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VOLUME 89, NUMBER 8, BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
From my perspective

A little more than two years ago, the American College of Surgeons established an affiliate organization with a more flexible 501(c)6 tax-exempt status—the American College of Surgeons Professional Association (ACSPA). This group’s first and most significant initiative to date has been the creation of a political action committee (PAC), ACSPA-SurgeonsPAC. This seems like a good time for an update on this restructuring and its achievements.

Why was the PAC formed?

The impetus for establishing the ACSPA-SurgeonsPAC was a proposal from the Board of Governors’ Socioeconomic Affairs Committee. The members of this committee believed that surgery needed a representative PAC to strengthen the profession’s grassroots advocacy efforts and to bring it in sync with other medical organizations that are attempting to influence health policy.

Over the course of several years, the Governors’ committee had attempted to encourage the Board of Regents to form a PAC. During the course of the debate, it became increasingly apparent that surgical practice was becoming more entrenched in politics and that the vast majority of health policy decision makers and advisors were from outside of the surgical community. Hence in 2001, the Regents acknowledged that we needed to make the changes that were necessary to establish a PAC to represent the surgical perspective.

Because of its restrictive tax-exempt status as an educational and philanthropic organization, a PAC could not be established within the College’s existing structure. So an affiliate organization with a different tax status was developed, which could work independently to cultivate the resources necessary for surgeons to have greater leverage over the evolving economic and political forces affecting the profession.

Why it’s important

Obviously, many of the current dilemmas facing the medical profession, such as the professional liability crisis, reductions in reimbursement, burdensome regulations, and federal funding for trauma systems, to name a few, must be addressed through political activism, either in Washington, DC, or in the individual states. Therefore, our profession must have access to legislators, and we must be able to support political candidates who have a health policy agenda consistent with what we believe is necessary to care for the surgical patient. A PAC is one of the most valuable tools available to accomplish these goals.

Surgeons also need to support colleagues who want to run for political office. So far, ACSPA-SurgeonsPAC has given financial assistance to a number of surgeons at the federal level, including Senate Majority Leader Bill Frist, MD, FACS (R-TN), and Rep. Michael Burgess, MD, FACS (R-TX).

How it functions

The ACSPA-SurgeonsPAC is governed by a Board of Directors that determines which members of Congress best represent surgeons’ policy objectives and, therefore, should receive PAC contributions. At this time, the board is ably chaired by Andrew Warshaw, MD, FACS, and is composed of 18 members drawn from all of the surgical specialties and all areas of the country (see roster on page 4). In deciding which candidates to support, the board considers their voting record, leadership...
positions, membership on key health care committees, and whether they are in the medical profession. Since January 2003, the PAC has donated $309,000 to 100 candidates and has raised close to $450,000.

To donate to the PAC, a surgeon must be an active ACSPA member in the U.S. who is still in practice. We anticipate that as surgeons become more comfortable with the PAC and more attuned to the political realities that affect their ability to practice, all of the College's eligible members will become involved in this process.

**PAC support**

ACSPA has determined that if every eligible member contributes $250 to the ACSPA SurgeonsPAC, it will superecede the trial lawyers in their annual giving. Other medical organizations, such as the American Society of Anesthesiologists and the American Academy of Ophthalmology, have found that their success in achieving positive results for their specialties has increased partly because their members have supported their PACs. ACSPA is currently making telephone calls to all its members in an effort to reach this full potential.

All of us can clearly articulate the problems affecting the surgical profession, not only in terms of quality of care, patient safety, and the adequacy of competence of the surgical workforce, but also with respect to the political, economic, and regulatory environment in which we practice. It is appropriate that surgeons point out these problems and the negative results that are associated with them. However, complaining and whining about the state of our profession does not generate positive solutions.

Much of what we need to do today and in the future revolves around influencing the political climate and creating the will to change. To stimulate a dialogue and to effect change, we must be political players. Clearly, the ACSPA-SurgeonsPAC is one of the more persuasive tools available to surgeons. The ACS cannot be involved in PAC solicitations, so information about the PAC is available on its separate Web site, at [http://www.facs.org/acspa/index.html](http://www.facs.org/acspa/index.html).

These are turbulent times. Without a robust effort to affect the political process, surgeons will be further disadvantaged. I encourage each of you to become educated about the issues and actively involved in the process in tangible ways.

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*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
ACS Career Opportunities
The American College of Surgeons’ online job bank

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Dateline Washington

New Jersey to tax surgical procedures

In a misguided attempt to fill New Jersey’s budget gap, the state legislature passed and the governor is expected to sign two bills taxing cosmetic surgical procedures and gross receipts of ambulatory care facilities, including surgery centers not licensed to a hospital. The bills, A. 3125 and A. 3127, would assess a 6 percent gross receipts tax on cosmetic procedures defined by the state as any treatments that do not meaningfully promote the proper functioning of the body or prevent or treat illness or disease. For ambulatory surgical centers, there would be a 3.5 percent gross receipts tax on facilities with gross receipts higher than $300,000.

The College’s New Jersey Chapter has developed a statewide coalition effort to overturn both of these arbitrary and discriminatory tax bills and to prevent further expansion of these punitive activities.

ACS comments on anti-referral regulation

The College has submitted comments on a regulation issued by the Centers for Medicare & Medicaid Services (CMS) that implements additional provisions of the physician self-referral law, commonly known as the “Stark” law. In the comments, the College expresses support for several newly created exceptions to the law that should be helpful to surgeons, including physician ownership or investment in rural area providers, intra-family referrals in rural areas, physician investment in publicly traded securities and mutual funds, and participation in a community-wide health information system.

Despite the College’s previous protestation, CMS has maintained its proposed definition of “referral” to include “incident to” services, meaning that those services performed by a physician’s employees, even if under the direct supervision of the physician, are still subject to the Stark law. The College also reminds CMS that, even with the new exceptions and clarifications provided by the rule, applying the law to particular scenarios will continue to be problematic due to its complexity. Accordingly, the comments ask that CMS persist in refining these regulations to further simplify compliance and reduce the risk of unintended violations.

Uninsured patients sue not-for-profit hospitals

In June, plaintiffs’ attorneys announced that class action lawsuits have been filed against large not-for-profit hospitals in eight states by uninsured patients who claim that the hospitals intentionally failed to provide charitable care as required by their tax-exempt status. The American Hospital Association (AHA) was named as a conspirator for providing advice and assistance to the defendants on matters such as billing and collection practices involving the uninsured. The uninsured patients allege that the hospitals charged them “sticker” prices for health care that were higher than those paid by any other patient group and then subjected them to harassment and aggressive collection practices.

The defendant hospitals are charged with breaches of contract, breaches of good faith and fair dealing, breaches of charitable trust, and consumer fraud and deceptive business practices. They also are accused of violations of the Emergency Medical Treatment and Active
Labor Act, unjust enrichment, civil conspiracy, conspiring with the AHA, and aiding and abetting in the breach of their tax-exempt agreements. According to the attorneys, similar cases will be filed against major hospitals in other states in the near future. Additional information can be accessed at www.nfplitigation.com or www.cliffordlaw.com/notforprofit/disclaimer.aspx.

A press conference introducing legislation that would provide for Medicare coverage of ultrasound screening for abdominal aortic aneurysms (AAA) was held June 23 on Capitol Hill. Robert Zwolak, MD, FACS, was the lead speaker at the press conference. H.R. 4626/S. 2553, the Screening Abdominal Aortic Aneurysms Very Efficiently (SAAAVE) Act, is a bipartisan effort cosponsored by Reps. Jim Greenwood (R-PA) and Gene Green (D-TX) and by Sens. Jim Bunning (R-KY) and Chris Dodd (D-CT). The College is a member of the National Aneurysm Alliance (NAA), which was formed to support the passage of a Medicare screening benefit for AAA. More information about this legislation and the NAA can be found at http://www.ScreenAAA.org.

More than 53 million Americans, or 18.6 percent of the population, were uninsured for at least part of 2003, according to estimates from the Centers for Disease Control and Prevention’s (CDC’s) latest National Health Interview Survey. That includes 23.8 percent of working-age adults and 13.7 percent of children under 18. About 15.2 percent were uninsured at the time of the survey, while 10 percent had been uninsured for more than a year, including 2.5 million more working-age adults than in 2002.

About one in 10 children were uninsured at the time of the survey, while 13.7 percent were uninsured for at least part of the past year and 5.3 percent for more than a year. The CDC attributed improvement in the rate of children’s health insurance coverage since 1997 to an increase in public coverage for poor and near-poor children, including the State Children’s Health Insurance Program. For more on the survey, visit http://www.cdc.gov/nchs/.

The CMS has several communications tools on its Web site that hospital staff and others may use to help Medicare patients understand the details of choosing Medicare-approved drug discount cards. The Web site features an 8-½ × 11-inch poster that can be downloaded and printed in Spanish or English and displayed wherever patients will see it, such as in waiting areas, exam rooms, cafeterias, lobbies, elevators, and pharmacies. The posters also can be ordered from CMS in 17 × 22-inch versions. The CMS site also includes two “tip” sheets: a Drug Discount Card Enrollment Tip Sheet (#11076) that shows patients how to enroll for a Medicare-approved drug discount card, and a Medicare-Approved Drug Discount Card Tip Sheet (#11071) that provides guidance for counselors, caregivers, and intermediaries who help people with Medicare compare and choose drug discount cards. These and other tools are available at www.cms.hhs.gov/medlearn/drugcard.asp.
What surgeons should know about...

...the next step for quality measurement: Paying for it!

by Jean A. Harris, Associate Director, and Barbara Cebuhar, Communications Specialist, Division of Advocacy and Health Policy

In the May 2004 issue of the Bulletin, ACS Executive Director Thomas R. Russell, MD, FACS, wrote about the College’s continuing efforts at quality improvement for surgical patients by measuring outcomes in a risk-adjusted way. The next move is to use quality measures to develop a pay-for-performance (P4P) model. The P4P is a concept that was implemented in manufacturing circles in the 1980s and 1990s to increase efficiencies and reduce costs. This system of paying more for services that meet higher measures of quality and predictability is rooted in the executive compensation and economic literature by Oliver Hart and Bengt Holmstrom. This article explores some concerns about P4P.

Who is advancing P4P and why?

Employers, faced with rising costs for employee health care benefits that add significant expense to their products, are concerned about staying competitive in a global economy. Health plans are anxious to reduce complications and errors that add to costs and raise the price of health insurance premiums. Certain payors, such as Medicare, are faced with providing care for a growing number of aging baby boomers and are trying to find ways to stretch program dollars by paying for better outcomes.

To help address some of their concerns, a coalition of 154 employers formed the Leapfrog Group, which has proposed standards for large purchasers (such as General Motors, 3M, and other corporate giants) to use as part of their contracting efforts for employee health plans. Leapfrog’s first proposals, which generated substantial controversy, included encouraging use of higher volume facilities for certain procedures, of hospitals that have invested in intensivists, and of hospitals that have computerized physician order entry software. Leapfrog has indicated that when the College completes validating the U.S. Department of Veterans Affairs’ (VA) National Surgical Quality Improvement Program (NSQIP) for use in community hospitals, they are willing to drop other process and structural measures and replace them with NSQIP. See the accompanying text box on page 9 for a description of NSQIP.

How many payors are using P4P?

Most major health plans are testing primary care programs, such as the employer-sponsored “Bridges to Excellence” program, which rewards physicians who adhere to diabetes and heart disease protocols. Medicare is partnering with the Premier Health System, which intends to demonstrate that they can improve 32 clinical measures over a three-year period. If these improvements occur, Premier hospitals will receive up to 2 percent more of their Medicare receivables. Those hospitals that fail to make the necessary improvements could be at risk of payments reduced by 1 to 2 percent.

The Center for Studying Health System Change (HSC) regularly makes visits to 12 sites to track changes in local markets, ranging from Greenville, SC, to Orange County, CA. In their 2002-2003 vis-
its they found seven sites had P4P programs. They tended to be sponsored by payors that have a large share of the market. HSC also reported little consistency among the programs in terms of what was measured, the incentive payment structure, or the size of the incentive.5

What kinds of clinical measures or data are being used?

The National Quality Forum (NQF) develops a consensus among the various stakeholders—purchasers, providers, consumers, and research organizations—on standardized quality measures. Plans are encouraged to select their quality measures from among those adopted by NQF.6 Performance is assessed using claims data as well as data obtained through chart review. Physician performance may be tracked by evaluating adherence to preventive protocols (such as immunizations and cancer screenings) and certain chronic disease interventions (such as retinal examinations and testing for glycosylated hemoglobin levels for diabetic patients). These measures will be updated or dropped based on the ongoing evaluation of scientific evidence.

Are other factors measured?

Some health plans use patient satisfaction measures for both physicians and hospitals. Others use standardized patient safety measures, such as the Safe Practices for Better Healthcare from the NQF.

How would payment work?

Two general approaches are used. One withholds a percentage of the payout on individual claims to finance periodic bonus payments; the other affects the amount of the annual update a provider gets, so the payment for a given procedure varies by provider. A typical arrangement is for providers in the top two deciles to “win,” and providers who find themselves in the bottom two deciles to risk loss of money. So far, the amounts of money in play have been on the order of 1 to 5 percent, although in Great Britain almost one-third of a general practitioner’s income could depend on recently introduced quality incentives.7

There are also plans for a Medicare demonstration project that divides responsibility and incentives for quality care between the hospital and the surgeon. The Virginia Cardiac Surgery Initiative plans to use risk-adjusted data from the Society of Thoracic Surgery’s database to assess the quality of outcomes from certain cardiac procedures.

How do we come up with a discrete set of universally understood quality measures?

There is a real need for standardization of measures. Although it does not involve P4P, Medi-
care has a three-state pilot project that is a major step toward the goal of standardization. As a result of the collaboration of the Centers for Medicare & Medicaid Services (CMS), the Quality Improvement Organizations (QIO) in Arizona, Maryland, and New York, and all hospitals in those states, the pilot project will test various methods of public reporting of quality data. The three states will have a standardized set of data to report. There will be field-testing of the survey of patient satisfaction with the hospital and the pilot will test various ways to communicate quality information with the public. As part of the QIO’s 8th Scope of Work, there is a plan to have those measures implemented nationwide.

