

BULLETIN

AMERICAN COLLEGE OF SURGEONS



February 2004
Volume 89, Number 2

A photograph of a stack of papers. A fountain pen with a gold nib and a black barrel lies on the papers. A large, rolled-up document is partially unrolled, showing its inner layers. The scene is lit from the side, creating soft shadows.

How a bill becomes a law

Bulletin of the American College of Surgeons (ISSN 0002-8045) is published monthly by the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. It is distributed without charge to Fellows, to Associate Fellows, to participants in the Candidate Group of the American College of Surgeons, and to medical libraries. Periodicals postage paid at Chicago, IL, and additional mailing offices. POSTMASTER: Send address changes to Bulletin of the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211. Canadian Publications Mail Agreement No. 40035010. Canada returns to: Station A, PO Box 54, Windsor, ON N9A 6J5.

The American College of Surgeons' headquarters is located at 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5000; toll-free: 800/621-4111; fax: 312/202-5001; e-mail: postmaster@facs.org; Web site: www.facs.org. Washington, DC, office is located at 1640 Wisconsin Ave., NW, Washington, DC 20007; tel. 202/337-2701, fax 202/337-4271.

Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the authors' personal observations and do not imply endorsement by nor official policy of the American College of Surgeons.

©2004 by the American College of Surgeons, all rights reserved. Contents may not be reproduced, stored in a retrieval system, or transmitted in any form by any means without prior written permission of the publisher.

Library of Congress number 45-49454. Printed in the USA. Publications Agreement No. 1564382.

NEWS

ACS and RCS(Eng) to sponsor research fellowship

21

GAO issues report on assistants at surgery

22

International Guest Scholarships available

24

2005 Australia and New Zealand Chapter Travelling Fellowship available

25

ACS Traveling Fellowship to Japan available

26

Trauma and Critical Care 2004 to be held in May

27

Contributions sought for 2004 Clinical Congress

29

Disciplinary actions taken

31

Correction

31

NTDB™ data points: The graying of America

32

by Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

Highlights of the ACSPA Board of Directors and the ACS Board of Regents meeting, October 18-19, 23, 2003

33

Letters

37

Chapter news

38

Rhonda Peebles

The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

Officers and staff of the American College of Surgeons

Officers

Claude H. Organ, Jr., MD, FACS, *Oakland, CA**
President
Anna M. Ledgerwood, MD, FACS, *Detroit, MI*
First Vice-President
Murray F. Brennan, MD, FACS, *New York, NY*
Second Vice-President
John O. Gage, MD, FACS, *Pensacola, FL*
Secretary
John L. Cameron, MD, FACS, *Baltimore, MD*
Treasurer
Thomas R. Russell, MD, FACS, *Chicago, IL*
Executive Director
Gay L. Vincent, CPA, *Chicago, IL*
Comptroller

Officers-Elect (take office October 2004)

Edward R. Laws, MD, FACS, *Charlottesville, VA**
President-Elect
Andrew L. Warshaw, MD, FACS, *Boston, MA*
First Vice-President-Elect
Henry L. Laws, MD, FACS, *Birmingham, AL*
Second Vice-President-Elect

Board of Regents

Edward M. Copeland III, MD, FACS, *Gainesville, FL**
Chair
Gerald B. Healy, MD, FACS, *Boston, MA**
Vice-Chair
H. Randolph Bailey, MD, FACS, *Houston, TX*
Barbara L. Bass, MD, FACS, *Baltimore, MD**
L. D. Britt, MD, FACS, *Norfolk, VA*
Bruce D. Browner, MD, FACS, *Farmington, CT*
Martin B. Camins, MD, FACS, *New York, NY*
William H. Coles, MD, FACS, *Chapel Hill, NC*
A. Brent Eastman, MD, FACS, *San Diego, CA*
Richard J. Finley, MD, FACS, *Vancouver, BC*
Josef E. Fischer, MD, FACS, *Boston, MA*
Alden H. Harken, MD, FACS, *Oakland, CA*
Charles D. Mabry, MD, FACS, *Pine Bluff, AR*
Jack W. McAninch, MD, FACS, *San Francisco, CA*
Mary H. McGrath, MD, FACS, *San Francisco, CA**
Robin S. McLeod, MD, FACS, *Toronto, ON**
Claude H. Organ, Jr., MD, FACS, *Oakland, CA*
Carlos A. Pellegrini, MD, FACS, *Seattle, WA*
Karl C. Podratz, MD, FACS, *Rochester, MN*
John T. Preskitt, MD, FACS, *Dallas, TX*
J. David Richardson, MD, FACS, *Louisville, KY*
Thomas V. Whalen, MD, FACS, *New Brunswick, NJ*
*Executive Committee

Board of Governors/Executive Committee

Courtney M. Townsend, Jr., MD, FACS, *Galveston, TX*
Chair
Rene Lafreniere, MD, FACS, *Calgary, AB*
Vice-Chair

Julie A. Freischlag, MD, FACS, *Baltimore, MD*
Secretary
Donald E. Fry, MD, FACS, *Albuquerque, NM*
Mary Margaret Kemeny, MD, FACS, *Jamaica, NY*
Mark A. Malangoni, MD, FACS, *Cleveland, OH*
Valerie W. Rusch, MD, FACS, *New York, NY*

Advisory Council to the Board of Regents (Past-Presidents)

W. Gerald Austen, MD, FACS, *Boston, MA*
Oliver H. Beahrs, MD, FACS, *Rochester, MN*
John M. Beal, MD, FACS, *Valdosta, GA*
Harvey W. Bender, Jr., MD, FACS, *Nashville, TN*
George R. Dunlop, MD, FACS, *Worcester, MA*
C. Rollins Hanlon, MD, FACS, *Chicago, IL*
R. Scott Jones, MD, FACS, *Charlottesville, VA*
M. J. Jurkiewicz, MD, FACS, *Atlanta, GA*
LaSalle D. Leffall, Jr., MD, FACS, *Washington, DC*
Lloyd D. MacLean, MD, FACS, *Montreal, QC*
William H. Muller, Jr., MD, FACS, *Charlottesville, VA*
David G. Murray, MD, FACS, *Syracuse, NY*
David C. Sabiston, Jr., MD, FACS, *Durham, NC*
Richard R. Sabo, MD, FACS, *Bozeman, MT*
Seymour I. Schwartz, MD, FACS, *Rochester, NY*
George F. Sheldon, MD, FACS, *Chapel Hill, NC*
G. Tom Shires, MD, FACS, *Las Vegas, NV*
Frank C. Spencer, MD, FACS, *New York, NY*
James C. Thompson, MD, FACS, *Galveston, TX*

Executive Staff

Executive Director: Thomas R. Russell, MD, FACS
Division of Advocacy and Health Policy:
Cynthia A. Brown, Director
American College of Surgeons Oncology Group:
Samuel A. Wells, Jr., MD, FACS, Group Chair
Communications: Linn Meyer, Director
Division of Education:
Ajit K. Sachdeva, MD, FACS, FRCSC, Director
Executive Services: Barbara L. Dean, Director
Finance and Facilities: Gay L. Vincent, CPA, Director
Human Resources: Jean DeYoung, Director
Information Technology: Howard Tanzman, Director
Journal of the American College of Surgeons:
Wendy Cowles Husser, Executive Editor
Division of Member Services:
Paul E. Collicott, MD, FACS, Director
Division of Research and Optimal Patient Care:
R. Scott Jones, MD, FACS, Director
Cancer:
David P. Winchester, MD, FACS, Medical Director
Trauma:
David B. Hoyt, MD, FACS, Medical Director
Executive Consultant:
C. Rollins Hanlon, MD, FACS

From my perspective

The December 2003 issue of *Cardiovascular Surgery* features the provocative article “Introduction: The decline of surgery” by Steven G. Friedman, MD, FACS.* In this article, the author points out the realities of surgical practice today and shows how market forces have eroded many of the guiding principles of the profession. Although surgery has remained relatively unscathed by corporate scandals and other aspects of modern society, Dr. Friedman maintains that a number of factors are leading to the decline and fall of our profession.

