuss the ethics of bariatric surgery.

For more information, contact Dawn Pagels at dpagels@facs.org, or tel. 312/202-5185

American College of Surgeons • Division of Education
with the American Society for Bariatric Surgery
Among the works of art that have taken up interim residence at 633 N. Saint Clair during the Murphy Memorial building renovation is a piece that was created in the likeness of a little known figure in the history of the College. The piece is a bust of F. Byron Robinson, MD, and now resides on the twenty-eighth floor of College headquarters. That the College should have a bust of Dr. Robinson has aroused some curiosity, since apparently no one at the College knew anything about him. But recently, in processing records on the College's buildings, I discovered a file that contained some information on him.

Dr. F. Byron Robinson was an internationally famed physician and surgeon who practiced medicine in Chicago at the end of the nineteenth and the beginning of the twentieth centuries. He died in 1910, three years before the College was born, which explains why he is not listed among the College founders. Although it should be noted that Dr. Robinson's background very nearly duplicates that of Franklin H. Martin, MD, FACS, founder of the College, who, as a friend and contemporary, mentions Dr. Robinson in his autobiography, The Joy of Living.

Dr. Robinson was born in 1854 on a farm near Hollandale, WI, and graduated from the University of Wisconsin with a bachelor of science degree in 1878. He taught school for a few years in both Ashland and Black Earth, WI, before entering Chicago's Rush Medical College. Robinson later became a professor of gynecology at the Chicago Post Graduate Medical School, before becoming a professor of gynecology and abdominal surgery at the Illinois Medical College. A long inscription on the bust includes the words “Byron Robinson, a gift of his students,” confirming the esteem in which he was held.

According to an article published in the Wisconsin Rapids, WI, Daily Tribune in 1967, “Robinson achieved world fame for his studies in anatomy and gross pathology in Chicago, between 1891 and 1910. His studies and research on the great sympathetic nerve (the abdominal “brain”), until then only a conjecture, proved of far reaching scientific value as he worked tirelessly to increase his knowledge.”

The bust had a place of honor at the University of Chicago until the institution moved, and the piece was sold. Many years later Benjamin H. Orndoff, MD, FACS, recognized the bust in an antique shop, purchased it, and presented it to the College as a gift. Two years before Dr. Robinson's death, he contributed some land to the city of Wisconsin Rapids, WI, where he practiced from 1882 to 1888, for development of a park, and the 19-acre site is currently a fitting memorial to his early years there. Having a place within the walls of the American College of Surgeons for Dr. Robinson's likeness is another fitting memorial to his contribution to the science of surgery.

For more information regarding the ACS Archives, contact Susan Rishworth at 312/202-5270 or via e-mail at srishworth@facs.org.

NTDB™ data points

The lethality of intent

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

This month we continue to explore the transition to the use of the external cause of injury code (E-code) groupings that were developed by the international injury prevention community. When we take a look at the various intent groupings and their associated number of deaths, we see a sobering picture. The two major intentional injury groups have a significantly higher lethality when compared to the unintentional group. This lethal trend is depicted in the graph on this page.

The assault grouping has a one-and-a-half-fold increase in percentage of deaths, while the self-inflicted group has a staggering six-fold increase in lethality.

Many of us who work in trauma centers are aware that this final self-event is not always the patient’s first attempt. There is a much larger group of patients who survive their self-inflicted event. In the records contained in the Annual Report for 2003 of the National Trauma Data Bank™, the survivors account for 75 percent of this category.

Although there are no official statistics on attempted nonfatal actions, it is estimated from data collected by the Centers for Disease Control and Prevention that there are at least eight to 20 attempts for each death by suicide. This finding places an additional responsibility on trauma care providers when caring for this group of patients.

For the 75 percent of survivors, we are obligated to not only initiate the necessary injury-related treatment, but also take into account the need for treating the patient’s mental health. With timely intervention and counseling, we may be able to have an impact on decreasing repeat attempts in the future.

While the NTDB reports on records it contains, these data represent real patients and real opportunities for intervention and prevention. By initiating and tracking prevention strategies that target this self-intent group, we should see with time a decrease in the number of self-inflicted records per year reported to the NTDB.

Throughout the year we will be highlighting these data through brief monthly reports in the Bulletin. For a complete copy of the NTDB Annual Report 2003, visit us online at http://www.facs.org/trauma/ntdbannualreport2003.pdf.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.
Chapter news

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

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

New York announces programs

The New York Chapter hosted a Legislative Day in Albany on Tuesday, March 16, in conjunction with a several statewide surgical and medical specialty societies. The briefings for the New York Chapter members and orthopaedic surgeons were provided by Heather Bennett, JD, Executive Director. In all, about 15 participated in the legislative visits (see photo, right).

The New York Chapter also announced the availability of a new practice management workshop. Entitled “HIPAA Security: Rule Requirement and Implementation,” the workshops will be held 4:00 to 7:00 pm on June 3 (Buffalo) and June 4 (Syracuse). To register or for more information, contact the New York Chapter at 518/433-0397.

2004 Leadership Conference

The 2004 Leadership Conference for Young Surgeons and Chapter Officers will be held May 16-18, in Washington, DC. The preliminary agenda and topics include:

Sunday, May 16: Concurrent sessions:
- Chapter Leaders—Member Issues and Strategies.
- Young Surgeons—Dealing with Change: Leadership Skills to Overcome Obstacles.
- Chapter Executives—Legal Issues and Problem Solving.

Monday, May 17:
- Keynote Address: The Consequences of Uninsurance. Shoshanna Sofaer, PhD, Baruch College, New York, NY.
- Panel Discussion: Quality Measurement and Improvement, and Pay-for-Performance. Steve Jencks, MD, MPH, director, Quality Improvement Group, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, Washington, DC; Gerry Shea, Assistant to the President for Government Affairs, Washington, DC; Allan M. Korn, MD, FACP, senior vice-president/chief medical officer, Blue Cross and Blue Shield Association, Chicago, IL; and Helen Darling, president, National Business Group on Health, Washington, DC.

Tuesday, May 18: Briefings, Capitol Hill visits, depart.

For more information about the 2004 Leadership Conference, or to register, contact the ACS Chapter Hotline at 888/857-7545, or visit the ACS Chapter home page at http://www.facs.org/about/chapters/index.html.

Chapter anniversaries

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College meets with IOM officials to discuss future of emergency care

On March 3, J. Wayne Meredith, MD, FACS, Chair of the ACS Committee on Trauma, met with Institute of Medicine (IOM) officials to discuss their new project, “The Future of Emergency Care in the U.S. Health System.” The College has accepted an invitation from the IOM to advise the project’s committee as it studies the challenges and opportunities facing the U.S. emergency care system, and recommends strategies to ensure that all Americans receive the best possible emergency care in the future. C. William Schwab, MD, FACS, University of Pennsylvania Medical Center, serves on the committee. For more information online, go to: http://www.iom.edu/project.asp?id=16107.

Next month in JACS

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

Original Scientific Articles
• Pancreatic Resection in the Elderly
• VA Study on Breast Cancer Surgery

Ravdin Lecture
• Immunotherapy for Cancer Patients

What’s New in Surgery
• Cardiac Surgery
• Trauma and Critical Care