NSQIP has a single hub where the data are manipulated in a standardized manner. A single point for data storage and processing has not been identified for nonsurgical data.

Are individual surgeons measured as part of these P4P efforts?

So far, the P4P programs that have received the most press attention have been either programs that measure quality at hospitals or programs aimed at preventive and chronic care in primary care offices. If NSQIP proves to be successful in all types of community hospitals and becomes a platform for P4P, we anticipate that all surgeons on a hospital’s surgical service will receive the same clinical score. Individual surgeons will receive their own patient satisfaction score.

What should surgeons do if a payor starts talking about a P4P system for surgeons?

It seems that, in spite of all the potential problems, P4P is here to stay. But only a valid, well-designed P4P system should be used. These are some points to consider:

- All measurements should be evidence-based, relate to the quality of the service, and on the list of approved measures maintained by the National Quality Forum (NQF). See the list of measures at http://www.qualityforum.org.

The Medicare Premier Hospital Quality Incentive: Demonstration Surgical Measures*

The Medicare Premier Demonstration covers coronary artery bypass graft (CABG) and hip and knee replacements (HKR).

- CABG using internal mammary artery (CABG only)\(^1,4\,^P\)
- Prophylactic antibiotic selection \(^2,7,8\,^P\)
- Prophylactic antibiotic received within one hour prior to surgical incision \(^1,2,8,^P\)
- Prophylactic antibiotics discontinued within 24 hours after surgery end time \(^1,2,8,^P\)
- Inpatient mortality rate \(^5,^O\)
- Postoperative hemorrhage or hematoma \(^6,^O\)
- Postoperative physiologic and metabolic derangement \(^6,^O\)
- Aspirin prescribed at discharge (CABG only) \(^3\,^P\)
- Readmissions 30 days post discharge (HKR only) \(^7,^O\)

1. National Quality Forum measure
2. QIO 7th Scope of Work measure
3. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Core Measure
4. The Leapfrog Group
5. Risk adjusted using 3M™ All Patient Refined Diagnosis Related Group (DRG) methodology
6. Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators and risk adjusted using AHRQ methodology
7. Medicare beneficiaries only
8. QIOs and/or JCAHO to align with this measure in 2004

P. Process measure
O. Outcomes measure

*Web site: http://cms.hhs.gov/researchers/demos/phqidemo.asp; click on “clinical areas & quality measures.”
• Elements measured should be under the surgeon’s control rather than the hospital’s control.
  • Start small with P4P, picking a very limited number of measures and have a very small amount of money at risk.
  • The money paid out in P4P should go to the surgeon and not to the hospital to be redistributed to the surgeons.
  • The program should reward both those with high quality scores and those with the most improvement.
  • Pay attention to the details and think about whether the concepts would work in the day-to-day practice of surgery.

Has any legislation been considered that has P4P implications?

Sen. Max Baucus (D-MT) recently introduced legislation that would set up two different P4P programs in Medicare in 2008. One would reward Medicare Advantage health plans, and the other would reward dialysis facilities. Annual bonuses would go to those centers that had high quality scores as well as those that improved their performance the most. The bill requires that all measures be evidence-based. The bonus system would be budget neutral and financed from a payment withhold of 2 percent. The bill obviously will not be passed this year because Congress is adjourning early for the elections. However, its introduction shows that Congress is ready to debate P4P next year, after the elections.

References
2. Website: http://www.leapfroggroup.org/FactSheets.htm.
Laparoscopy at sea: Overcoming unique challenges

by

Lt. Cdr. David S. Thoman, M D, FACS,
San Diego, CA
Surgical procedures may be performed aboard several different classes of U.S. Navy vessels. The most advanced are the two hospital ships, the USNS Mercy and the USNS Comfort. These ships are essentially floating 1,000-bed hospitals with fully manned 12-room operating suites. There is arguably little difference between medical care rendered here and in civilian hospitals. However, the aircraft carriers and amphibious assault ships represent more austere environments in which performing operations is possible but with certain limitations.

The aircraft carrier's mission is to provide forward deployed offensive capability. Surgical support, including one operating room and three intensive care beds, is intended only for the crew of the ship and the surrounding support ships in the carrier battle group. Amphibious assault ships are either LHA class (general purpose) or LHD class (multi-purpose). The LHD class is newer and larger with six operating rooms and 17 intensive care beds. However, the medical manning is identical to the LHA class. The amphibious assault ship travels in an amphibious readiness group (ARG), which typically includes at least two other ships. The ARG transports and supports a Marine expeditionary unit, along with all of their equipment and aircraft. Similar to the carriers, the amphibious ships provide medical support to their crew and to the smaller ships traveling with them. However, the main reason these ships have surgical capability is to care for the U.S. Marines who may become injured ashore during their missions.

The USS Tarawa is an example of an LHA class, and is where the subsequently described procedures were performed. The LHA class has four operating rooms, of which two are typically functional. The ship deploys with a general surgeon, nurse anesthetist, two primary care physicians, several general medical officers, an operating room nurse, and a critical care nurse. Additionally, approximately 30 hospital corpsmen fill roles in various areas including the pharmacy, preventive medicine, X-ray technology, the laboratory, the blood bank, surgical technology, and medical records administration. During times of conflict, additional personnel may be added, including general surgeons, orthopaedic surgeons, anesthesiologists, intensivists, nurses, and corpsmen.

The operating rooms are equipped with modern anesthesia and monitoring equipment, along with most instruments required for general, vascular, and thoracic operations. Basic orthopaedic and neurosurgical instruments are also available. The OR houses a laparoscopic tower with camera, light source, insufflator, and monitor. The USS Tarawa was fortunate to have both 0° and 30° 5-mm and 10-mm laparoscopes, along with two reusable 5-mm working ports. Laparoscopic instruments included several graspers, two Maryland-type dissectors, scissors, and a 10-mm stone scoop (see Figure 1, page 14). Several disposable 5-mm and 10-mm working ports were procured before departure.

The table on this page lists the procedures performed on the USS Tarawa during four months of its 2003 western Pacific deployment, which included participation in Operation Southern Watch and Operation Iraqi Freedom. The following cases are representative and illustrate how certain unique challenges may be overcome.

Case number one

An 18-year-old female presented to the medical officer on a nearby ship with severe left lower quadrant pain. A white blood cell count was taken and was normal. She was diagnosed with gas pain and given an injection of ketorolac. This treatment provided only minimal relief, and she was flown to the USS Tarawa for surgical evaluation. On arrival, the pain had been present for 15 hours and was unrelenting. Examination revealed evidence of peritoneal irritation and she was taken emergently to the operating room. The presence

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number</th>
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<tbody>
<tr>
<td>Appendectomy</td>
<td>4</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>3</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>4</td>
</tr>
<tr>
<td>Salpingo-oopherectomy</td>
<td>1</td>
</tr>
<tr>
<td>Varicocele ligation</td>
<td>3</td>
</tr>
<tr>
<td>Diagnostic laparoscopy</td>
<td>1</td>
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of a 7-foot swell required the surgical team to take some extra measures in securing all equipment and the patient (see Figure 2, page 15). A laparoscope was placed via a 10-mm working port at the umbilicus. Abdominal visualization quickly demonstrated the problem, which was an ovarian torsion secondary to a 4-cm cyst. Five-mm working ports were placed on either side of the lower abdomen. The point of torsion involved the Fallopian tube and proper ovarian ligament. An 0-Chromic suture was tied intracorporeally just proximal to the torsion using two Maryland dissectors. An 0-Vicryl suture ligature was then placed past the tie, using the Maryland dissector as a needle driver. The tube and ovary were then excised and placed into a plastic sandwich bag, which had been previously sterilized in activated dialdehyde solution. This facilitated removal from the 10-mm umbilical port with minimal enlargement. The patient had only slight incisional pain after surgery. She was observed on the ward until postoperative day two, when her pain was controllable with only ibuprofen. She was flown back to her ship on day four and returned to work on postoperative day six.

Case number two

A 30-year-old male was seen at a Kuwaiti hospital for right upper quadrant pain. A mildly increased bilirubin was noted, and an ultrasound demonstrated gallstones with a thickened gallbladder wall and a normal common bile duct. Laparoscopy was not available locally, and he was flown to the USS Tarawa in the Northern Arabian Gulf. Laparoscopic cholecystectomy was performed routinely, although lack of a clip applier or cholangiogram catheter required some modifications. The cystic duct was dissected free and tied-off just under Hartmann's pouch with an 0-Chromic tie. The cystic was then partially incised and a grasper was used to “milk back” bile from the common bile duct. The presence of free-flowing golden bile without debris gave some reassurance that common duct stones were not present.

The cystic duct stump was then tied off with a pair of 2-0 silks. The cystic artery was tied off with a 2-0 silk proximal and cauterized distally. Because of the theoretic concern of a power density being created at the tie when cautery is used in this fashion, it was applied to the individual branches just off the gallbladder. The rest of the procedure was performed routinely. The patient was observed for four days on the ward, at which time he required only ibuprofen for pain relief. He was returned to full duty on postoperative day eight.

Case number three

A 21-year-old male with three weeks of left inguinal pain and bulge was transferred from another ship for evaluation. He had a history of
A bilateral inguinal hernia repair at age two. Examination revealed a moderate-size left inguinal hernia. He was taken the next day for laparoscopic bilateral hernia repair. Neither a balloon dissector nor Hasson canula were available. A purse-string suture was placed in the anterior rectus fascia and generous finger dissection was performed. A 10-mm disposable port, which had been salvaged and resterilized, was then tied in with the purse string. The laparoscope and insufflation were used to create the preperitoneal working space. Five-mm ports were then placed into this space from either side of the lower abdomen. Dissection was performed routinely and a moderate-size left indirect hernia was reduced. Two separate pieces of 12-cm × 10-cm polypropylene mesh were fashioned with a slit and passed into the abdomen to cover either myopectineal orifice. A clip applier was unavailable; therefore, a 2-0 Vicryl suture was used to fix the two pieces of mesh together in the midline at two places, as well as gently tacking them to the anterior rectus muscle fibers (Figure 3, page 16). Dessufflation was performed under direct vision to assure the mesh remained in position. He was returned to his ship on postoperative day four and resumed full duty the next day taking only ibuprofen.

Case number four

A 22-year-old male was transferred from a nearby ship with a painful scrotal mass. Examination revealed a left, grade III varicocele. An inguinal approach would require a Doppler probe, which was unavailable. However, a Medline search revealed several series reporting excellent results with a laparoscopic approach.1,2 I explained to the patient that I had no experience with varicocele surgery, but was confident a laparoscopic approach could be performed safely. He did not want to be evacuated from the theater of operations and elected to proceed.

He was given general anesthesia, and the abdomen was insufflated with a Veress needle. A 5-mm laparoscope was placed at the umbilicus, and 5-mm ports were placed on either side of the lower abdomen. Visualization revealed the left gonadal vessels to be somewhat dilated compared to the right. Additionally, he had a small indirect hernia on the left. The peritoneum was opened above the internal ring as for a transabdominal preperitoneal hernia repair. The hernia sac was reduced and the gonadal vessels were dissected free. Three 2-0 silk ties were placed around the vessels intracorporeally, and they were divided en masse. A 12-cm × 10-cm polypropylene mesh was then fashioned and passed into the abdomen after removing one of the 5-mm ports. The mesh was tacked to the anterior rectus just above the pubis with a 2-0 Vicryl. The peritoneum was then closed with a running 2-0 Vicryl incorporating the mesh so it would be unlikely to migrate. He had minimal incisional pain postoperatively and returned to work in three days.

Figure 2. Securing of the laparoscopic tower during heavy seas.
Discussion

Laparoscopic surgery may be performed aboard certain U.S. Navy combat vessels. The well-known advantages of a minimally invasive approach become even more profound at sea. Many procedures can be done through 5-mm wounds with truly minimal postoperative pain. At sea, this result is important for several reasons, the most obvious one being that every extra work hour lost degrades the readiness of the ship. Every sailor is critically important to completion of the mission. Extended periods of care not only tie up limited medical resources, but leave the ship understaffed. It has been said that the goal of Navy medicine is to keep as many sailors at as many guns for as many hours as possible.

Along with a finite number of personnel to run the ship, supplies are limited. Patients with requirements for large amounts of pain medicine can quickly deplete stores, with resupply at sea always posing a challenge. The large amphibious ships deploy with a single nurse capable of assisting in postoperative care. There is no patient-controlled analgesia, and, needless to say, a patient requiring around-the-clock morphine injections can create a problem. Our ward nurse, previously unimpressed with laparoscopy, soon became its biggest advocate.

Probably the hardest adjustment for a young surgeon, trained with unlimited access to modern diagnostic tests and imaging modalities, is being forced to make decisions based on physical exam and basic blood work. Evacuation to a hospital is occasionally impossible. When land is within reach, it is often foreign soil where the health care standards are not as high as those of the U.S. Medical evacuation also requires a ride in at least one helicopter, which can present its own health risks. All of these factors lower the threshold for performing a diagnostic operation when abdominal pathology is suspected. The entire abdomen can be thoroughly evaluated with three 5-mm incisions. It was my policy to routinely explore the entire abdomen, even when an obvious source was quickly identified. Although the extra probing may slightly increase the risk of the procedure, I believe it is necessary to maximize the accuracy of the only diagnostic modality available. If lower abdominal pain was present, the appendix was routinely removed in the absence of an alternative source. This approach was followed based on at least one series demonstrating the inaccuracy of laparoscopically identifying a normal appendix. In three consecutive cases of lower abdominal pain and normal-appearing appendix, the patient was pain-free and back to work within a few days after removal. If unexpected pathology is identified, it can invariably be managed with the laparoscope. The first case described in this article is a good example of diagnostic laparoscopy leading to a therapeutic intervention.
There are also several challenges to performing laparoscopy at sea. By the time we arrived in the Arabian Gulf, the ship’s supply of carbon dioxide had been exhausted. An effort to resupply in Singapore had failed. We had to cut through many layers of bureaucratic interference to obtain more. The ship has a large supply of nitrous oxide, which could be used as an alternative if the proper connectors are available.4

The second problem is the limited number of instruments. This is really more of an inconvenience. Sewing with a Maryland dissector instead of a needle driver is annoying but possible. Tying vessels and ducts off, rather than clipping, simply takes more time. The second and third cases demonstrate the ability to substitute sutures for clip appliers or tackers. The lack of a suction-irrigator was harder to overcome. Fortunately, the ship machinists were able to construct a primitive 5-mm valved sucker, and irrigant was simply flushed through the working-port CO₂ inlets.