Decline

For example, he notes that surgery remains a male-dominated profession, which often has been unwilling to accept into its fold females and members of other minority groups. As a result, we have too few role models to offer the increasingly diverse medical student body, more than half of whom are women.

Other problems that Dr. Friedman highlights are socioeconomic in nature, including the huge expenses that trainees incur due to the length of residency training. Debt-ridden young surgeons then enter into practice only to be further encumbered by restrictions on reimbursement. In addition, he notes that professional liability premiums and lifestyle issues are among other serious problems that clearly face our profession.

All of these factors, Dr. Friedman says, have culminated in a declining pool of medical students who are interested in pursuing a surgical career. As he points out in his article, one effort to make surgical residency more palatable to medical students—and to lessen public concerns about the possible effects of fatigue on caregivers—is the recently implemented mandate from the Accreditation Council for Graduate Medical Education, which requires all residency programs to adhere to an 80-hour workweek. Dr. Friedman notes that this requirement will have profound effects on the training of surgical residents. He quite eloquently suggests that one way to change the way surgeons are trained is to shorten the number of years in residency and thus allow surgical residents to more quickly attain their goals.

*Friedman SG: Introduction: The decline of surgery. *Cardio Surg*, 11(6):449-452, Dec. 2003.



Most of us realize that change is necessary if we are going to appeal to the caliber of students that will be required in the future.

Ascent

While I acknowledge that Dr. Friedman raises some very important issues for our consideration, his article seems to present a rather bleak vision for the future of the profession. Clearly, in his scenario the glass is half empty. I happen to hold a more optimistic view of the future of our profession. In fact, I believe that if one looks at the situation from a different perspective, the glass is half full. Indeed, I would offer a counterpoint article and title it “The Ascension of Surgery.” In it, I would demonstrate that for many of the problems Dr. Friedman discusses, there are solutions that we need to pursue and reasons why we should be sanguine about the future.

First of all, let us remember that surgeons in all specialties will always be in demand. Unfortunately, surgical diseases and conditions are not going to disappear any time soon. Allied health care providers have neither the skills nor the training to perform operative procedures safely and effectively. Hence, an adequate surgical workforce will continue to be necessary.

Medical students apparently are becoming increasingly aware of the stability of surgical practice, as demonstrated in recent data from the Na-

tional Resident Matching Program. The various surgical specialties continue to have high match rates. For example, in 2003 general surgery residencies filled 99 percent of their slots, and 83 percent of individuals who matched are graduates of U.S. medical schools. Similarly, match rates in other surgical specialties were as follows: neurosurgery, 97 percent; orthopaedics, 99 percent; otolaryngology, 94 percent; and urology, 95 percent. In contrast, only 76 percent of the family practice positions filled, and the match rate for all specialties was 90 percent.[†]

In many ways, we have been the profession's own worst enemy. Our unwillingness to accept the fact that we need to make changes in the way we approach medical students and the way we train residents has prevented us from attracting more people to the profession.

As professionals, we must act as positive role models. We need to avoid dwelling on the problems in our health care system when talking with medical students and, instead, we must focus on some of the favorable aspects of our profession, such as the joy and pleasure we derive from using our hard-earned skills and knowledge to alter the lives of our patients in a positive way.

Additionally, we need to make surgical rotations more interesting for medical students. One way in which that goal can be accomplished is through efforts such as technical skills testing in laboratories. Interactive approaches to learning are likely to stimulate medical students in their development of technical and cognitive knowledge. Moreover, as good mentors, we should seek not to develop clones of ourselves, but to simply introduce medical students to the excitement and pleasures of a surgical career, which can span the horizon from ophthalmology to orthopaedics, and not necessarily focus on our own specialty.

As we forge ahead, we also must be aware of the lifestyle issues that are very much on the minds of medical students today. Clearly, the way we train residents in the future will be very different from the traditional process. The 80-hour workweek is just the beginning. To attract a more diverse group of residents, we will need to account for changing lifestyle concerns and the fact that many younger people will want to split practices or work in a less

intense environment in order to accommodate their lives outside of the OR.

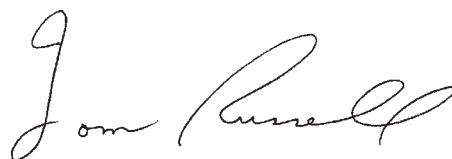
Currently, most of the surgical specialties are participating in active dialogue about training pathways for the future, and are discussing efforts to shorten the number of years and to allow a more direct track to gaining expertise in a certain area of surgery. Some tension will come out of this dialogue, but I believe the discussion will yield better ways to train surgeons—methods that will be at least as effective and certainly more efficient than those used in the past.

Change comes from within

As we reflect on the way we were trained, most of us realize that change is necessary if we are going to appeal to the caliber of students that will be required in the future. Many of us are “recovering surgeons,” trained in an era of total immersion in our profession to the exclusion of other aspects of life. This process trained generations of dedicated and competent surgeons, but it will no longer work.

Claude H. Organ, Jr., MD, FACS, President of the American College of Surgeons, has stated that he would like his term to be remembered as the year of the resident. Dr. Organ has continuously repeated this sentiment in his talks around the country, recognizing that now is the time when we must begin to address the needs of the residents so that they will find a career in surgery to be fulfilling and rewarding in all of its many aspects.

As the profession evolves and begins to implement these modifications, I believe we will discover that the glass truly is half full. I am confident that we will continue to see the ascension of surgery as fundamentally and critically important to our nation's patients and its health care system.



Thomas R. Russell, MD, FACS

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

4 [†]National Resident Matching Program, 2003 match data.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

Drug law's implementation affects Medicare in 2004

A number of provisions in the Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA) of 2003, P.L. 108-173, became effective on January 1, 2004. The resultant changes are as follows:

- The 2004 physician fee schedule conversion factor was increased 1.5 percent to \$37.34.
- The deadline for physicians to make their Medicare participation decision for 2004 was extended until February 17.
- Payment formulas were raised in several areas, providing that the work geographic practice cost index (GPCI) in any Medicare payment locality cannot be less than 1.00 (the national average), and in Alaska the work, practice expense, and malpractice GPCIs cannot be less than 1.67. As a result, physician payments in some areas of the country will increase by as much as 4.8 percent and in Alaska by 52 percent.
- In a complex set of provisions, the price paid for most physician-administered drugs was lowered, but that reduction was offset by an increase in payments for drug administration. Urology, which receives 43 percent of its Medicare money from drugs, loses 4 percent in this cost shift.