I had anticipated the lack of another surgeon or resident to assist, particularly with the camera, as another possible hurdle to overcome. However, I was pleasantly surprised by the proficiency of several of the Navy corpsmen in assisting. These individuals are enlisted sailors, some only a few years out of high school, with no prior experience in the operating room. They were enthusiastic about participating, and at least as capable as the average second- or third-year resident in terms of their ability to follow with the camera and to hold instruments. They informed me that these tasks are less challenging than playing some of the current video games.

There are several unique challenges to performing laparoscopy at sea in an austere environment. However, the benefits of reduced pain and faster return to full function can significantly and positively impact mission readiness. To provide optimal care, surgeons should become proficient at laparoscopic suturing and intracorporeal tying prior to deployment at sea. There should be a low threshold for performing a thorough diagnostic laparoscopy for acute abdominal pain in this environment.

The views expressed in this article are those of the author and do not reflect the official policy or position of the U.S. Department of the Navy, U.S. Department of Defense, or the U.S. government.

References

Dr. Thoman was a general surgeon for Fleet Surgical Team-9, U.S. Naval Medical Center, San Diego, CA. He is now associate director of surgical education at Santa Barbara (CA) Cottage Health System.
Like most artists, Janice F. Lalikos, MD, FACS, has an exquisite sense of perception, noticing how shafts of light illuminate hairline ridges and crevices as they glint off the surface of a leaf and how shadows play along the ground as the wind rustles the branches of a tree. That sensitivity to color and form heighten her appreciation of the processes of pathology: the ways disease and injury alter underlying anatomy and architecture and mottle the topical landscape.

“Artists continually analyze not only what they see but why they see something a certain way,” Dr. Lalikos said. “The Pointillism movement came out of the desire to make light fractal, to figure out why a leaf looks this way at this time of day, what colors generate that picture on our retina.”

A medical illustrator and associate professor of plastic surgery at the University of Massachusetts Memorial Health Care, Worcester, Dr. Lalikos has always looked below the surface to find out why patients have certain physical features. Even in medical school at Johns Hopkins Medical School, Baltimore, MD, when she was still learning the names of specific diseases and trying to keep biochemistry formulas from flying out of her head as soon as she finished an exam, Dr. Lalikos easily recognized the manifestations of disease: concavities where softly swelling muscles should be,
protrusions in the place of long flat bones, webs of petechiae on otherwise smooth, clear skin.

While all medical students eventually hone their attention to physical nuances, Dr. Lalikos had an almost intuitive sense about patients because of her artistic eye and her training as a medical illustrator. "Having observed and drawn the human form in life drawing classes for upwards of five years, I knew when a patient’s color wasn’t right, when the skin wasn’t hanging right, when the veins weren’t where they were supposed to be," she said.

Specializing in plastic surgery was a natural fit because of its appreciation of spatial relationships and esthetics, technical skill, and variety. "Plastic surgery is the most creative of the surgical specialties, where you have guidelines and rules and anatomy as your core, but also variability. In plastic surgery, you can do six different things depending on the problem and the patient," she said.

Dr. Lalikos now brings her illustrator’s talents to her patients and her research. "Every day, I draw for my patients. If I’m repairing a facial fracture, I draw the skull in front of the patient and the family to show them where all the bone plates are," she said. She also does the illustrations for the papers she has published on such topics as the healing of surgical scars and bony reconstruction.

Two lifelong interests

Dr. Lalikos has been "bouncing back and forth" between the biological sciences and the biological arts since college. At the time she was graduating from high school, she had difficulty deciding whether to attend a fine arts college or a liberal arts institution. She ultimately enrolled at Case Western Reserve University in Cleveland, OH, as a biology major, but in her sophomore year, she learned that the Cleveland Institute of Art, on Case Western Reserve’s campus, was graduating bachelors of fine arts in medical illustration.

More interested in life drawing, sculpture, and basic design than fabric and jewelry making, which were essential courses in the fine arts curriculum, Dr. Lalikos tailored a bachelor’s degree course of study more to her liking, focusing on medical illustration and biological sciences and graduating with a degree in medical illustration in 1984.

After two years of college, she started freelancing as a medical and biological illustrator for an orthopaedic surgeon who wanted stand-alone pieces of art on adhesive capsulitis. She made a series of drawings of the anatomy of the shoulder, diagrams of the surgical correction, and sketches of the rehabilitation process. "Every time I came back with sketches, I would have a litany of questions that had nothing to do with the art: how the surgeon decides whom to operate on, whom to follow, and so on. Finally he said to me, ‘Lady, I need you to color the arteries in red and the veins in blue. To get the answers to all those other questions, you need to go to medical school.’"

So, at the eleventh hour, the summer before her senior year in college, Dr. Lalikos decided to go to medical school. The summer between her junior and senior years, she crash-coursed physics and physics lab, took the MCAT the last time
it was offered that year, and was accepted at Johns Hopkins the following summer.

While taking anatomy in medical school, Dr. Lalikos became acquainted with master’s degree students in medical illustration. “I started talking to them about their curriculum and found there was a great deal of overlap, especially in the scientific courses, with what they were doing and what we were doing as medical students in the first two years.”

Making another connection with art, Dr. Lalikos arranged with Johns Hopkins School of Medicine to substitute some courses in medical illustration as electives and allow her to pursue a master’s degree in medical illustration. After match day, while other medical students were vacationing until the start of their internships in July, she was preparing her master’s thesis on animal studies of the treatment of traumatic fractures of the face with bone grafts from other parts of the body.

Working with Paul Manson, MD, FACS, now chair of plastic surgery at Johns Hopkins, Dr. Lalikos created onlay bone grafts from the tibia and the cheekbone and placed them on the calvarium in rabbits. For her thesis, Dr. Lalikos not only performed the bone grafts and examined them under the microscope, she also made drawings of the operation, stained the bone, and generated graphs of the findings, comparing endochondral and membranous bone grafts.

After graduating with a master’s degree in medical illustration and an MD, Dr. Lalikos had to decide whether to become a full-time illustrator or move on to internship and residency, and she consulted surgeons who were also artists. As she recalls, heart surgeon and watercolorist Vincent Gott, MD, FACS, advised, “If you at all think you want to be a surgeon, you have to do it now. Your art will always be with you; it will be your joy and your avocation, and even a source of a freelance career. But if you want to be a surgeon, you have to do your training now, because you won’t have the stamina for it later.”

Dr. Lalikos went on to a general surgery residency at Vanderbilt University, Nashville, TN, a research fellowship at the University of Pittsburgh, PA, and a plastic surgery residency at the University of Massachusetts. All the while, she continued her art, doing commissioned portraits for surgeons and their wives and families, sketches for her patients, line drawings for her clinical papers.

**Similar yet different**

Although medical illustration and plastic surgery fit like hands in gloves in many respects, the two pursuits are decidedly different. “If I’m doing a painting or a drawing or a sketch and it’s just not working, I can stop, go away for a while, drink a cup of coffee, take a walk, and clear my head. Nine times out of ten when I come back, it’ll pop into my mind: ‘That’s why it’s not working.’

“But in surgery, when you are operating on a patient with a head injury, the patient is on the table, and his nose is bare, you can’t leave and come back tomorrow. You have to finish, and it has to be perfect.”

**Ms. Sandrick** is a freelance writer in Chicago, IL.
Securing the future of general surgery: A rural surgeon’s perspective

by Richard A. Armstrong, MD, FACS, Newberry, MI

Many issues challenge the future of this profession, not the least of which is the steadily declining interest in general surgery among young people. While this trend is of concern to all surgeons, it is particularly disturbing to those of us who practice in rural areas of the country, which have long suffered from a dearth of surgeons.

A number of factors prevent young physicians from entering general surgery and confound those of us who have been in practice for a number of years, regardless of practice location. Those inhibiting circumstances include reimbursement reductions, coding hassles, evolving issues in graduate education and training, and new expectations for general surgeons.

The College is undertaking a number of initiatives to address these problems. In light of these continuing endeavors, I am offering the following thoughts and observations regarding these matters and their implications for specifically rural surgeons.
In-hospital practices could expand access in rural areas

The article that this piece accompanies spotlights issues that are of concern to all surgeons, with an emphasis on how they uniquely affect rural practitioners. In this item, I propose that some of the problems facing rural health care could be addressed through the development of general surgery practices run within critical access hospitals.

According to recent estimates, 25 percent of the U.S. population resides in rural areas. However, only 10 percent of general surgeons currently practice in rural locations, and experts say 19 percent of general surgeons should be practicing in these areas to ensure adequate access to care.

Critical access hospitals

Critical access hospitals were established in the U.S. to allow many small rural facilities to remain open despite continuing financial pressures. Currently, 782 critical access hospitals are operational nationwide. They must adhere to specific guidelines to remain eligible for special treatment under Medicare. For example, acute care is limited to 15 beds and an average length of stay of 96 hours. Although these facilities may maintain emergency services and surgical services, they cannot house intensive care or obstetrical services units. They must be 35 miles from the nearest hospital (15 miles over rough terrain) and must have transfer agreements with a local referral hospital in place.

Many critical access hospitals have no or limited surgical coverage, and those services that are available are provided by visiting consultants. In many cases, it is economically infeasible for these hospitals to offer 24-hour on-call emergent care. However, it is possible for these facilities to provide day surgical services based on the freestanding ambulatory surgery center (ASC), including short inpatient admissions.

Reimbursement

All of my colleagues have expressed concern about the lack of equity in payment to rural surgeons as compared with their urban counterparts when they provide identical services. The College has been a strong advocate in urging Congress to change the flaws in the Medicare fee schedule that make possible the disparities in payment to rural and urban physicians. The goal of these negotiations should be to raise the level of payment for surgeons in rural areas to match payment to surgeons in urban environments. In other words, reducing reimbursement to urban surgeons would not be a viable solution.

It is important to note that private insurance companies do not set their payment rates on the basis of the surgeon’s geographic location. Only the Medicare program makes this distinction. Medicare’s method of setting payment for rural physicians at a lower rate has the perverse effect of encouraging surgeons to practice in urban areas and of avoiding practice in the places where they are needed the most. My plea to Medicare officials would be to simplify this complex payment system, so that surgeons who do the same amount of work get paid the same amount of money. While my private practice has not suffered financially in 18 years, we do know that our volume of cases needs to be much greater than our urban counterparts to achieve the same income.

If the Medicare program is consistent on including practice location as an element in its payment equation, perhaps the program should factor in whether the surgeon has provided the service in an academic setting. Without question, performing a procedure in a teaching hospital with a resi-
dent learning how to do the operation requires more time and resources than would be necessary when doing the same procedure in a private facility with fully trained assistants. So, it makes sense that surgeons who operate in a teaching facility should be paid at a higher level.

Coding and billing
Nearly all surgeons, regardless of whether they are practicing in an urban or a rural environment, surely agree that our current billing and coding system is too cumbersome and complex. The College has done a superb job of teaching surgeons how to code and bill appropriately, largely through the practice management workshops that the organization presents. However, a worthy goal would be to develop a system that would allow a surgeon to send a bill for a certain procedure, say laparoscopic cholecystectomy, and know exactly how much would be paid. Under our current system, intermediaries often deny entire claims or “down code” certain billings based on their own payment policies. To secure full and proper payment, many surgeons need to have a billing and coding expert on staff to negotiate with the payors and to examine each claim meticulously.

A proposal to ban payors from denying or limiting payment for certain facets of a procedure may strike some people as idealistic, anti-competitive, and, therefore, the rhetoric of socialized medicine. But the fact of the matter is that Medicare is socialized medicine, and it makes little sense to run the program using anything other than a single, standard payment rate for each service provided to a beneficiary. Capitalism works in the private insurance marketplace, where beneficiaries and

Expanding the concept
These facilities could be expanded and put to better use for rural populations by allowing general surgeons to establish in-house practices. The development of in-house general surgery practices at critical access hospitals would benefit the facility, the surrounding community, and general surgeons.

For the hospital, keeping common surgical and endoscopic services within the facility is a perceived good, and patients and their families would be pleased to avoid driving 35 to 100 miles for a simple procedure, such as hernia repair or colonoscopy. Rural hospitals would no longer have to refer virtually all of their surgical consultations and cases to the regional medical center or discuss cases by phone with a consultant at the regional medical center.

How it could work
Critical access hospitals are generally staffed by a mix of primary care physicians and physician extenders, who are used to being on-call for the emergency admissions and may also staff the emergency room. Very few general surgeons would agree to practice in an environment where they had to be on-call all of the time. A critical access hospital, because it follows the ASC model, would offer an ideal situation for a general surgeon—one free of after-hours emergency on-call time requirements. The surgeon would still need to be available by pager and on-call to treat any patients admitted after an operation, but the need to contact the surgeon would be limited because the majority of cases would be elective procedures.

True surgical emergencies occurring at night or on weekends would still be transported to the local referral center. Of course, this arrangement would mean that the general surgeon would handle few trauma cases, but he or she should be willing to assist in the ER when available and in updating the ER personnel on current Advanced Trauma Life Support® guidelines.

Furthermore, a general surgeon would be of tremendous importance to the hospital and the community by offering a myriad of services that would otherwise be unavailable. Virtually all procedures that can be performed on an outpatient or short-stay basis and almost all endoscopy could be done in a critical access hospital. Office-based ultrasound for breast and thyroid procedures would be particularly suited to this type of ambulatory practice.

Conclusion
This proposal to make general surgeons key members of the critical access hospital staff may be one solution to the problem of encouraging surgeons to practice in rural parts of the country. As we struggle to address some of the most vexing issues regarding rural surgical practice, we must open our minds to new and innovative possibilities. Creating new practice opportunities and pleasant work environments may help us attract surgeons who otherwise might avoid rural practice.

—Richard A. Armstrong, MD, FACS
providers choose which health plans in which to participate, but it is contradictory to the aims of the Medicare program to have competing intermediaries. We need to develop a system that ensures that the surgeon in private practice gets paid an honest wage for an honest day’s work.

**Education and training**

We live in an exciting time with respect to the changes taking place in surgical education. It is wonderful to witness what is almost a renaissance in thought regarding the training and continuing education of all surgeons. As we consider means of improving the graduate medical education system, we need to focus on the development of the whole person. The most successful surgeons seem to be those individuals who begin their careers with healthy minds and bodies. Our profession requires mental and physical stamina. As educators, we should be concerned about the overall fitness of the individuals who enter surgical training and their ability to cope with periods of major stress. It’s a given that medical school is tough and that some people will find this part of their education difficult enough to make them think twice about choosing such a taxing line of work. Nonetheless, as educators we need to be able to spot the top performers by taking into consideration not only how well medical students fare academically but also their resilience when under pressure.

Furthermore, we should create a training environment that is conducive to both professional and personal development. Program directors need to be more sensitive to people who want to have families and enter practice at the same time—a topic of real concern to the growing number of female medical school graduates. We also need to promote good health. Some program directors and chiefs of surgery have long recognized that residents and attending surgeons who are physically fit and well-rested tend to perform more competently.

Too many of my colleagues complain of being “burned out” and wish that they could just quit practice. This is a sad comment to hear from people who once were excited and enthusiastic about surgery. This disappointing attitude possibly could be averted if the surgical lifestyle was less exhausting and more rewarding.

In the special circumstance of training individuals for rural practice, it is imperative that we provide opportunities for medical students and residents to attain experience in this setting. Studies indicate that the best time to attract physicians to a specialty or practice type is while they are still in the formative stages of their career. An excellent prototype for a training program that allows young surgeons to get a taste of rural surgery has been developed by John G. Hunter, MD, FACS, and Karen E. Deveney, MD, FACS, at the Oregon Health & Science University. (See “Training the rural surgeon: A proposal,” Bulletin, 88(5):13.) Rural surgeons need to emphasize to those individuals who do a rotation under their leadership that practice outside of metropolitan areas affords them the opportunity to manage a broad range of cases and to have greater control over their own destinies.

**General surgeons**

We need to carefully reconsider the core definition of what it means to be a general surgeon. This reexamination of the concept of general surgery is especially pertinent to any discussion of rural practice because physicians in more remote locations so often are called upon to handle cases that require knowledge and skills outside of their traditional purview. For example, they need to be able to perform routine obstetrical-gynecological procedures, including cesarean sections. They need to have enough orthopaedic trauma training to handle common orthopaedic emergencies. Competence in the treatment of critical care, trauma, vascular, and thoracic procedures is essential. Fortunately, I became familiar with this broad range of surgical procedures while training in the Navy, but I’m not sure that all training programs offer such wide experience.

One of the greatest challenges in rural areas is call coverage, especially if a group of less than three surgeons is serving a location. This is a topic that requires further discussion, but one potential solution is to have surgeons in neighboring communities network to provide call coverage. Additionally, rural primary care and emergency room physicians should be trained to deal with common surgical problems, to recognize when a surgeon is truly needed, and to know when to seek the experience and advice of a surgeon. This arrangement would limit the times rural surgeons are called.
Due to the limited number of surgeons who practice in rural areas, the few who do decide to practice outside of metropolitan areas must be exceptional people with a broad range of surgical interests, a deep sense of self-confidence, and plenty of common sense. They should want to be actively involved in patient care and be willing and able to do their own critical care management, in addition to the technical aspects of their work.

As the health care system evolves, it is evident that all surgeons will also need to be knowledgeable about the entire course of disease processes—not just how to cure a condition by using an operative procedure. For example, I believe that today’s residents should be exposed to a broad range of pathology.

**Future survival skills**

All surgeons of the future also will need to have a better understanding of quality of care issues, of how to monitor their outcomes, of interpersonal and communication skills, and of what it means to be a leader.

All surgeons, of course, must be able to arrive at sound judgments and be committed to achieving the highest quality in the performance of all the daily tasks we carry out. In fact, a surgeon’s success depends completely on his or her devotion to quality. No other aspect of daily practice is as important as delivering optimal care in and out of the operating room.

Keeping track of one’s cases and outcomes is a subject that has received considerable attention lately as part of the quality debate and the development of best practices. Surgeons must get in the habit of monitoring their practice patterns. Maintaining these records can serve as our best defense against those individuals who would limit our privileges. This case log does not have to be anything fancy or particularly formal. I have kept track of my morbidity and mortality data in a notebook that I store in my changing room locker, adding cases after each operation.

Perhaps the College could help surgeons just getting started in this area by developing a software program for maintaining a case log that is user-friendly and portable. Of course, some people might say we are better off wait-

**Conclusion**

We have the opportunity at this time to create an environment that encourages surgeons to pro-

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*Dr. Armstrong* is clinical assistant professor of surgery, College of Human Medicine, Michigan State University, and a general surgeon practicing in Newberry, MI.
The Governors’ Committee on Physician Competency and Health

By Lynn H. Harrison, Jr., MD, FACS, New Orleans, LA

The Board of Governors’ (B/G) Committee on Physician Competency and Health is the product of the recent merger of the previous B/G Committee on Physician Competency and Liability and the Committee on Physician Health. Because it is new, the committee is still evolving with respect to its charge and focus. Nonetheless, the following summary of our current and future activities should convey which issues are of greatest concern to the committee at this time.

The impaired surgeon
The relationship between physician competency and physician health is obvious, and many of the committee’s efforts in the past have focused on disruptive behavior and substance abuse as reflected in the Out of Control video. The College distributes the video to surgeons, other physicians, and surgical residents to help them understand what it means to be out of control with regard to alcohol and drug use and to provide confidential resources that people in trouble can turn to for help.

Clinical Congress program
At the 2004 Clinical Congress in New Orleans, LA, the committee will sponsor a panel discussion entitled Issues Surrounding the Decision to Retire. Lazar J. Greenfield, MD, FACS, will moderate the session and will present a talk entitled Recognizing Disability at the Operating Table. Additionally, Arthur J. Donovan, MD, FACS, will present on economic planning for retirement; Thomas L. Dent, MD, FACS, will talk about applying the years of hard-won experience; and Wallace P. Ritchie, Jr., MD, FACS, will give a talk entitled “What to Do with All That Time.”

Core competencies
The committee conducted an ongoing discussion in parallel with a Regents’ task force that has been investigating the Accreditation Council on Graduate Medical Education’s core competencies, and the means available to practicing surgeons to assess their capabilities in these areas in a helpful and confidential way. Although
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the task force and the Governors’ committee were working independently, we came to remarkably similar conclusions. To avoid duplication of effort, the committee has agreed to leave this issue in the capable hands of Ajit Sachdeva, MD, FACS, FRCSC, Director of the ACS Division of Education.

Quality assurance
Fellows of the College have expressed a clear need for disinterested external review of individual surgeons’ practices when local hospital quality assurance (QA) committees conclude that a problem may exist. Traditionally, the results of their deliberations have been undiscoverable in lawsuits; however, recently the courts have sided with plaintiff attorneys, who allege that members of the QA committee were, in fact, in competition with the surgeon being reviewed and for that reason those deliberations were discoverable.

To help address this problematic situation, ACS Past-President Claude Welch, MD, FACS, established the American Medical Foundation for Peer Review and Education, a not-for-profit agency for medical staff peer review. Although it is well staffed and well financed, this foundation is not widely known, particularly among practicing Fellows. The committee is currently considering a means by which the College might provide a similar service, as it is to this organization that most surgeons and hospitals turn for assistance when these internal conflicts of interest arise.

Although these plans are currently in only the discussion phase, it is foreseeable that the College could identify panels of experts in the various areas of surgical practice. These panels might, at the inviting institution’s expense, review patterns of practice that have been brought into question by local QA committees. Any opinion that these panels render would be undiscoverable by virtue of the fact that the panel members would not be in direct or indirect competition with the surgeon being reviewed. They would be useful to hospitals and surgical departments as well as to individual practitioners in the improvement of surgical practice at their institutions.

Health screenings
The committee has initiated what we hope will be the first of many general health screenings that will be made available to the Fellows on the occasion of the annual Clinical Congress in October. At the upcoming meeting in New Orleans, blood pressure screening will be performed. In future years, simple blood test screenings for prostate cancer or noninvasive vascular ultrasound screenings might be made available.

Work hours
On the horizon, the 8-hour workweek for residents in training will surely be brought to bear on practicing surgeons. The committee anticipates the need to address this issue as well.
The Aetna and CIGNA settlements: Part II
by Irene Dworakowski, Regulatory and Coding Associate, Division of Advocacy and Health Policy

During the 1990s, a number of lawsuits were filed across the country on behalf of physicians against managed care organizations. These lawsuits alleged that the health plans conducted improper contracting and payment practices. In October 2000, the lawsuits were consolidated and transferred to the U.S. federal court in Florida as a class action lawsuit. Two of the defendants, Aetna and CIGNA, agreed to settlements rather than continue the litigation. The other managed care companies that are defendants in this litigation have not agreed to settlements at this time and the lawsuit against those organizations continues to move toward a trial, which is currently scheduled to begin in March 2005.

The first article in this two-part series provided information about the Aetna settlement (July 2004, page 12). This second article continues with a discussion of physician compensation available under the CIGNA settlement, the appeals process, and the enforcement procedures established to ensure that Aetna and CIGNA comply with the provisions of the settlements in the future.

The final order for the CIGNA settlement was issued in April 2004. The elements of prospective relief provided by the settlement are similar to the disclosure and business practice changes established in the Aetna settlement. It establishes a Web portal through which CIGNA participating physicians may check patients’ eligibility, status of claims, fee schedules, policies, and procedures, as well as any updates and changes to these items. CIGNA is providing $15 million in funding for The Physicians’ Foundation for Health Systems, which is charged with developing health care initiatives for patients and providers. CIGNA has also established a physician advisory committee to advise the company on national health care issues.

Surgeons who are party to the class action should have received CIGNA's formal notice of commencement of claims period that was mailed on July 8, 2004. During the claims period, which begins August 23, 2004, and ends February 18, 2005, class action members may apply for compensation from the funds established by the settlement. Claims for denials of or reductions in payment that were a result of payment and benefit limitations (such as coordination of benefit rules, violations of preauthorization or referral requirements, limitations cited in capitation agreements, and services excluded from coverage under the CIGNA member’s plan) are ineligible for compensation.
Douglas Corporation, the settlement administrator for CIGNA, will handle all compensation claims. Physicians may apply for compensation from either the Category A settlement fund or the claims distribution fund.

**Category A settlement fund**

All class members may apply for compensation from CIGNA's Category A settlement fund regardless of whether they have submitted any claims to CIGNA HealthCare during the period from August 4, 1990, through September 5, 2003, as long as they have submitted claims for payment during that period to Aetna, Aetna-USHC, Anthem, CIGNA, Coventry HealthCare, Health Net, Humana Health Plan, Humana, PacificCare Health Systems, Prudential Insurance Company of America, United Health Care, United Health Group, or Wellpoint Health Networks.

Physicians who opt to apply to the Category A settlement fund are not expected to produce documentation in order to receive compensation, which will be distributed according to a formula contained in the settlement. They must complete and return a Category A claim form to the settlement administrator. All payments from the Category A settlement fund will be made approximately two weeks after the claims period has ended. Please note that, in lieu of receiving payment, physicians may contribute their share of the settlement fund to The Physicians' Foundation for Health Systems or to a similar entity established by any medical society that signed or joined the settlement.

**Claim distribution fund**

Surgeons who believe they were specifically denied appropriate payment for services by CIGNA Corporation or its subsidiary entities (CIGNA Healthcare, Connecticut General, Healthsource, Lovelace Health Systems, Ross Loos Hospital) from August 4, 1990, through April 22, 2004, may choose to forgo compensation through the Category A settlement fund and apply to CIGNA's claim distribution fund. A complete list of the CIGNA entities can be found at http://www.cignaphysiciansettlement.com/entities.htm. There are three categories of the claim distribution fund: Category One, Category Two, or medical necessity denial. Requests for payment may be submitted under any or all of the three separate categories.

Category One applies to claims that are defined by a negotiated list of code edits published as part of the settlement.* This option requires a valid proof of claim that the procedures were denied by CIGNA. The code edits for which additional payment is due that may be of most interest to surgeons are:

- Biopsy of skin, subcutaneous tissue and/or mucous membrane that were bundled into destruction of skin lesions (codes 17000-17999 paid; code 11100 not paid).
- Destruction of lesion(s) that were bundled into shaving or excision of epidermal/dermal lesions (codes 11300-14000 paid; code 17000-17004 not paid).
- Chemical cauterization of granulation tissue that was bundled into collection of venous blood by venipuncture (code 36415 paid; code 17250 not paid).
- Upper gastrointestinal endoscopy with biopsy that was bundled into upper gastrointestinal endoscopy with insertion of guidewire and dilation or balloon dilation of esophagus (codes 43248-43249 paid; code 43239 not paid).
- Sigmoidoscopy with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery that was bundled into sigmoidoscopy by snare technique (code 45385 paid; code 45384 unpaid).

A complete list of Category One code edits can be downloaded in Adobe Acrobat (.pdf) format at http://www.cignaphysiciansettlement.com/categoryone.htm.

Category Two compensation applies if the payment denial or reduction was a result of the application of CIGNA’s proprietary coding and bundling edits that are unspecified as eligible for Category One compensation. CIGNA has provided the settlement administrator with a facilitation list that identifies provider claims for which payment was denied or reduced because code edits were applied, modifiers and add-on codes were not recognized, or multiple procedure rules were applied incorrectly. To determine whether to pursue payment, all specific references to CPT terminology and phraseology are © 2003 American Medical Association. All rights reserved.
through the Category Two list, physicians should request a facilitation list for their claims from the settlement administrator.

To request compensation for claims that were improperly denied by CI GNA as not medically necessary or as experimental or investigational, physicians should apply to the medical necessity denial compensation fund.