The law also amended the Emergency Medical Treatment and Labor Act (EMTALA) to allow emergency room services to be evaluated for medical necessity on the basis of information available to the treating physician *at the time the services were ordered*. Some carriers had been evaluating the services based on the principle or final diagnosis.

The new provisions are described in a rule that can be viewed at <http://www.cms.hhs.gov/physicians/pfs>. The complete MPDIMA, including the EMTALA provisions in section 944, is available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:h1enr.txt.pdf.

Health care spending continued to climb in 2002

The Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) published a report in January indicating that health care spending in the U.S. climbed to \$1.6 trillion, or approximately \$5,440 per person, in 2002. This 9.3 percent increase in 2002, together with the 8.5 percent increase in 2001, has contributed to a spike of 1.6 percentage points for health care's share of the gross domestic product since 2000.

Spending accelerated for most services. Increases in hospital spending (\$486.5 billion) rose 9.5 percent following a period of managed care expansions (1993-1998) in which hospital growth averaged only 3.4 percent. Spending for physicians' services increased 7.7 percent in 2002 to \$339.5 billion, a decline from the 2001 growth rate of 8.6 percent. While Medicare payment accounted for only 20 percent of payment to physicians (\$68.8 billion), the 4.8 percent decline in the fee schedule conversion factor was the primary driver behind the spending deceleration for physicians in 2002.

HHS announces Medicare discount drug program

Health and Human Services (HHS) Secretary Tommy G. Thompson issued an interim final regulation for the Medicare prescription drug discount card program in December. This rule represents the first step toward implementation of the benefit expansions made through the MPDIMA and will allow seniors and individuals with disabilities to use these cards to save about 10 to 15 percent on their total drug costs. All Medicare beneficiaries, except those who already have Medicaid outpatient drug coverage, will be able to enroll in Medicare-approved drug discount card programs, with benefits beginning in June, and they may continue participating until the Medicare prescription drug benefit is implemented in 2006.

A key element of the Medicare prescription drug discount card program is a subsidy of up to \$600 a year for eligible low-income beneficiaries. Individuals who earn less than \$12,124 each year and married couples who have incomes of less than \$16,363 may qualify for this subsidy. In addition, Medicare will cover the cost of the enrollment fee for these low-income cardholders. For more information about the regulation, go to: <http://www.hhs.gov/news/press/2003pres/20031210a.html>.

Operating costs for orthopaedic surgeons increase 12.3 percent

A Medical Group Management Association study indicates that professional liability premiums and escalating staff costs are two factors contributing to a 12.3 percent rise in median operating costs for orthopaedic practices between 2001 and 2002. Staffing costs increased 8.1 percent, and professional liability insurance costs nationwide jumped 26.1 percent—with practices in many states absorbing even greater hikes. The study also found that Medicare payor charges were up 6.2 percent in the examined year, while total median medical revenue increased 6.6 percent. For most group practices, ancillary services, such as physical/occupational therapy, diagnostic X ray, and magnetic resonance imaging, appear to be keeping them afloat financially. For more information, visit <http://www.mgma.com/press/>.

AMA focuses on liability issues

During the American Medical Association's (AMA's) 2003 interim meeting of its House of Delegates (HOD), the College and a number of the surgical specialty societies successfully raised the profile of the need for stronger AMA policy regarding expert witness testimony. In response to a resolution authored by the College and subsequent reference committee testimony, the HOD has charged the AMA's Board of Trustees with developing recommendations for stronger expert witness standards for the HOD to review and approve at its 2004 annual meeting. In 2004, the College intends to center more of its state advocacy efforts on this particular aspect of liability reform.

HOW DOES A BILL BECOME A LAW ?

by Jennifer Razor, JD,
Government Affairs Associate,
Washington Office,
Division of Advocacy and Health Policy

A N I N S I D E R S G U I D E

One of the most important traits of individuals who succeed at congressional lobbying is that they have a strong grasp of legislative procedure. This article provides an introduction—or refresher, as the case may be—on that process, including insight into how laws are shaped from the ground up.

Introduction

The whole process begins when a member of Congress introduces a piece of legislation, which may originate in either the House of Representatives or the Senate. Typically, legislative proposals come in the form of bills. For example, during the last session of Congress, members introduced nearly 9,000 bills. This article will track a bill's life, starting first in the House and then moving over to the Senate, though certainly bills are just as likely to originate in either chamber.

Any member may introduce a bill at any time while the House is in session. To introduce a bill in the House of Representatives, a member simply places it in the “hopper,” a wooden box located on the House floor. The member who introduces the bill is known as its primary sponsor. An unlimited number of additional members may co-sponsor a bill.

The clerk assigns the bill a number. A bill originating in the House of Representatives is designated by the acronym “H.R.,” followed by a number. Likewise, “S.” followed by its number designates a Senate bill. Many pieces of legislation will be introduced in similar or identical form in both the House and Senate. These are commonly referred to as “companion bills.” Last year, medical liability legislation was introduced in this form as H.R. 5 and S.11 in the House and Senate, respectively.

Referral to committee

Once a bill is introduced, the clerk assigns it to each committee that has jurisdiction over its subject matter and sends a copy to each committee chair. In the House, most health care bills are referred to the Energy and Commerce Committee, the Ways and Means Committee, or both. However, other committees do focus on issues of concern to surgery. For example, bills that would enact medical liability reform or an anti-

trust exemption for physician joint negotiations are referred to the Judiciary Committee.

Perhaps the most important phase of the legislative process occurs when a bill is “in committee.” Many issues first gain recognition at this stage. Due to the great volume of bills referred to committee, however, most bills never progress beyond this point. For example, in an effort to stop the 5.4 percent Medicare physician payment cut from taking effect in 2002 nearly a dozen bills were introduced in the House alone but never progressed beyond committee consideration, despite broad bipartisan support of the issue.

Committee consideration

The committees give the most intense consideration to a proposed measure. Before analyzing a specific piece of legislation, a committee or one of its subcommittees may hold a hearing on the issue. Members of the committee or subcommittee hear testimony from witnesses, including members of Congress, cabinet officers, high-ranking government officials, or private citizens.

After hearings are completed, the subcommittee will usually hold a session that is popularly referred to as a “markup.” During this process, the Representatives meet in the hearing room and work through the legislation line by line, discussing sections and offering amendments. At the conclusion of the discussion, the subcommittee votes to determine the next action. Most often, the subcommittee will report the bill favorably to the full committee, with or without amendment.

Upon the recommendation of the subcommittee, the entire subcommittee process may be repeated at the full committee level. Of course, it is within the discretion of the committee chair to take action on the legislation. If the chair chooses to move the bill forward, the full committee usually marks up the legislation, offering and debating additional amendments, and then the committee votes on how to report on the bill to the full House.