Applying for compensation

Physicians requesting compensation from the claim distribution fund must submit the appropriate proof of claim form. (Proof of claim forms should not be submitted until the claims period begins.) CIGNA advises claimants that they should use only the “official version” of the proof of claim form (bar-coded) when submitting request for payment. A single proof of claim form may be used for more than one compensation request. A separate cover sheet and the required documentation for each request must be attached to the form. Copies of the official forms (including the cover sheets for Category One, Category Two, and medical necessity denial claims) can be found at http://www.cignaphysiciansettlement.com/documents.htm or requested from the settlement administrator.

The required documentation for Category Two and medical necessity denial requests consists of a copy of the original HCFA-1500 form or the relevant CI GNA remittance form. (If those forms are unavailable, printouts of accounts receivable or paid account records will be accepted.) Claimants also must provide clinical information relevant to each claim. For denial of claims for surgical procedures, claimants must provide clinical notes and operative notes. To view the list of documentation requirements for other CPT codes, please go to http://www.cignaphysiciansettlement.com/clinicalDocumentation.htm. Two exceptions have been made to the clinical information requirement. No clinical documentation is required if: (1) the request for payment is for a claim where CI GNA HealthCare failed to recognize modifiers 50, RT, LT, FA-F9, or TA-T9, and denied payment for one or more CPT codes as duplicative of other CPT codes reported; or (2) CI GNA HealthCare incorrectly processed one or more modifier 51 exempt CPT codes and/or add-on CPT codes due to CI GNA edit software when those codes were exempt from multiple procedure reduction.

Some practice management software maintains electronic records that contain information that would be included on a HCFA-1500 form and can generate a print image file. Practices that use this software can submit claims documentation electronically to a Web portal that is being operated by Infinedi LLC, which will create HCFA-1500 forms containing the claims information. If supporting documentation is required for a claim and it is possible to create a .pdf or .tif file, that documentation can be uploaded to the Infinedi site, and the complete file will be transmitted to CI GNA by Infinedi. Proof of claim forms must be completed and signed prior to electronic submission. For more information about electronic submission of compensation claims, please go to www.cignaeclaims.com.

If CI GNA denies compensation for a Category Two or medical necessity compensation request based on its determination that the original decision to reduce or deny payment was appropriate, that request will automatically be forwarded to an independent review entity (IRE) to determine the appropriateness of the decision.

The settlement administrator for any of the items cited in this article can be contacted by e-mail at http://www.cignaphysiciansettlement.com/contact.htm, by phone at 1-877/683-9363, or by mail at CI GNA Physicians Settlement, Settlement Administrator, P.O. Box 3170, Portland, OR 97208-3170.

The enforcement process

Both Aetna and CI GNA have revised their appeals processes as a result of the settlements. If physicians believe that any claims submitted after the deadlines for compensation under the settlements have been improperly denied or paid, they will have to first appeal those disputes with Aetna or CI GNA. The CI GNA agreement allows for two levels of internal appeal. If the determination of initial appeal is unsatisfactory, physicians may request that the claim be reviewed by a member of the same specialty as the performing physician. The review of and response to claim disputes must be completed within 45 days. If the response to an appeal is also unsatisfactory, independent
review mechanisms have been created to offer physicians additional avenues for reconsideration and to ensure that Aetna and CIGNA are complying with the settlements. They are as follows:

- Billing dispute resolution process. The IRE process may be used for retained claims (defined below), coding, and other payment rule disputes, including disputes over burdensome record requests, after completion of the Aetna or CIGNA internal review process.

  For CIGNA, retained claims are ones that either were filed but not adjudicated (including any internal appeals) as of April 22, 2004, or claims that have not yet been filed but for which the filing period has not expired. The settlement agreement stipulates that claims that involve the application of CIGNA’s coding and payment rules and methodologies that were finally adjudicated between March 24 and April 21, 2004, are also considered retained claims. Detailed information on the submission of retained claims to the billing dispute external review process can be found at www.CIGNAforHCP.com.

  For Aetna, billing disputes for $500.01 or more may be submitted to the IRE within 90 days of an Aetna appeal decision. (Physicians may request that the IRE aggregate similar claims for up to one year to reach the required $500.01.) The filing fee for the service is a minimum of $50 and an additional 5 percent of amounts in dispute over $1,000, capped at 50 percent of the IRE’s charge for the review. In most cases, the IRE will issue its decision within 60 days of the date the appeal is filed.

- Medical necessity dispute resolution process. If a physician receives a denial based on Aetna’s or CIGNA’s determination that the services were not medically necessary or were experimental or investigational, the decision may be appealed to the appointed external review organization. (If a patient has filed an Employee Retirement Income Security Act of 1974 lawsuit in a federal court, this review is not an option.) For Aetna, this process should be available this month, and there is a filing fee of $50 or up to $250 for cases requiring prior authorization.

  The date for the initiation of CIGNA’s process and any fees associated with filing of billing dispute or medical necessity dispute claims have not been announced.

  These processes are optional with Aetna but binding if used. Physicians are free to pursue remedies independent of the established processes, such as resolution of a dispute by arbitration. The Aetna settlement establishes a cap of $1,000 for arbitration fees for solo and small practices.

- Compliance dispute resolution process. The settlements provide a mechanism whereby noncompliance by Aetna or CIGNA to the obligations set forth in the agreements may be reported. This process would most likely be used if a pattern of behavior was identified. Compliance disputes may be filed by any class member who has been adversely affected by a breach of the settlement agreements or by a signatory medical society on behalf of a physician or a practice. Any compliance disputes will be reviewed by an appointed compliance dispute officer. If the compliance dispute officer finds that noncompliance has occurred, the offending party will have 30 days to resolve the problem. Failure to remedy the noncompliance could result in legal intervention to force compliance. All Aetna and CIGNA compliance disputes will be handled by the compliance dispute facilitator.

  As a reminder, the state and local medical societies and associations that are signatories to the settlement agreements may represent physician members who have future disagreements with Aetna and CIGNA through the compliance dispute process for violations of the terms of the settlement as well as violations of state law relating to such terms. Physicians who choose to opt out of the class action may not use the compliance dispute process. Surgeons should contact the appropriate medical or specialty society in their area for more specific information about the effects of the settlement on their practices.

The information contained in this article is based on documents provided by the American Medical Association in March 2004 and supplemented with information contained on the Aetna provider Web site, the CIGNA Healthcare physician settlement Web site, the HMO Crisis Web site maintained by the Law Offices of Archie Lamb, and the HMO settlements Web site maintained by Milberg Weiss Bershad & Schulman LLP. The Law Offices of Archie Lamb and Milberg Weiss Bershad & Schulman LLP represented physicians in the Aetna and CIGNA health care litigation.
Chapter leaders learn about politics and advocacy

by Diane S. Schnedman, Senior Editor

The second Chapter Officers and Young Surgeons Leadership Conference took place May 16-18 in Washington, DC, and featured an insider’s look at health policy advocacy. Approximately 150 Chapter Officers, Chapter Executives, and Young Surgeon Representatives attended the meeting, which was coordinated by the Division of Member Services and the Washington Office of the Division of Advocacy and Health Policy. Highlights included: a preconference “professional speaking lab”; concurrent sessions tailored to the specific needs of the attendees; a keynote address on the uninsured; a panel discussion on quality improvement; a perspective on the upcoming presidential elections; and Capitol Hill visits.

Young surgeons’ program

The first day of meetings featured concurrent sessions targeted at each category of meeting participants—Young Surgeon Representatives, Chapter Officers, and Chapter Executives. The Young Surgeon Representatives’ program focused on cultivating surgical leadership skills.

In welcoming the Young Surgeon Representatives, Claude H. Organ, Jr., MD, FACS, 84th President of the American College of Surgeons, said, “We need your help. I meant it in my Presidential Address when I said, ‘You can make a difference.’”

Dr. Organ said the College is trying harder than ever to appeal to young surgeons and to get them involved in ACS activities early on in their careers. To spotlight this movement, ACS Executive Director Thomas R. Russell, MD, FACS, and Dr. Organ agreed that the theme of his Presidential term would be “the year of the resident.” One effort under way to guarantee that young surgeons play more prominent roles within the organization is the creation of resident seats on College committees.

In addition, Dr. Organ noted
that the College is reaching out to medical, surgical, government, and private sector groups to build consensus on how best to improve patient care. “The College is no longer a ‘sleeping giant,’” he said. “We don’t stand alone any more.”

- **Leading change.** Stephen R.T. Evans, MD, FACS, professor and chair, department of surgery, Georgetown University, Washington, DC, spoke about leadership during times of change. Dr. Evans said that change allows institutions and individuals to do more than merely survive. It allows them to connect with others in a way that makes life better, to be part something great, and to make a difference in the lives of others.

According to Dr. Evans, individuals who want to initiate change need to take four steps: (1) make observations about existing challenges; (2) ask constituents for their perspectives; (3) offer interpretations about the problems and possible solutions; and (4) take action. “Let the issue ripen. Find out what else is on people’s minds, how deeply people are affected by the problem, and how much people need to learn,” he advised.

Dr. Evans noted that surgeons possess several characteristics that make them strong “vehicles for change.” They are intelligent, tenacious, hard-working, high-profile members of their institutions, who are trained to identify and fix problems. On the other hand, a number of traits may work against surgeons as leaders, including elitism, a tendency to overextend themselves, lack of experience with change, diminishing career satisfaction, and egocentrism, Dr. Evans said.

Overall, though, “surgeons are well-positioned to implement change,” Dr. Evans concluded. “Choose your battles carefully, be patient, educate yourself, and don’t underestimate your capabilities to implement significant change,” he said.

- **Arenas for change.** Dr. Russell explained how the College is attempting to create a...
“tipping point” in the future delivery of surgical services by being active in several arenas, including political advocacy. Dr. Russell noted that the ACS formed the American College of Surgeons Professional Association (ACSPA) in 2002. The ACSPA functions under 501(c)(6) tax status and, therefore, was able to establish a political action committee (PAC). The ACSPA-SurgeonsPAC actively seeks financial contributions, which are used to help fund the candidacy of legislators who support the College’s views.

Additionally, the ACSPA has joined with other medical and surgical specialty societies to form Doctors for Medical Liability Reform (DMLR), Dr. Russell said. DMLR is spreading the message in states with a U.S. senator who is blocking passage of liability reforms that the malpractice insurance crisis affects access to care.

The College also is helping to promote evidence-based medicine that will lead to scientifically sound guidelines for surgical procedures and best practices. “To get this idea into practice is no small task,” Dr. Russell said. “We are trying to get surgeons involved in outcomes research.”

Surgical education and training are another arena in which the College is involved, Dr. Russell said. For example, the College worked with the Accreditation Council on Graduate Medical Education to develop the 80-hour workweek for residents to ensure that the rules were crafted by the medical community. “Had we not been involved, the government would have done it,” Dr. Russell noted.

The College also is leading efforts to improve patient safety and quality of care, including bringing the Department of Veterans Affairs’ National Safety and Quality Improvement Program to the private sector. “We at the College really think this is our issue,” Dr. Russell said.

Furthermore, the College strives to help surgeons acquire the skills they will need to deliver care to patients in the future, Dr. Russell added. For example, the next generation of surgeons will provide disease-specific rather than specialty-specific services. As a result, surgeons will need new skills and will find themselves working in teams of professionals.

Getting involved. John H. Armstrong, MD, FACS, director, U.S. Army Trauma Training Center, Miami, FL, and assistant professor of surgery, Uniformed Services University of the Health Sciences, Bethesda, MD, offered his perspective on how young surgeons can achieve organizational change. He said that young surgeons who want to have an impact should focus on issues that they have strong feelings about, join organizations that represent their views, and be active in the local surgical community.

Young surgeons who want to make a difference need to “get to the right place within the organization to effect change,” Dr. Armstrong added. They need to understand the internal and external processes of the association. After attaining some influence within an organization, advocates for change must send a message that resonates with

Left to right: Dr. Russell, Barry Brown (chief of staff for Rep. Burgess); Rep. Michael Burgess (R-TX); Joseph Kuhn, MD, FACS (Texas Chapter); and Mrs. Kuhn.
other members of the society and "negotiate with respect and courage," Dr. Armstrong said.

Chapter Officers' program
The program for Chapter Officers focused on "Member Issues and Strategies." Paul Collicott, MD, FACS, Director, ACS Division of Member Services, chaired the program and provided an update on trends in the College's membership. Ray Price, MD, FACS, Past-President of the Utah Chapter, described how that chapter was able to "kick start" its activities and revitalize the membership. Mary E. Maniscalco-Theberge, MD, FACS, Immediate Past-President of the Metropolitan Washington Chapter, discussed how education programs for surgical residents brought new energy to that chapter. Finally, Dr. Organ explained why he chose to make "the year of the resident" the theme of his Presidential term.

Chapter Executives' program
Henry Schaffer, JD, Jenner & Block, Chicago, IL, provided an update on legal issues affecting tax-exempt corporations, including non-dues revenues, as well as regulatory and compliance issues. In addition, the Chapter Executives participated in a roundtable discussion of their "greatest challenges" and how they overcame them.

Preconference session
Preceding the concurrent sessions, J. Robin Wright, president, Wright Communications, Inc., Evanston, IL, led a workshop that allowed participants to polish their presentation skills. Topics covered during the session included capturing the audience's interest, delivery styles, and responding to hostile questions.

Health policy initiatives
All of the meeting participants gathered together on the second day of the meeting to learn about health policy and the legislative process. Dr. Russell opened this portion of the meeting by explaining the College's activities. Dr. Russell said the College is focusing on the complexities of a new health care system, rather than pining for the relative simplicity of times past. "We've got to look forward. We've got to look at the future," he said.

In Dr. Russell's view, the College functions as both a trade association and a professional association. As a trade association, the College's policies protect the rights of its members, ensuring their fair treatment with respect to reimbursement and government regulation. As a professional association, the College seeks to educate its members, to promote ethics, and to ensure patient safety and quality of care.

Hence, the College's programs include developing surgeon leaders, promoting practice-based learning and outcomes studies, working with training program directors to help them apply the 80-hour workweek standards, developing guidelines and best practices, and conducting clinical trials, Dr. Russell reported. In terms of politics, the College's Health Policy Steering Committee is examining the future configuration of the health care system, and the ACSPA-SurgeonsPAC is helping the organization to establish contacts on Capitol Hill.

To carry out these initiatives, the College is working with a range of other groups, including the American Medical Association, business consortiums, and other organizations that are concerned about access to quality care, Dr. Russell said. Most importantly, however, "We really want to get the membership involved. It's the membership that drives the College's health policy initiatives," he added.
The uninsured

Keynote speaker Shoshanna Sofaer, PhD, professor, Baruch College, New York, NY, said, "We cannot afford not to cover the uninsured.” Dr. Sofaer co-chaired the Institute of Medicine’s (IOM’s) Committee on the Consequence of Uninsurance.

Dr. Sofaer noted that the 43.8 million Americans without health care coverage tend to have poorer health and shorter lives than individuals with insurance and, hence, are major contributors to the rising costs of health care. Uninsured individuals use $99 billion in total health care services annually. One-third of those expenses are paid out-of-pocket; the rest is paid through tax revenues and other types of public funding, she said.

The committee determined that any plan to extend coverage to the uninsured should be universal, continuous, affordable, and sustainable, Dr. Sofaer said. It also should enhance the well-being of all Americans by promoting access to effective, efficient, safe, timely, patient-centered, and equitable care.

Using these criteria, the IOM committee developed four prototypes of a reformed health care delivery system. One would expand existing public programs (Medicare, Medicaid, and the State Children’s Health Insurance Program) and provide a tax credit for moderate-income individuals. The second model would require employers to offer coverage and to contribute to their workers’ premiums; employers of low-wage workers would be eligible for premium subsidies. A third proposal would mandate that individuals obtain health insurance for themselves and their families and provide a tax credit for purchasing insurance. The fourth prototype would establish a single-payer system. "Any of the prototypes could do better than the status quo,” Dr. Sofaer said.

Dr. Sofaer encouraged surgeons to play an active role in the development of a reformed health care system. “We need political intelligence and leadership. We need champions of many kinds participating,” she said. “You need to recognize that you’re part of the polity.”

Panel on quality

R. Scott Jones, MD, FACS, Director of the College’s Division of Research and Optimal Patient Care, moderated a plenary session examining how current efforts to improve surgical care will affect the future delivery of surgical services.

The health care delivery system is ready for a transformational change, according to Stephen Jencks, MD, MPH, director, Quality Improvement Group, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services (CMS), Washington, DC. Specific transformations that need to occur, according to Dr. Jencks, include: (1) changing the way people think about performance; (2) supporting and creating partnerships; (3) promoting teamwork; (4) defeating secrecy; (5) improving information systems; (6) helping health professionals to recognize that guidelines and protocols “are not mindless exercises”; and (7) basing payment on performance. Surgeons need to promote outcomes and pay for performance. “This is your opportunity,” Dr. Jencks added.

Offering the workers’ perspective, Gerry Shea, assistant to the president for government affairs at the AFL-CIO, Washington, DC, said that because many employers are shifting costs for health care coverage to employees, consumers are going to more closely scrutinize quality indicators. Therefore, “a robust set of measures that makes sense to consumers and clinicians” is needed, Mr. Shea added.

Surgeons have been pioneers in quality measurement for decades, noted Allan M. Korn, MD, FACP, senior vice-president/chief medical officer, Blue Cross and Blue Shield Association, Chicago, IL. “What we need is for you to take over. None are in a better position than you” to lead this movement, Dr. Korn said. “You have the track record and the will to make it work.”

Although Dr. Korn said that surgeons should take the lead in quality improvement, he noted that implementing a quality-based health care delivery system will require collaboration between all stakeholders. “We’re not the solution. You’re not the problem,” he said.

Helen Darling, president of the National Business Group on Health, Washington, DC, echoed a similar sentiment, saying, “We all have to work together to create a system that is safe and efficient.”

Ms. Darling also said that the business community believes that the most serious problems in the nation’s health care system are rising costs and uneven
The young surgeon advocate experience
by Laurel Soot, MD, FACS, and Scott Soot, MD, FACS, Portland, OR

Several months ago, we were invited to serve as Young Surgeon Representatives for the Oregon Chapter at the College’s 2004 Chapter Officers and Young Surgeons Leadership Conference in Washington, DC. As recently initiated Fellows of the College, we were pleasantly surprised that the organization was interested in including young surgeons in this forum.

We did not know what to expect at the meeting but thought the agenda looked interesting. Nowhere on it were sessions regarding the utility of a new device, drug, or procedure. Instead it addressed change, the foundation of medicine, and how we can effectively play a role in the evolution of surgical practice in this country.

The leadership challenge

Importantly for us, the program for Young Surgeon Representatives outlined the role of an effective leader at the local, regional, and national levels. The talks entitled “Dealing with Change—Leadership Skills to Overcome Obstacles” and “New Arenas for Achieving Change” certainly dealt with issues that we encounter almost daily as surgeons in Oregon, where the socioeconomic climate continues to become more hostile toward medicine.

As we have noted in conversations with some of our peers, although our surgical residencies trained us well in the workup of esophageal disorders and in how to competently perform a Whipple, none of our training programs had provided us with formal background in leadership skills. We have become painfully aware of this omission from our education now that we are attempting to take on various leadership roles and to institute policy and practice changes in our respective hospitals.

During the conference, we learned that competent leadership requires a willingness to embrace change. Although this point may seem obvious, the frenetic pace of surgical practice makes it easy to forget that if surgeons and other members of the medical community don’t make the decisions about practice and patient care, someone else will make them for us. As surgeons we often feel that we lack the time and energy to address these issues. Something else always appears to be more important, or at least more urgent. Unfortunately, because we have not invested a serious group effort in the political arena, the government and other parties often make these choices for us, and their decisions are not necessarily the ones we would make ourselves.

Capitol Hill visits

Capitol Hill runs a lot like a large hospital. People come and go, performing a myriad of jobs and promoting many different, and sometimes opposing, agendas. When we visited Capitol Hill, people were lobbying on behalf of just about every special interest imaginable.

Traditionally, surgeons have had a rather muted voice in the offices of our respective legislators, but we can play an important political role. We need to express our concerns because very few nonphysicians will pick up the torch for our cause. No one is better able to educate politicians and society about these issues and how they affect our ability to practice medicine.

All of the ACS Fellows who participated in the Capitol Hill visits had the opportunity to discuss medical liability reform, Medicare reimbursement, and trauma funding with their respective senators, representatives, and/or their health legislative assistants. We met with the aides to our legislators and found these individuals to be very knowledgeable and genuinely interested in our agenda, despite some differences of opinion about how to solve the problems. For example, Capitol Hill staff cited a variety of reasons for their legislators’ unwillingness to support liability reform. Imperfections in the current bill were the most common reason, along with a moral dilemma about setting caps on noneconomic damage awards. We came upon similar explanations for opposition to the current attempts at Medicare reform.

Although we cannot say whether our discussions will have any bearing on the way our members of Congress vote in the future, we are certain that we would not have had any influence with regard to change without these conversations. The immediate resistance that we encountered may be discouraging, but surgeons must bear in mind that we are one of many voices trying to bend an ear in this very charged and competitive environment.

Furthermore, politics is a different game than the one we play in the operating room, so we are out of our element. Washington operates under a set of rules governing the advancement of any agenda. Politicians think about not only
what is the best for society, but about what will ensure their reelection as well. We may not understand it, but most elected officials and their staffs like being part of the government and want to enjoy another term. If that means casting a vote in opposition to their personal beliefs, they sometimes are willing to pay the price.

Our job as advocates is to show them just how important those votes regarding health care are to us and, ultimately, to society. We must participate in the political promotion of medicine. It is important that we succeed, but it is even more vital that we try. Participation and “grassroots movements” are the foundation of our government. Armchair quarterbacks sitting in the physicians’ lounge pining for the “good old days” will accomplish nothing meaningful.

Only the beginning
Since returning from the meeting in Washington, we have sent follow-up letters and plan to visit our Oregon representatives when they are in the local area. All senators and representatives have offices in their home states, and surgeons should arrange visits with their elected officials when they are in town.

Surgeons also should contribute to the American College of Surgeons Professional Association’s political action committee (ACSPA- SurgeonsPAC), which contributes to the campaigns of candidates who support our views. The PAC is an easy and effective way to ensure that surgery’s voice is heard. The College has a cadre of lobbyists who work to educate Congress on these important issues, and their access to congressional leadership has improved as a result of the contributions from ACSPA-SurgeonsPAC.

Conclusion
Surgeons are all leaders by the very nature of the profession they have chosen. We frequently manage life-threatening emergencies, and consulting physicians often look to us for guidance. Politics is a different arena than the hospital, but it is one where we can use these same skills to become very effective community leaders. Persistence, patience, and a positive attitude are all that is necessary.

As ACS Executive Director Thomas R. Russell, MD, FACS, so succinctly said, “You cannot practice surgery effectively while looking through the rear view mirror.” Change is inevitable. As Fellows of the American College of Surgeons, we must stand up and voice our perspectives to protect our patients and what we have worked so hard to obtain.

Drs. Laurel and Scott Soot are both clinical professors of surgery at the Oregon Health and Science University, Portland.
quality. To help overcome these problems, the business sector has developed a strategy based on the following guiding principles: (1) cost sharing is important but is only one part of the strategy; (2) greater efficiency is needed; (3) consumers should have options; and (4) the public needs information that will allow them to make better decisions and experience improved outcomes.

Presidential election
Stuart Rothenberg, a Washington, DC, political analyst, spoke about the factors affecting the upcoming Presidential election. Mr. Rothenberg said that the national mood is the primary driver of people’s voting decisions, and “the current mood is bad and getting worse.” Exemplifying people’s dissatisfaction with the current state of affairs are polls showing that most Americans believe the country is on the wrong track. When people believe that the nation is being misdirected, they tend to vote against the incumbent.

Even so, the polls show that the upcoming presidential election is almost a dead heat. Mr. Rothenberg said that voters haven’t turned away from President Bush because Sen. John Kerry (D-MA) has failed to warm to the public and to take advantage of the president’s slide in the polls. Of course, it’s too soon to predict how the election will turn out. “A day from now, we could have an event that will change everything,” Mr. Rothenberg said.

Advocacy update
The College made some significant inroads toward achieving surgeons’ health policy agenda in 2003 and is busy carrying out a number of activities this year, according to Cynthia A. Brown, Director of the Division of Advocacy and Health Policy.

In 2003, the College won a two-year reprieve from negative Medicare adjustments, actually securing a 1.5 percent increase in payments, Ms. Brown said. The ACS also helped to achieve passage of medical liability reform legislation in the House and led a movement for continued trauma systems funding, Ms. Brown said.

Because the November elections dominate Capitol Hill this year, it is unlikely that major reform of federal programs will occur. Hence, the College is maintaining momentum and preparing to make a major push in 2005 for the following types of legislation: liability reform; a requirement that CMS fix the problems inherent to the Medicare payment system, which are expected to result in -5 percent decreases 2006 to 2012; funding for trauma systems; patient safety; graduate medical education loan repayments; and scope of practice.

In terms of regulatory activity, the College is focusing on public
and private sector payment policies and the five-year review of the Medicare fee schedule, which will take place next year, Ms. Brown said. The College also is working on a number of issues that play out at the state level, including office-based surgery, liability, and expert witness testimony.

"The most important thing for the Fellowship is to stay informed," Ms. Brown said. "Do express your views to members of Congress, but do express your views to us as well." Means at the Fellows' disposal for boosting their awareness and effectiveness include accessing the Web-based Legislative Action Center and contributing to the ACSPA-Surgeons-PAC, she added.

Be heard

Ilona Nickels, congressional scholar for the Center on Congress at Indiana University, Washington, DC, provided the meeting participants with a context for understanding Capitol Hill. "There isn't a single issue you can name that isn't going to arrive at Congress without some controversy or conflict," Ms. Nickels said.

To resolve those conflicts, legislators often look to their constituents. "Legislators don't view issues strictly through an intellectual lens. They respond from a local, provincial point of view," Ms. Nickels said. "Members can and do vote contradictory to their own intellectual knowledge if it opposes their constituents' demands," she added.

Hence, Ms. Nickels said that if surgeons want their federal legislators to hear their position on important issues, they need to follow up on their Capitol Hill visits by meeting with their senators or representatives when they are in town. "Nothing works as well as seeing them when they're at home," she said. Successful advocacy is "about what you can do to wake up the grassroots."

Preparing for visits

To help prepare for Capitol Hill visits, Christian Shalgian, ACS Manager of Congressional Affairs, led two briefings on issues for the chapter leaders to discuss when meeting with legislators and/or their health policy staff and on what to expect during the visits.

One issue that he encouraged meeting participants to address is medical liability reform. Mr. Shalgian noted that approximately 19 states are experiencing a malpractice insurance crisis, and another 25 are approaching one. He noted that the House passed bills in 2003 and this year that would enact federal reforms similar to those in California’s Medical Injury Compensation Reform Act. However, the Senate has repeatedly blocked companion bills.

Additionally, Mr. Shalgian suggested that the meeting participants ask their legislators to sign letters circulating on Capitol Hill requesting that the CMS make adjustments in the Medicare fee schedule. These "fixes" would help to avert further pay cuts and ensure that physicians continue to participate in the Medicare program.

The third topic that Mr. Shalgian called upon the chapter leaders to discuss during their meetings was funding for trauma care systems. In this instance, too, a letter is circulating in the House and Senate. The letter expresses the signers' support for increased funding of the Trauma Care Systems Planning and Development Act.

Rubbing elbows

In between briefing sessions, participants participated in a reception on Capitol Hill, which was attended by several members of Congress, including Reps. Sherwood Boehlert (R-NY), Michael Burgess (R-TX), Howard Coble (R-NC), and Joe Wilson (R-SC). Another member of Congress, Rep. John Thune (R-SD), made a special guest appearance during the briefings that took place immediately before meeting participants conducted their Capitol Hill visits. Representative Thune said he is running for the Senate this year because he believes that branch of Congress "has become, for all intents and purposes, a dysfunctional place," which needs to be revitalized with some new membership.

In the sidebar on pages 38-39, two Young Surgeon Representatives describe their experience on Capitol Hill. The Capitol Hill visits concluded this year's meeting.
Announcing
THE BASIC ULTRASOUND COURSE
now on CD-ROM

The American College of Surgeons and the National Ultrasound Faculty have developed “Ultrasound for Surgeons: The Basic Course” for surgeons and surgical residents on CD-ROM.