If the committee votes to report the bill to the House, the committee staff drafts a report, which describes the purpose and scope of the bill and the reasons for its recommended approval. Generally, a section-by-section analysis is provided, explaining precisely the intents of each portion. All changes to existing law must be detailed in the document. Executive branch communications on

the bill are also appended at this stage. Committee reports are perhaps the most valuable element of the legislative history of the law. Executive departments and courts will later use these reports to determine legislative intent.

Consideration and debate

In the House, the Rules Committee specifically has jurisdiction over resolutions relating to the order of business in the House. This small committee determines when and how a particular bill will be debated and voted on. It designates the time for debate and whether amendments may be offered on the floor. Once the Rules Committee has reached an agreement, the whole House votes on the rule for debate on the individual bill. When a majority of members vote favorably on the rule, the House may proceed to consider and debate the bill itself. Legislation usually passes by a simple majority vote.

Once one chamber passes a piece of legislation, the process begins anew in the other chamber. In this case, the bill would move to the Senate, where it would be referred to committee. Senate committees give the bill the same detailed consideration as it received in the House. They may report the bill out of committee with or without amendment. After suffering through the Senate committee process, with some exceptions, the bill can move to the Senate floor for debate.

The rules of procedure in the Senate differ to a large extent from those in the House. The Senate was designed to serve as a deliberative body and relies heavily on the practice of obtaining consensus for actions to be taken. Debate ends only after a Senator yields the floor and no other Senator seeks recognition, unless a unanimous consent agreement limiting the time of debate is operating.

While this open debate forum offers many benefits, it often lacks expediency. For example, when a bill is reported from committee, the Senate Majority Leader Bill Frist, MD, FACS (R-TN), may ask for unanimous consent for the immediate consideration of the bill. The Senate does not have a panel that is comparable to the House Rules Committee. If the bill is not controversial, barring an objection, the Senate may pass the bill with little or no debate, including only a brief explanation of its purpose and effect. However, even in this in-

stance, the bill is subject to amendment by any Senator. As a general rule, just a simple majority vote is necessary to carry an amendment as well as pass the bill.

On occasion, Senators who oppose a measure may extend debate by making lengthy speeches intended to prevent or defeat action. This tactic is commonly known as a “filibuster.” Once the presiding officer recognizes a Senator, that individual may speak for as long as he or she wishes and loses the floor only after yielding or forfeiting it. Use of this strategy has traditionally prevented Senate consideration of medical liability reform, for example.

Conference committee

If a piece of legislation passes both the House and the Senate, it is ready for final action. If the chambers passed identical bills, the legislation may proceed immediately to the President. However, presumably amendments were accepted along the way or the bills differed from the start, which means that the bills must be reconciled through a conference of the House and Senate.

The mere fact that each chamber may have passed its own bill on a subject is insufficient grounds for making either bill eligible for conference. One chamber must first take the additional step of amending and then passing the bill of the other body and requesting a conference. If the other body agrees to the request, each body appoints a number of members representing both political parties to represent the House and the Senate.

Many high-profile pieces of legislation stumble at this point in the race. For instance, in the summer of 2001, the House and Senate both passed the Patients’ Bill of Rights. Unfortunately, conferees never met to reconcile the two bills, which were passed with vastly different provisions. When Congress adjourned its two-year session late in 2002, the bill died. For that legislation to be signed into law, it would need to return to the starting gate and be reintroduced.

When the conferees, by majority vote of each group, have reached complete agreement, they make their recommendations in a conference report. On occasion, the conferees may agree on some but not all of the provisions. The report is then sent back to the House and the Senate for consid-

WAYS TO HELP

Fellows may serve as a voice for surgery on Capitol Hill by joining one of the College’s federal advocacy teams, which are as follows:

The Capitol Team

Surgeons on the Capitol Team work directly with College lobbyists to build strong relationships with their Senators and Representatives. With the support of College staff, each team member will contact one congressional office on a regular basis to discuss how federal health care policies affect surgery. Members of the Capitol Team must be willing to spend, on average, one hour per month learning about federal policies, talking with College lobbyists, and contacting congressional staff. College staff will provide team members with all necessary background information, contact names and numbers, and legislative updates.

The District Team

Surgeons on this team work with their chapters and College lobbyists to schedule local meetings with their Senators and Representatives when Congress is out of session. Members of the District Team must be willing to meet with their representatives once or twice each year in their hometown. College staff will provide team members with local contact names and numbers, as well as talking points and briefing materials.

The Constituent Team

Surgeons on the Constituent Team receive e-mail action alerts about timely legislative issues. The action alerts contain a brief legislative update and a Web link to a prewritten letter that may be e-mailed to their representatives. Members of the Constituent Team must be willing to spend, on average, 10 minutes a month e-mailing or calling their representatives.

To inquire about participation in any grassroots effort, Fellows are encouraged to contact the Department of Advocacy and Health Policy at 202/337-2701 or via e-mail at hap@fac.org.

Congressional procedure terms

Act: Legislation that has passed both houses of Congress and has been signed by the President or that has been vetoed with Congress overriding that decision.

Amendment: A change in a bill during legislative consideration, or change in an existing law by enactment of new legislation.

Cloture: The process that ends a Senate filibuster, requiring the vote of 60 out of 100 senators to pass.

Companion bills: Identical or similar bills introduced in both houses of Congress.

Conference committee: The committee formed to reconcile differences between similar House and Senate bills that have been passed by both houses.

Hopper: Box on the House clerk's desk where members deposit bills to introduce them.

Cosponsor: A member who joins one or more members in sponsoring a measure.

Filibuster: A delay tactic used by the Senate minority party to prevent a vote on a bill.

Hearings: Committee sessions for taking testimony from witnesses, which usually include specialists, government officials, and entities affected by the legislation under study.

Markup: A process whereby a bill is revised in committee or subcommittee.

Rider: A provision that is attached to a bill that may have no direct relationship to that bill.

Veto: The President's disapproval of a bill or joint resolution.

G L O S S A R Y

eration. Each must now pass the revised legislation in identical form.

Presidential action

A final bill that has survived all the previously mentioned stages in the process becomes law only after the President reviews it. As was the case with the Medicare prescription drug bill, the President will often approve the legislation by signing it. If

the White House objects, a piece of legislation fails to become law without the President's signature, unless Congress overrides a presidential veto with a two-thirds vote in each chamber.

Procedure as a tool


Mastering the basics of congressional procedure is essential to moving an agenda on Capitol Hill. As constituents, surgeons wield more power in Congress than they often realize. Senators and Representatives are sensitive to physicians' views. They frequently want input from surgeons regarding health care policy.

Enacting a particular piece of legislation, as outlined above, by and large entails a number of steps. Elected officials remain susceptible to influence at a variety of points along the way. Usually, the most effective stage for Fellows' active involvement is the week leading up to action on a bill, whether it is a markup, a floor vote, or a meeting of the conference committee.

When a committee or subcommittee holds hearings on an issue, the College communicates its position to congressional staff through letters and written statements. The ACS may arrange to have witnesses at hearings and often encourages surgeons whose representatives serve on the subcommittee to contact their lawmakers.