The objective of the course is to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications.

* Replaces the basic course offered by the American College of Surgeons.*
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$300 for nonmembers
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$125 for residents with letter proving status
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For additional information, contact Dawn Pagels, tel. (312) 202-5185, e-mail dpagels@facs.org

*The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this educational activity for a maximum of 6 Category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity. The American Medical Association has determined that physicians not licensed in the U.S. who participate in this CME activity are also eligible for AMA PRA Category 1 credit.*
Dr. Britt receives distinguished educator award

ACS Regent L.D. Britt, MD, MPH, FACS, was awarded the Distinguished Educator Award by the Association for Surgical Education at its annual meeting, on April 2, 2004, in Houston, TX. This award is the most prestigious honor presented by the association to a surgical educator for a lifetime record of outstanding achievement in surgical education. It may be presented to an individual only once.

During the presentation ceremony, Dr. Britt was recognized for his many significant contributions to surgical education throughout his distinguished academic career. Dr. Britt’s pivotal leadership role in taking educational activities of many prestigious national organizations to new heights and his numerous contributions to surgical education were cited. Dr. Britt’s contributions to the educational endeavors of the American College of Surgeons, National Board of Medical Examiners, Association of Program Directors in Surgery, Residency Review Committee for Surgery, and the Association for Surgical Education were especially mentioned. Dr. Britt’s leadership and vision, as well as his stellar mentorship of many surgeons, surgical residents, and medical students throughout his illustrious career, were highlighted.

Dr. Britt has previously received other prestigious education awards, including the highly coveted Alpha Omega Alpha Robert J. Glaser Distinguished Teaching Award of the Association of American Medical Colleges, the Sir William Osler Award, and the Dean’s Outstanding Faculty Award.

Upon receiving the honor, Dr. Britt recognized the previous recipients of this prestigious award and dedicated his award to his late mother, who served with distinction as a high school teacher for many years. For further information about this award, please contact Ajit K. Sachdeva, MD, FACS, FRCSC, at asachdeva@facs.org

A rural surgeon’s perspective, from page 25

vide quality patient care and that promotes the rewards of practicing surgery in all geographic locations. We have a chance to work with policymakers to develop a system that ensures that patients in rural areas have access to the same level of care as city dwellers and that rural surgeons receive payment that matches that of their urban counterparts. These are exciting times, and I anticipate that they will yield positive changes for all surgeons and their patients.
Report of the 2004 Australia and New Zealand Travelling Fellow

by Joseph J. Cullen, MD, FACS, Iowa City, IA

As the 2004 Australia and New Zealand Travelling Fellow, my family and I had the unique opportunity to both explore Australia and to meet some outstanding members of our profession. After flying into Sydney, and taking a few days to recover from the jet lag, we flew to Cairns and stayed in Port Douglas, allowing us to visit the rain forest, the Great Barrier Reef, and the Aboriginal Cultural Center, where we learned how to throw a boomerang.

Sydney

We then flew back to Sydney, and I met with Prof. Stephen Deane, President of the Australia New Zealand Chapter of the American College of Surgeons, and gave surgical grand rounds and medical grand rounds at the Liverpool Health Service Unit of the Southwestern Sydney Area Health Service. My topic was Preventing Postoperative Infections Due to Staphylococcus Aureus.¹

Sydney was outstanding. We toured the opera house and went to a performance later that evening. We also visited the Blue Mountains to the west of Sydney, the AMP Tower, the National Maritime Museum, the Sydney Aquarium, Manly Beach, and Taronga Zoo. My wife Laura and oldest daughter Jessica did the famous “bridge climb” up the Sydney Harbor Bridge.

Dr. Cullen and his family in front of the Twelve Apostles.
Bridge, which stands 439 meters above sea level and took 1,439 steps to ascend.

Adelaide

Our next stop was Adelaide, where I made surgical rounds with Adrian Anthony, consultant in surgery, and the registrars and medical students at the Queen Elizabeth Hospital. Later that morning I was able to listen to numerous presentations by surgical investigators and surgical fellows, who demonstrated the wide scope of both basic science and clinical research projects being conducted within the department. I presented recent work from our laboratory on the role of antioxidant enzymes in pancreatic cancer growth at the department of surgery research meeting at Royal Adelaide Hospital.

Later that evening, our family had dinner with Profs. Peter Devitt and Glyn Jamieson and the latter’s wife. On the weekend, Prof. Guy Maddern and his family gave us a tour of the hills surrounding Adelaide. That experience was delightful. We also had a typical Australian barbecue with a visiting surgical research fellow from Belfast, Ireland, Gary Spence, and his wife Susan. I repeated my talk on the role of antioxidant enzymes in pancreatic cancer growth at the Royal Hobart Hospital in Hobart. While in “Tazzy,” we visited the Cadbury chocolate factory and Port Arthur penal colony. We then made the short flight to Melbourne for the last stop on the trip.

Melbourne

While in Melbourne for the Royal Australasian College of Surgeons (RACS) meeting, I co-chaired the rural surgery section with Rodney Judson and was an invited discussant for the symposium, “The Abdominal Catastrophe,” chaired by Graeme Campbell of Bendigo. The next day I gave the American College of Surgeons’ lecture, Preventing Postoperative Infections Due to Staphylococcus aureus. My final two presentations included Diagnosis and Management of Biliary Dyskinesia for the rural surgery section and The Pendulum of the Nasogastric Tube for the surgical history section. The RACS meeting was special because I had met so many surgeons during our travels and was able to meet and talk with them again at the meeting. Perhaps the highlight of this leg of the trip was when Tracy Bucknall and Andrew O’Kane, friends of ours in Melbourne, took us to an Australian rules football game and arranged for my son Brendon to play for the Melbourne Kangaroos juniors during halftime. It was quite a thrill for an Iowa kid to play in front of 50,000 in the Telstra Dome.

Conclusion

Australia is an outstanding place for Americans to visit because of the unusual wildlife (of which many species are capable of killing you), the beautiful cities and scenery, and the great climate. However, it was the people we met who made our visit truly memorable. They were gracious, helpful, and friendly, ranging from professors of surgery to volunteers in information centers in the smallest of towns. They made us feel at home and were excited to show us the best Australia has to offer. We are truly grateful for this experience.

References

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- Get FREE marketing by partnering with the CoC and American Cancer Society (ACS) in the Facility Information Profile System (FIPS)—an information sharing effort of resources and services and cancer experience for the ACS National Call Center and Web site.
- Participate in the National Cancer Data Base (NCDB)—a nationwide oncology outcomes database for 1,500 hospitals in 50 states—and get benchmark reports containing national aggregate data and individual facility data to assess patterns of care and outcomes relative to national norms.

Programs already participating in the Approvals Program have made the investment to benefit their patients, community, institution, and health care providers. If your facility is committed to providing high-quality cancer care, then Take The Next Step and become one of the more than 1,500 CoC-approved programs in the United States and Puerto Rico that can display the CoC stamp of Approval.
It was an honor and a privilege to be named the first Health Policy Scholar of the American College of Surgeons and the Society of Thoracic Surgeons (STS). I am also grateful to both societies for the opportunity to serve on their respective health policy committees.

Prior to accepting this scholarship, I had no formal experience in the areas of health policy and public administration. Nonetheless, like most surgeons, I was (and remain) quite concerned about the overall direction of America's health care system, both from the perspective of a practicing professional and from that of a potential patient.

As we all know, a considerable portion of the health care dollar is currently spent on administrative expenses, defensive medical practices, and the costs associated with spurious litigation. At a time when adequate access to health care is limited for many people in our country, it is distressing that the financial resources devoted to our medical system are not being used in a more productive way.

It was with this general sense of concern that I sought to learn more about the formulation of health care policy and the means by which surgeons can take a leadership role in this process. I was, therefore, delighted when I learned that I had won this scholarship and am again grateful for the opportunity that it has provided.

The American College of Surgeons/Society of Thoracic Surgeons Health Policy Scholarship is composed of two complementary elements. First, the recipient spends nine days in residence at Harvard University's Kennedy School of Government, taking an intensive executive course in health care policy entitled Skills for the New World of Health Care.

This program is a joint offering between Harvard Medical School, the Harvard School of Public Health, the John F. Kennedy School of Government, and the Harvard Division of Health Policy Research and Education. The second component of the scholarship consists of an opportunity to serve for one year as an ex officio member of the health policy committees of both societies.

My first day at the Kennedy School began with an exercise designed to help us understand the various components of the federal budget. I remember meeting in groups with the assigned task of freeing up a given amount of money to improve access to health care by cutting other discretionary budget outlays. This exercise not only familiarized us with the federal budget itself, but also acquainted us with the type of horse-trading that is inherent in the allocation of limited public funds.

The next major focus of the course centered on the structure and economics of the American health care system. Our class delved deeply into the administration and financing of our nation's major health care entitlement programs, and compared our system of health care administration to that of other nations. Also, we learned various concepts in health care insurance, such as moral hazard and adverse selection, and worked to develop an understanding of how these drivers guided resource allocation under various insurance schemes. Central to this discussion was the notion that "insurance" is a bit of a misnomer for what is provided by our patchwork of third-party payors.

Traditionally, insurance provides relief to someone who suffers the rare catastrophic event. It represents the pooling of re-
resources in small amounts by the many to protect the unlucky few. In contrast, it can reasonably be expected that we will all someday endure illness to a predictable catastrophic end. Thus, our system of health insurance is really a cumbersome mechanism to force savings and to transfer wealth from one person to another, and from the future to the present.

Our discussions then turned to some of the newer trends in health care reimbursement with attention to the much ballyhooed pay-for-performance concept. This reimbursement strategy is designed to encourage the practice of evidence-based medicine by rewarding certain practice patterns while penalizing others. Unfortunately, like many previous attempts at controlling health care expenditures, this reimbursement model primarily redistributes the current health care dollar, without truly addressing the major drivers of wasteful expenditure in the delivery of health care.

The next phase of our intensive program involved an examination of how our government and political system functions. This phase consisted of a very practical series of symposia designed to help us understand strategies and mechanisms for influencing both public opinion and political action. I vividly remember a colloquium with a local politician who was quite frank about the fact that politicians are principally beholden to the short-term interests of their constituency. As such, there is little political reward for long-term planning, particularly when its costs are to the detriment of present circumstances. Perhaps this is why Plato thought that a benevolent dictatorship would be the best form of government. Unfortunately, as Lord Acton observed, benevolent dictators are hard to come by.

The final several days of our intensive program discussed a number of current proposals to optimize the health care system with a focus on issues such as evidence-based practice, professional liability reform, preventive care, and the limitation of end-of-life care, which is often futile and expensive. Finally, our nine-day program was peppered with a variety of colloquia designed to develop leadership skills in the areas of conflict resolution and change management.

All in all, the program at the Kennedy School provided a comprehensive introduction to the arena of health care policy, taught by a superb and diverse faculty, all with considerable professional experience and expertise.

On a personal note, my brief stay at the Kennedy School was the first time that I had returned to Cambridge in any official capacity since graduating college in the mid-1980s. I found the experience of going back to the classroom on a full-time basis to be intellectually stimulating, and I eagerly looked forward to each successive day—a feeling that stood in sharp contrast to a number of memorable college mornings when I had to drag myself out of bed to attend my premedical classes. I guess it is one of the ironies of youth that one cannot wait to finish school in order to enter the workforce.

The second component of the American College of Surgeons/Society of Thoracic Surgeons Health Policy Scholarship was the opportunity to serve for one year on the health policy committees of both societies. The American College of Surgeons Health Policy Steering Committee is ably led by Josef E. Fischer, MD, FACS; and the Society of Thoracic Surgeons Workforce on Health Policy, Advocacy, and Reform is in the capable hands of Kevin D. Accola, MD, FACS. Both of these physicians went out of their way to integrate me into the functions of the committees, providing an outstanding practical experience in health policy formulation and advocacy.

Over this past year, both committees have tackled a number of difficult issues in health care policy. The American College of Surgeons Health Policy Steering Committee formulated a position statement on the structure of America’s future health care system, which preserves patient choice while simultaneously addressing the restrictions on access to care that many of our country’s citizens face. This position statement advocates liability reform and evidence-based practice as mechanisms to fund increased access to care for those individuals who are currently underserved by our health care system.

The Society of Thoracic Surgeons Workforce on Health Policy, Advocacy and Reform also weighed in heavily on the toll that escalating liability premiums are having on the practice of surgery. This situation is particularly troublesome when one realizes that the majority of
malpractice awards do not provide redress for patients who have been aggrieved and that most patients with legitimate claims never receive fair compensation.

Both societies also lobbied strongly to prevent catastrophic reductions in health care reimbursement and to encourage Congress to revise in a durable fashion the manner in which health care reimbursements are calculated. Finally, both societies have come out strongly in support of systems-based reforms to limit medical errors and enhance patient safety.

Over the past year, the American College of Surgeons/Society of Thoracic Surgeons Health Policy Scholarship has given me a broad and substantive acquaintance with the many facets of health policy. Most importantly, it has made me aware of the importance of becoming active in the public sector, so that we can regain control of our own profession and appropriately shepherd limited health care resources for the optimal benefit of our patients. As of late, we have become victims of our own apathy, while those not directly charged with patient care have taken advantage of our altruism and our political naiveté. It is imperative that each of us works with our professional societies in their advocacy efforts on behalf of our profession and our patients.

Dr. Allan is assistant professor of surgery, Harvard Medical School, division of thoracic surgery, Massachusetts General Hospital, Boston, MA.

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**Dr. Schultz to head FDA’s Center for Devices and Radiological Health**

Daniel G. Schultz, MD, FACS, Gaithersburg, MD, has been selected to lead the division of the Food and Drug Administration (FDA) that is responsible for the review of all medical devices and radiation-emitting products, such as magnetic resonance imaging equipment and X-ray machines. Dr. Schultz will also be responsible for overseeing the continued implementation of the Medical Devices User Fee Act of 2002, which authorizes the FDA to collect user fees for review of medical device marketing applications and sets performance goals for those reviews.