Once a bill reaches the floor for a vote by the whole House or Senate, the focus switches to encouraging all members to vote for or against the measure. The ACS regularly meets with Congressional offices in Washington, but constituent support for a measure can often be the key to gaining a member's support. Hence, surgeons may be effective in many places along the way to passage of a bill.

Getting involved

Surgeons are encouraged to use the College's Legislative Action Center <http://capwiz.com/facs/home/> to send letters to their legislators regarding issues that are important to surgery. In addition, the College can offer interested Fellows help in getting involved in grassroots advocacy, regardless of previous experience. Fellows are encouraged to contact the office for assistance in communicating with Congress at 202/337-2701 or via e-mail at hap@facs.org. 

A surgeon reports on his experience as a patient in an ACOSOG trial



by Ralph Keill, MD, FACS, Monterey, CA

I had been retired from my last position as a hospital medical director for about two years when I first noticed some soreness in my abdomen after doing curls at the gym. I thought the pain was just the result of a strained rectus muscle, so I avoided abdominal exercises for several weeks, but when I tried again, the soreness returned. I decided to avoid abdominal exercises altogether and experienced no more pain. However, over the next month or so, my abdomen seemed to feel increasingly full and firm. I figured I may have developed a rectus muscle hematoma because I had been taking 1,000 mg of aspirin daily since having a stroke in 1998. The symptoms persisted, but no others developed.

Diagnosis

The timing was very bad because my physician had just closed his practice, and I had yet to establish care with a new physician. My elderly mother-in-law's health was declining, and my son was about to get married, so I planned to postpone seeing anyone about my concerns until these other situations settled down.

As fate would have it, I received a mailing about a screening ultrasound in the area and, thinking I certainly didn't want to be sitting on an aortic aneurysm, I decided to go. The results revealed no aneurysm but did show a large abdominal mass with mixed echoes. I had never seen anything like it. Having been in the private practice of general and vascular surgery for 22 years, those results convinced me that I needed to see someone.

I called to make an appointment the next day with an internist in my community. He scheduled a computed topography (CT) scan, which revealed a large, well-circumscribed mass arising from the anterior wall of my stomach. The next day I had an ultrasound-guided biopsy, the results of which showed I had a stromal tumor. The biopsy itself was completely painless and interesting to watch. At the time, they also aspirated 1,000 cc of serous but blood-tinged fluid from the mass. Afterward, I felt much less bloated.

I knew nothing about the surgeons in the area because my last position had been at a hospital in a nearby community. I called an infectious disease specialist who was on staff at all the hospitals in the county for a recommendation. I had become acquainted with him in my medical director posi-

tion, knew him to be an excellent physician, and believed he would make a good recommendation. He suggested a surgeon, and I made an appointment.

Hope

I felt very good about the surgeon, Lane Verlenden, MD, FACS, when I met him. After a visit, some preoperative lab work, and some time spent giving a unit of blood for autotransfusion, on November 7, 2002, I had the mass, along with a portion of my stomach, resected. My postoperative recovery was uneventful, almost easy. Before I left the hospital, however, I again was told that I had a stromal tumor with a low mitotic rate. It was at this time that I first heard about a new oral drug called Gleevec that had been used to treat this tumor and another condition.

After my discharge from the hospital, I began researching Gleevec on the Internet and first came across the term gastrointestinal stromal tumor (GIST). I also received some recent literature from a friend's son who had recently completed his surgical residency. I learned that GIST is rare, that it is sometimes benign and sometimes malignant, and that it is difficult to tell which tumors will behave which way.

The surgeon provided me with a copy of my pathology report, and further research showed that my tumor had mostly benign but some malignant characteristics. I also had learned that Gleevec was very effective against this tumor, but it had only been used and approved for treatment of patients with recurrent or unresectable tumors. I began thinking about possibly taking the drug as a form of adjuvant therapy. The surgeon referred me to an oncologist to discuss this possibility.

I immediately liked the oncologist. We had much in common. We had both been in the military during the Vietnam era, had begun practice within a few years of each other, and had both been instrumental in getting a hospice established in our communities. He learned that the American College of Surgeons Oncology Group (ACOSOG) was initiating a clinical trial to study the effects of Gleevec on GIST. The only difficulties with regard to participating in the ACOSOG trial were that the study had a tight timeline for entry, it required taking the drug for a year, and it would involve a detailed and long-term follow-up process.

Entering the study

I decided to try and gain entrance to the ACOSOG trial and quickly set about arranging the necessary exams, blood tests, and CT scans. The side effects described seemed to be mostly of the aggravating but not dangerous variety. No one had much experience with the drug, and the oncologist had only used it on a handful of patients for its other indication. I was accepted into the study and began taking the medicine January 27, 2003, at the protocol's prescribed dose of 400 mg/day.

The dose consisted of four 100 mg tablets each day after a large meal, preferably the evening meal. The informed consent included a disclosure of the common (greater than 10%) and uncommon (less than 10%) side effects. I also was informed that the study would consist of about 89 subjects nationally. I began taking Gleevec and quickly discovered that if I took it as recommended, I experienced absolutely no side effects. If I forgot to take the medicine right after dinner and instead took it before I went to bed, I would have mild diarrhea. I quickly fell into a routine and never missed a dose. My weight remained stable, and I felt well and completely normal.

The first two months I was on the medication, I saw the investigating physician and had blood tests every two weeks. This regimen was to be followed by visits and tests once a month for another four months, then every three months for the first two years, and then every six months for the next three years. In addition, I was supposed to have a thoracic, abdominal, and pelvic CT scan every three months for the first two years and then every six months for the next three years.

The investigating physician had a nurse whose only responsibility was to coordinate clinical research studies, and she kept my treatment scheduled and on track. I was in regular communication with her and found that her efforts kept me organized with respect to what was expected and planned. Participating in the study did not affect my lifestyle at all, and I could continue all my normal activities. My red blood cell count did decrease somewhat but not to anemic levels.

Side effects arise

In mid April 2003 my wife and I went on a trip to Paris and Ireland. Several days after arriving in Paris, I became aware that I was having edema of

my feet, lower legs, and hands, and a pruritic rash covered my body. I also developed large blisters on the soles of my feet. I was aware that edema was one of the known side effects of the medicine. I also thought the edema might be related to the long airplane flight and remembered that I developed a skin rash after being on Ticlid for over a month due to the previously mentioned stroke. Additionally, I wondered if the rash could be due to something the bed sheets had been washed in, because it was worse on my back. A few days after the onset of these conditions, I stopped the Gleevec for several days, but noticing no improvement, I resumed taking the medicine. The rash and edema persisted throughout the trip, but I continued the medication until I returned home.

Once home, I checked the Gleevec Web site and learned that 38 percent of the people taking the medicine developed a rash and other skin conditions and 76 percent developed edema. I saw the oncologist, who stopped the medicine and started me on a diuretic. The edema quickly resolved and the rash began to disappear. Most of my symptoms abated within a week of being off the medication, so I went back on it at a lower dose, per study protocol. Within a week, the rash and edema came back with a vengeance. This time I developed very hypertrophic skin with flaking and extreme dryness on some parts of my body, along with fissuring on my fingertips and on my feet. My wife remarked that it looked like my skin had aged 10 years in a week. I was again taken off the medication, and, although the edema disappeared within a week, it took several weeks for my skin to return to normal. My physician contacted the study leader, and they decided that I should not resume the drug therapy. Thus, I stopped Gleevec after being on it for between three and four months.

Normal life resumes

In late July 2003, I had follow-up blood tests and a CT scan as required by the study. At that point I was about nine months postoperative. My hemogram, which had decreased a bit while on the medication, was back to normal levels, and the liver function tests and the CT scan were normal. Another set was planned when I approached the one-year anniversary of the operation. I have not found the frequency of the follow-up visits and studies to be problematic at all, and I have been able to con-

continue all my activities and travels without interruption.

Two important lessons

I would certainly participate in the clinical research study again if confronted with the same decision, and believe I have reached two major conclusions as a result of this experience. First, "a physician who treats himself has a fool for a patient." Second, clinical trials are useful tools in determining how to effectively treat many diseases.

The relationship between a physician and a patient is a partnership in which both people need to have a voice in decisions. When physicians become patients they probably have a greater understanding of the issues than a random patient, so they can be more active participants in the decision-making process. Ultimately, though, it is the treating physician who must decide on the best course of care. Physician/patients do a disservice to themselves if they try to manage or dictate their own care.

I had a previous significant experience as a patient when I had the major stroke mentioned previously. In that instance, I was hospitalized for three weeks, underwent therapy for eight months, and received follow-up care from several physicians for a number of years. During that time I had to accept that I was dependent on others and felt I had a real partnership with my physicians. I had the same experience this time as a physician/patient. In both these cases, I had no previous contact with the physicians involved but still felt a closeness and confidence with those caring for me.

The second lesson learned involves my feeling about the importance of clinical research studies in general. The first time I entered a clinical trial, I participated in a physician's health study conducted at Harvard to determine if low-dose aspirin lowered the incidence of heart disease in normal males and if betacarotene lowered the incidence of certain types of malignancies in normal males. It was a double-blind study, so we didn't know whether we were taking the items being studied or a placebo. The aspirin part of the study stopped after five years because it was clear that aspirin did reduce the incidence of heart disease, but the betacarotene part was carried out for 10 years before it was discontinued. I still receive a questionnaire 20 years later for follow up.

I firmly believe that these clinical research studies are a worthwhile tool for determining the best therapy for patients. The Harvard study was invaluable in revealing that low-dose aspirin had a protective effect on lowering the incidence of heart disease in normal males and that betacarotene was not beneficial in protecting against certain types of malignancies.

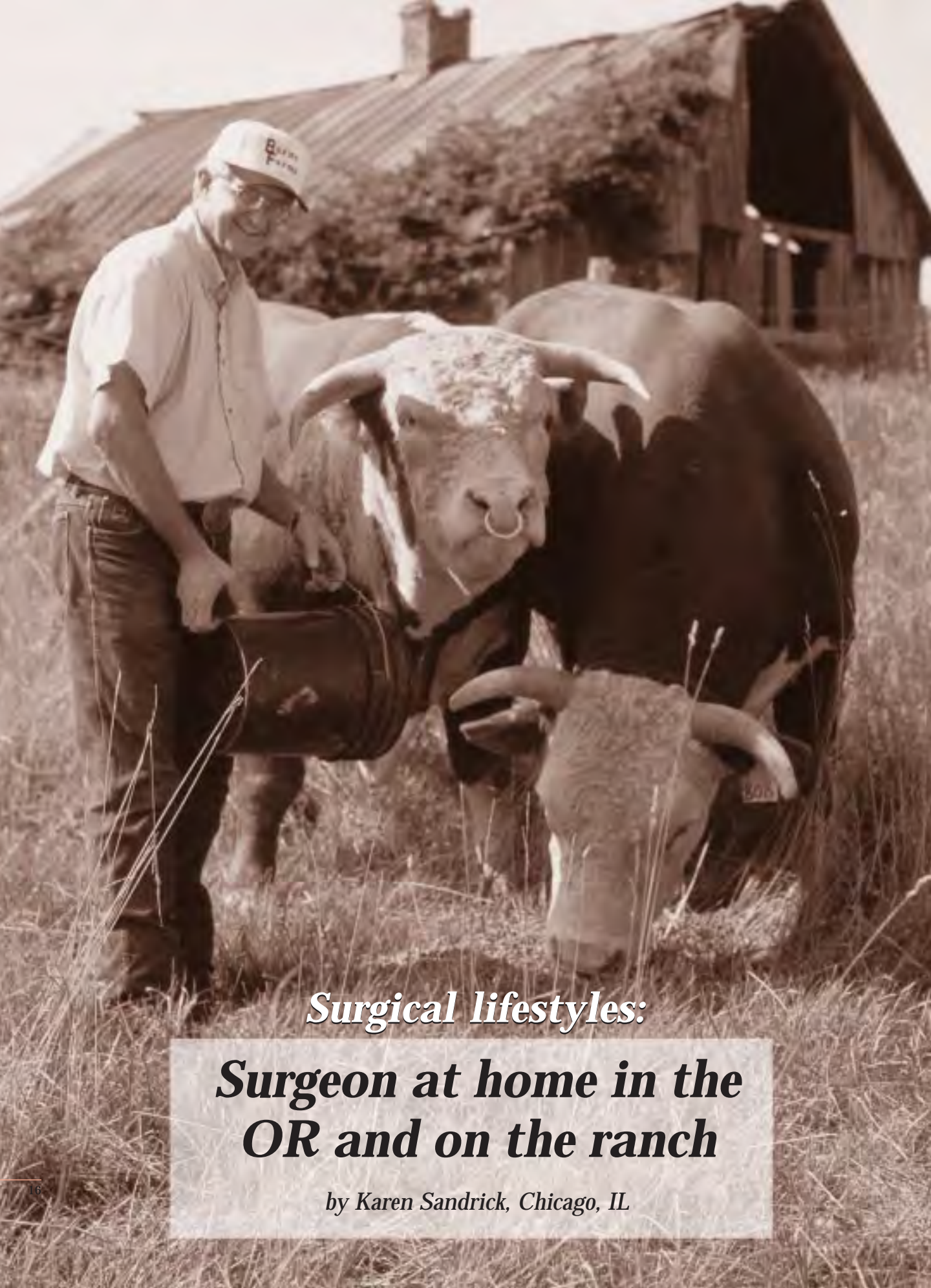
Hopefully, this study about Gleevec in treating GIST will reveal if it has a place as an adjuvant therapy for this rare gastrointestinal tumor. Even though I was unable to tolerate the medication for the duration of the study, my participation may be helpful in determining the optimal length of therapy. We are all aware that the initial length of adjuvant therapy for breast cancer was much longer than it is today. That determination was most likely gleaned from the results of study participants.

To conclude, I am happy to report that I just completed my one-year follow-up exam, blood tests, and CT scans with no evidence of recurrence. I intend to continue to participate in the follow-up studies as long as it is requested. I would certainly participate in the study again if the same choices were presented to me. I also would encourage any physician confronted with being a patient to be exactly that. Don't try to manage your own illness, but work in partnership with your physician to achieve the optimal care for your illness or problem.