Dr. Schultz started his career with the FDA in 1994 and has served as an officer in the General Surgery Branch, the Division of Reproductive, Abdominal and Radiological Devices, and as Director of the Office of Device Evaluation. He received his medical degree from the University of Pittsburgh (PA), finished a combined internship in pediatrics and medicine at the University of New Mexico, and completed his general surgery residency at the Public Health Service Hospital in San Francisco, CA. In October 1981, he moved to Denver to finish his general surgery training and a fellowship in pediatric surgery. He maintains board certification in general surgery and family practice.


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**ACS Scholars to present at the Surgical Forum**

The International Relations Committee is pleased to report that one current and one former International Guest Scholar, Dan D. Hershko, MD, of Haifa, Israel, and Mingqiang Xie, MD, FACS, of Guangzhou, China, respectively, will give presentations at the Surgical Forum during the 2004 Clinical Congress in New Orleans, LA.

In addition, 22 U.S. and Canadian awardees (various years) of the Scholarships Committee, plus the ACS/RCS Research Exchange Fellow, Wai-Yee Li of London, UK, will also present at the Surgical Forum in October of this year.
O **ONLINE CME:** Courses from the American College of Surgeons’ Clinical Congresses are available online for surgeons. The online courses feature printable written course transcripts, audio of sessions, video of the introduction of each session, post-test and evaluation, and printable CME certificates upon successful completion. Several of the courses are offered FREE OF CHARGE. The courses are accessible at: [www.acs-resource.org](http://www.acs-resource.org).

O **BASIC ULTRASOUND COURSE:** The ACS and the National Ultrasound Faculty have developed this course on CD-ROM to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. It replaces the basic course offered by the ACS and is available for CME credit. The CD can be purchased online at [http://www.facs.org/education/usoundCDROM.html](http://www.facs.org/education/usoundCDROM.html) or by calling ACS Customer Service at 312/202-5474.

O **BARIATRIC SURGERY PRIMER:** Developed by Henry Buchwald, MD, PhD, FACS, and Sayeed Iramuddin, MD, FACS, the primer addresses the biochemistry and physiology of obesity; identifies appropriate candidates for bariatric surgery; and discusses the perioperative care of the bariatric patient, basic bariatric procedures, comorbidity and outcomes, surgical training, and the bariatric surgical and allied sciences team, along with facilities, aspects of managed care, liability issues, and ethics. The CD-ROM is available by contacting ACS Customer Service at 312/202-5474.

O **SYLLABI SELECT:** The content of select ACS Clinical Congress postgraduate courses is available on CD-ROM. These CD-ROMs are able to run in the PC and Mac environments and offer you the ability to word-search throughout the CD, along with the convenience of accessing any of the courses when you want, and where you want. The CDs can be purchased by calling 312/202-5474 or through the College’s Web site at [https://secure.facs.org/commerce/2003/current.html](https://secure.facs.org/commerce/2003/current.html). The 2004 CD will be available in October.

These fine educational products are available for your learning convenience.

Please visit our **E-LEARNING CENTER** at [www.acs-resource.org](http://www.acs-resource.org) to view new products available from the ACS Division of Education.

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

• The American Medical Association’s Board of Trustees elected John H. Armstrong, MD, FACS, to serve as the board’s secretary, making him the first young physician trustee elected to serve on the body’s executive committee. Dr. Armstrong is an assistant professor of surgery at the Uniformed Services University of the Health Sciences, Bethesda, MD.

• Edmond B. Cabbabe, MD, FACS, a plastic surgeon in St. Louis, MO, was installed as the 2004-2005 president of the Missouri State Medical Society during the organization’s 146th annual meeting in April. Dr. Cabbabe is chief of plastic surgery at St. Anthony’s Medical Center in St. Louis and DePaul Health Center in Bridgeton and is a clinical professor of surgery in the division of plastic surgery at Saint Louis University School of Medicine.

• Capt. Dana C. Covey, MD, FACS, recently received the Sir Henry Wellcome Medal Prize, which is awarded to the author of an essay that reports on original research work in the field of military medicine. At press time, Captain Covey was serving at a U.S. Marine Corps surgical hospital in Fallujah, Iraq.

• Asklepiad Press announces the new text, A Brief History of Disease, Science, and Medicine, by Michael T. Kennedy, MD, FACS. Dr. Kennedy has turned a series of lectures into a brief history of medicine for medical and nursing students, young physicians, and other readers with some science education but no previous exposure to medical history. The text, which is listed on amazon.com, features a 40-page index, detailed bibliography, and over 550 footnotes—most of them references to original articles.

• Eugene Myers, MD, FACS, professor and chair of the department of otolaryngology at the University of Pittsburgh (PA) School of Medicine, recently participated in a number of international meetings. More specifically, he was a guest lecturer at: the Asia-Oceania Otolaryngology-Head and Neck Surgery Congress in Kuala Lumpur, Malaysia, the III Curso Internacional Teorico-Pratico de Cirurgia da Laringe, in Rio de Janeiro, Brazil; and the annual meeting of the Hungarian Society of Otolaryngology in Sopron, Hungary.

• Frederick W. Reckling, MD, FACS, along with J anolyn G. Lo Vecchio and JoAnn B. Reckling, are co-authors of a new biography about the late Leonard F. Peltier, MD, PhD, FACS (1920-2003). Onward and Upward: The Career Trajectory and Memories of Leonard F. Peltier, MD, PhD, is published by the Clendening History of Medicine Library and Museum at the University of Kansas Medical Center, Kansas City. Dr. Reckling is professor emeritus, department of orthopaedic surgery, University of Kansas School of Medicine.

• Cerebrovascular surgeon Robert H. Rosenwasser, MD, FACS, has been named chair of the department of neurosurgery at Jefferson Medical College, Thomas Jefferson University, Philadelphia, PA. He succeeds William Buchheit, MD, FACS, who is retiring. At press time, Dr. Rosenwasser continued to serve as professor of neurosurgery and director of the division of cerebrovascular neurosurgery and neuroradiology at Jefferson Medical College and Thomas Jefferson University Hospital. Dr. Rosenwasser is an expert in preventing and treating life-threatening brain aneurysms.

• Carl Snyderman, MD, FACS, William Welch, MD, FACS, and Amin Kassam, MD, recently performed the first endoscopic resection of the odontoid process of C1 in a patient with brain stem compression secondary to rheumatoid arthritis of the odontoid process. Drs. Snyderman and Kassam are co-directors of the center for cranial base surgery at the University of Pittsburgh Medical Center and are considered pioneers of minimally invasive procedures for tumors of the brain base. Dr. Snyderman is associate professor of otolaryngology at the University of Pittsburgh School of Medicine, PA, and Drs. Kassam and Welch are both in the institution’s department of neurosurgery.
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. Pories, 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. Cowan, 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
NTDB™ data points

“Water and alcohol don’t mix”

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

Summer is in full swing, and in the Midwest that means that the best months for boating are here. Operating a boat on a lake or inland waterway is often a peaceful and relaxing venture. Unfortunately, recreational boating is not immune to human indiscretions. In order to take a boat out on the lake, all you need is the vehicle. There are no formal licensing processes, no testing requirements, no “rules of the road,” or any traffic signs. There is just a lot of water, sunshine, and plenty of cool beverages to be consumed.

Let’s take a closer look at the kinematics of watercraft injuries. For those persons who have not boated before, certain aspects often require a fair amount of skill. Take the process of docking a power boat. I liken that procedure to getting into a luxury automobile and pulling up alongside a guard rail. Slow the vehicle down to five miles per hour, and then place the shifter into neutral. You are now coasting in a 20,000 pound vessel without brakes while trying to rub up against the guard rail ever so slightly to slow down the boat’s momentum, while trying not to mar the arctic white fiberglass finish. The first mate will attempt to get off of the slow moving boat, assuming that is has been brought close enough to the dock, in order to place the lines over the dock cleats to secure the boat. Now imagine this exercise after having consumed several alcoholic beverages. It is easy to see where torso crush injuries can occur.

Now let’s take the boat out of the marina and onto the lake. High speeds, endless water, the lack of proper safety gear, and the consumption of alcohol can be a formula for disaster. There are only a couple of thousand water craft injury records contained in the National Trauma Data Bank’s Annual Report 2003. But of those records tested, almost one-third had consumed alcohol. The results are depicted in the chart on this page.

According to the U.S. Department of Homeland Security, U.S. Coast Guard Boating Statistics Report, over one-third of all boating fatalities involved the consumption of alcohol. Considered by some individuals to be freak accidents, boating-related fatalities now rank second only to car crashes as the cause of transportation-related deaths in the U.S. More people die in boating accidents every year than in airplane crashes, train wrecks, or bus accidents.

As with “drinking and driving” responsibly, we need to make sure that we exhibit a high level of caution when consuming alcohol and venturing onto the three-fourths of the earth’s surface that is covered by water.

Throughout the year we will be highlighting these data through brief monthly reports in the Bulletin. For a complete copy of the National Trauma Data Bank Annual Report 2000, visit us online at our new Web address: http://www.ntdb.org. 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 or to share photos of your chapter’s events, please contact Rhonda Peebles toll-free at 888/857-7545 or via e-mail at rpeebles@facs.org.

Maine meeting focuses on practice management

Members of the Maine Chapter met June 4-6 to examine various topics related to practice management. The first day of the education program, which was planned by William R. Horner, MD, FACS, Immediate Past-President, focused on coding and financial issues, and the following day included an examination of models for data collection to measure outcomes. Thomas R. Russell, MD, FACS, ACS Executive Director, updated the chapter on the College’s involvement with the National Surgical Quality Improvement Program.

Ohio meeting centers on advocacy

The Ohio Chapter’s annual meeting, which took place May 4-5, followed a new format and focused on advocacy activities. After briefings on state legislation by ACS staff and the Ohio Chapter’s lobbyist, Dan Jones, chapter members headed to their state capitol in Columbus to meet with legislators and their staff. The first day of events concluded with a reception that many state legislators attended. On the second day of the meeting, the Ohio Chapter awarded its Distinguished Service Award to D. Ross Irons, MD, FACS, who has served the chapter in many leadership capacities over the years (see photo, top right).

Sessions during the annual meeting addressed several topics of importance to Ohio Fellows, including:

- The results of a survey of Ohio Fellows showing that some surgeons are partnering with hospitals to help address concerns related to professional liability insurance.
- An update on the chapter’s political action committee, which has received contributions totaling more than $14,000 during its first year of operation.
- Plans to conduct a study to examine the extent to which surgical residents leave the state after training.
- Endorsement of a protocol to ensure correct site surgery, which was developed by the Ohio Patient Safety Institute.
- Election of the following new officers: Michael S. Nussbaum, MD, FACS (left), presents the chapter’s Distinguished Service award to Dr. Irons.
Brooklyn-Long Island conducts young surgeons' dinner

The Brooklyn-Long Island Chapter conducted its 32nd Young Surgeons’ Dinner, which was held in conjunction with the chapter’s 2004 annual meeting. Claude H. Organ, Jr., MD, FACS, ACS President, represented the College at the event (see photo, opposite page).

Chapter anniversaries

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New York continues advocacy agenda

In May, the New York Chapter wrote to Gov. George Pataki (R), urging him to apply for a 2005 grant from the hospital preparedness program to support the state’s trauma system and registry. Then in June, the chapter convened a group of program directors to hear presentations from the New York State Department of Health and Regulations, and from the New York State Council on Graduate Medical Education. John D. Nicholson, MD, FACS, the Immediate Past-President of the chapter, noted that this new Program Directors Committee would provide opportunities to frame problems related to work-hour restrictions and to work on solutions together.

Finally, the New York Chapter is conducting a survey related to premiums for professional liability insurance. The survey is a joint effort sponsored by several statewide medical and surgical professional societies representing ophthalmology, obstetrics and gynecology, orthopaedic surgery, thoracic surgery, emergency medicine, and internal medicine, as well as the Medical Society of the State of New York. For more information on the survey, or to participate, contact the New York Chapter at 518/433-0397.

Dakota chapters unite

The North Dakota and the South Dakota Chapters met April 30-May 2. These two chapters have been meeting jointly and sharing education program planning responsibilities since 1997. This year, Keith Lillemoe, MD, FACS, served as the visiting professor, and during the joint social event, Miles E. Tieszen, MD, FACS, delivered a stunning presentation on his experiences in Iraq. In addition, the South Dakota Chapter recognized several

Education activities strengthen surgery in the Dakotas

by Mark O. Jensen, MD, FACS, Fargo, ND

The education programs presented jointly by the North Dakota Chapter and South Dakota Chapter of the College have helped to strengthen surgery in both states by:

- Analyzing what local surgeons are doing in their ORs. Despite grand rounds and morbidity and mortality conferences, the procedures being performed locally and regionally may surprise some surgeons and will define their communities’ “standards of care.”
- Providing a venue for community surgeons and academic surgeons to report on unique aspects of their practices. Surgeons in private practice often lead the way in technology applications and new procedures.
- Mentoring residents and medical students. Since the North Dakota Chapter began to focus its activities on these two groups of young surgeons, the University of North Dakota has increased its match rate in surgery and other surgical specialties by 30 percent.

by Mark O. Jensen, MD, FACS, Fargo, ND
Past-Presidents (all Fellows of the College): Samir Abu-Ghazaleh, Terry Alstiel, Mary Milroy, Gary Timmerman, Peter Andreone, Edward J. S. Picardi, Gregg Tobin, and Greg Schultz.

**Illinois contributes to PAC**

Subsequent to the 2004 Leadership Conference, which was held May 16-18, in Washington, DC, the Illinois Chapter contributed $2,500 to the American College of Surgeons Professional Association’s SurgeonsPAC (political action committee). Under the leadership of Lorin D. Whittaker, Jr., MD, FACS, Immediate Past-President, the Illinois Chapter is the first to make such a contribution. Additionally, the Illinois Chapter became a Life Member of the Fellows Leadership Society in 2003.

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**Next month in JACS**

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

- **Original Scientific Articles**
  - New Transanal Excision for Rectal Tumors
  - Open vs. Closed Sphincterotomy for Anal Fissure
  - Fatalities Associated with Surgical Staplers

- **Collective Review**
  - Accelerated Partial Breast Irradiation

- **What’s New in Surgery**
  - General Surgery: Endocrine Surgery
  - Urology