Finally, I would like to thank ACOSOG for undertaking this study of the adjuvant use of Gleevec in GIST at just the perfect time for my participation. □

Dr. Keill is a retired vascular and general surgeon living in Monterey, CA.





Surgical lifestyles:

***Surgeon at home in the
OR and on the ranch***

by Karen Sandrick, Chicago, IL

R Phillip Burns, MD, FACS, grew up in the cattle business. At the age of nine, in 1951, he mortgaged a horse he had bought with a World War II war bond he received from his uncle, and with the \$500, he purchased two steers. After tending to the steers and showing them at a state fair, he sold the cattle at auction, paid off the bank loan, borrowed another \$1,500, and bought five more steers.

The son and grandson of ranchers, Dr. Burns wanted to spend his working life with livestock, but his father discouraged him from majoring in agribusiness in college and then working the family's cattle ranch in the lower, southeastern section of Tennessee. "We had not inherited land; we had bought it on borrowed money, and the margin of profit was so narrow, my father felt it would be difficult for me to make a living in the cattle industry," he said.

So, Dr. Burns decided to enroll in a preveterinary program to at least keep in contact with animals and livestock. However, in his sophomore year, he realized he didn't want to end up treating dogs and cats and suspected a veterinary practice devoted to large animals would be questionable financially. "There wasn't that much profit in the cattle side of veterinary medicine because most cattlemen weren't using vets for routine work," he said.

After working with a general surgeon in his hometown, Dr. Burns found that surgery not only was fascinating but allowed him to work with his hands. So he switched to medicine and then specialized in surgery. Since then, he's been both a surgeon *and* a cattleman.

Two careers

Today Dr. Burns is chair of the department of surgery at the University of Tennessee College of Medicine, Chattanooga. He is a former member of the American College of Surgeons' Advisory Council for Surgery and a current member of the general surgery residency review committee.

Dr. Burns also runs a 1,500-acre ranch with his brother that at any one time has 400 breeding cows for calving and a total of 700 to 900 head. "But it's not a white-fence place; it's a working ranch. We keep fences up, but they're not painted or for show.

They're just to keep the cows in," he stressed. And Dr. Burns is not a gentleman rancher. "I don't drive around in a truck and ask somebody else to do things. If something needs renovating in the barns or wherever, I get to do that," he said.

Dr. Burns and his brother raise Herefords, which were first bred in Hereford, England, about two and one-half centuries ago. The breed, which is a cross between red Yorkshire livestock and white-faced animals from Holland or a mix of Welsh and Herefordshire stock, is an ideal source of beef because it fattens at an early age, and it produces large amounts of milk.

Herefords are one of the oldest breeds of cattle in this country and many years ago replaced both the longhorn and the western shorthorn cattle as the dominant breed in Texas.

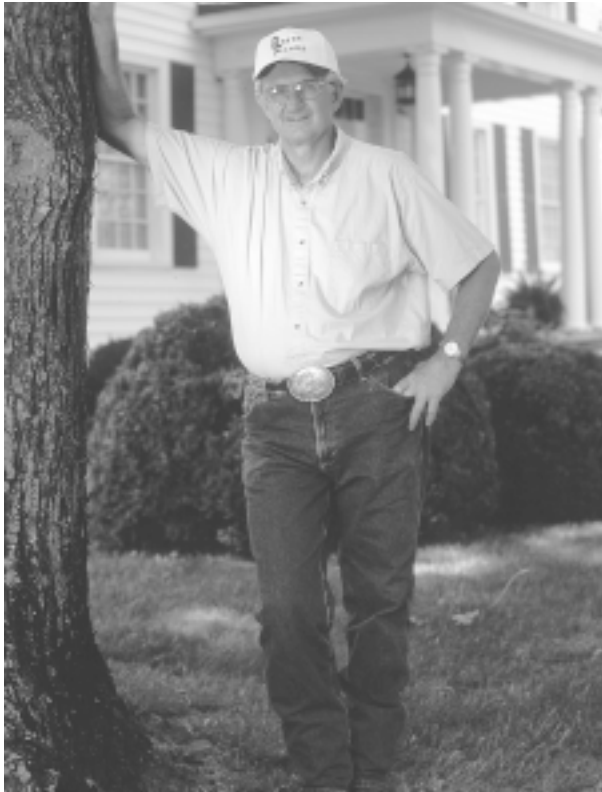
Characteristic Hereford cattle, which range in color from dark red to reddish yellow with a white face, crest, dewlap, and underline, now can be found throughout the country from California, Colorado, Montana, Oklahoma, Kansas, Nebraska to Illinois, Kentucky, and Dr. Burns' home state of Tennessee.

Cattle industry promoter

Dr. Burns is so dedicated to the breed that he is the only physician to serve on the board of directors and as president of the American Hereford Association. While active in the leadership of that organization, Dr. Burns helped establish its business direction and management, overseeing the passage of chief executive officer reins and overall organizational reengineering, as well as the promotion of a branded Hereford beef program. Begun in 1994, the certified Hereford beef program labels beef products that have been genetically proven to provide better tasting beef. Over the last few years, the program has mushroomed. In 2002, the Certified Hereford Beef program grew faster than any other year, accounting for nearly 28 million pounds in beef sales, an increase of 106 percent in sales over the previous year, and causing the American Hereford Association to create the not-for-profit Certified Hereford Beef, LLC, to license and protect the use of the Certified Hereford Beef trademark and market the brand.

Clearly, Dr. Burns' involvement in the cattle industry is not a hobby; it's serious business. "Every day is a work day for me," he said. Whenever

Opposite page: Dr. Burns with his herd bulls in Pikeville.



Dr. Burns

he is not performing surgery or teaching, he is working with cattle—on his family’s ranch or in cattlemen’s association meetings. And he doesn’t spend much time in the morning drinking coffee deciding what to do.

Dr. Burns and his wife live in Signal Mountain, TN, which is west and slightly north of Chattanooga overlooking the Tennessee Gorge. The cattle ranch is 45 to 50 minutes west. Because the division between Eastern and Central time zones runs right down Signal Mountain, Dr. Burns can rise at 6:00 am, leave his home at 6:15 am, and get to the ranch at 6:00 am. Of course, he loses an hour on the return trip, but he doesn’t mind since he’s just going to go to bed.

He not only sells cattle but shows them as well, participating in all of the clipping, feeding,



Dr. Burns (right) with bull Bf808 Domino 092.

breaking, and leading. Last year, he had a particularly good string of show cattle, especially a bull that captured the top prize at all state and regional fairs in Tennessee. But that achievement is only the latest example of Dr. Burns’ eye for first-quality cattle. In 1994, Dr. Burns, his brother, and another couple from Tennessee selected a bull calf that won the Kentucky Derby of cattle shows, the National Western Hereford Show, in Denver, CO, the next year.

Roping it together

Balancing the demands of academic surgery and those of the cattle business is not always easy. “If you want to keep more than one ball in the air, you have to be willing to take on the stress that brings,” Dr. Burns said. But he has been able to keep both in focus. “When you’re doing one thing, you’re often thinking about another. You can’t do that all the time, but you can do it part of the time,” he said.

At the same time, he’s kept both professional areas separate. “As someone once told me, ‘You’re a doctor among doctors and a cattleman among cattlemen.’”



Ms. Sandrick is a freelance writer living in Chicago, IL.

Socioeconomic tips

Organizing your surgical practice

By Tom Loughrey, Pittsburgh, PA

Dozens of surgeons took advantage of the practice management consultations offered by the College at its 2003 Clinical Congress in Chicago, IL. These surgeons had an opportunity to get advice on a variety of practice management subjects, ranging from starting a practice to retiring and virtually every area in between. Particularly noticeable this year was an earnest desire on the part of surgeons to meet all the socioeconomic challenges facing today's practices through better organization and the application of best practices. Surgeons' questions centered on where they need to focus their efforts and available resources. Following are some of the most frequently asked questions that surgeons posed and the consultant's responses.

I want to be in control of my practice's operating costs. I'm not opposed to spending money where it is needed, but I don't want to waste any money either. How can I control costs and make my income goal?

The best way to take charge is to develop a budget for the coming year. First, establish a realistic desired income goal. Add to this amount the expenses you anticipate for the year. The sum is your cash need for the year. By dividing this total by the collection rate, a practice can determine its needed charges. We recommend breaking this figure down to the number of days you will work in the coming year to arrive at a daily charge goal. This information can be tracked in a simple spreadsheet. By budgeting the expenses, including cash purchases of capital items, a practice can control exactly when and how its money is spent. The practice can plan for cash flow deficits and be aware of when expenses are out of line. The best way to monitor this activity is to follow a monthly financial statement compared to budget. Creating and then adhering to a budget is the best way to control expenses and meet income goals.

Around the corner

- Economedix teleconferences are scheduled as follows: Negotiate Winning Third Party Contracts (Feb. 25 and 28); Preparing for the HIPAA Security Rules, (March 10, 13, 24, and 27). For more information and to register, go to <http://yourmedpractice.com/ACS-Teleconference>.
- ACS-sponsored basic and advanced coding courses and practice management course for surgeons on March 25-27 in Houston, TX. Visit the ACS coding and practice management course Web page at <http://www.facs.org/dept/ahp/workshops> to register.

We seem to be inundated this year with compliance regulations. How can we keep track of these and know we are staying out of any regulatory trouble?

There are several areas of "compliance," but the ones getting the most attention right now pertain to complying with rules emanating from the Health Insurance Portability and Accountability Act (HIPAA), fraud and abuse related to billing, and the Occupational Safety and Health Administration (OSHA). Additionally, practices must abide by federal and state laws on employment practices, access for persons with disabilities, and patient translation services, among many others.

The best way to deal with HIPAA compliance for privacy and security is to have a policy and procedure handbook and to train all employees and physicians in its use. The HIPAA rules for submitting compliant electronic claims are somewhat different. Compliance in this area is largely going to be accomplished by your software or service vendor. Stay on top of them and get written confirmation

of their efforts. Currently, most payors are paying old claims even if the format is not compliant. This policy most likely will end sometime this year, and practices do not want their cash flow interrupted.

OSHA compliance varies depending on practice location. In some states it is administered as a state program, and in other states it is a federal program. In every case, posting and reporting of workplace injuries is required. Of primary concern for physicians are the regulations for blood-borne pathogens, typically spread by needlesticks. All staff members need adequate protection, safe sharps collection systems, and, most of all, adequate training to protect themselves and others. Staff and physicians must also be offered hepatitis B immunizations, and if they forego vaccination they must confirm this choice in writing.

Fraud and abuse compliance is simply a matter of making certain your billing is consistent with your documentation. Informal internal audits are an easy way to ensure compliance. Review the guidelines for documentation in your copy of *Current Procedural Terminology*, and then pull several charts for each surgeon, and look at the documentation. Recode the services based on the documentation, and then compare it with what was actually coded and billed. Check for improper coding and provide necessary retraining to individuals needing it. Repeat this procedure several times a year.

We seem to be sloppy when handling routine patient encounters. We seem to be reinventing each step as we go along. Sometimes they are managed well, and other times poorly, depending on who is doing the job and when. How can we be more consistent in our day-to-day work?

Inconsistency is usually a sign of inadequate policies and procedures or lack of compliance with and enforcement of the policies and procedures. One place to start is with the development of a list of common tasks in the office, such as opening the office, taking messages, arranging appointments and operations, sterilizing instruments, ordering supplies, sending claims, and cleaning the exam room. In any office, dozens of major tasks and hundreds of minor tasks must be completed. By describing the major tasks and how, when, and by

whom they are to be done, these responsibilities can be effectively organized.

Assignment of these tasks becomes the basis of job descriptions. When people understand their jobs and have the resources and authority to complete them, employees will generally carry out their responsibilities to the limit of their skills, training, and motivation. Management must then decide whether an individual's abilities are sufficient or whether he or she needs more training, better skills, or different motivation. First, however, the specific tasks and the persons responsible for their execution must be defined.

My partners and I generally get along well, but we disagree about the direction of the practice. We are at different stages in our careers and have different expectations with regard to income, time off, taking call, practice expansion, and governance. How can we all get on the same page and still recognize our individual needs?

Too often in busy practices the physicians and top management simply get together too rarely to discuss these issues. The best way to do it in an organized way is to start with an annual physician/management retreat. It is best if some of the retreat is for physicians only then followed by time with management. At this meeting, the big issues can be discussed, including the mission of the organization, plans for the coming year and beyond, capital budgets for equipment, and expansion and practice growth. Discussion of these issues will usually reveal individual preferences, which are most often accommodated by compromises on everyone's part. Productive compromise is the ultimate expression of group and individual maturity. It requires mutual respect, a solid set of personal and professional values, and willingness to think about the big picture rather than short-term rewards.

The next step toward achieving organization in
continued on page 27

Mr. Loughrey is CEO of Economedix, LLC, a practice management consulting and training firm based in Pittsburgh, PA. He may be reached at tloughrey@economedix.com or 714/633-2251 for more information or materials to assist surgeons in developing more organized practices.

ACS and RCS(Eng) to sponsor research fellowship

The American College of Surgeons (ACS) and the Royal College of Surgeons of England (RCS) are offering a two-year research fellowship to a young U.S. or Canadian surgeon to gain training in specific research methods through active participation in a surgical research project in the United Kingdom. Applications will be considered in any aspect of surgery or surgical care, including related basic science, diagnosis, treatment, surgical technology, or logistics. Applicants should ensure that their proposals clearly indicate the research and development training they expect to receive. The fellowship award is \$52,000 (U.S.) per year for each of two years as a stipend for the fellow and in support of the research training project, and is not renewable thereafter.

General policies covering the granting of the ACS/RCS Research Fellowship Exchange are:

- The award is open to members of the American College of Surgeons who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of

Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

- Applicants should provide evidence of productive initial efforts in surgical research.

- The award may be used for stipend or other purposes at the discretion of the recipient. Indirect costs are not paid to the recipient or to the recipient's institution.

- Applicants may not be current recipients of major research grants. Application for this award may be submitted even if comparable application to other organizations has been made. If the recipient accepts a scholarship, fellowship, or career development award from another agency or organization, the ACS/RCS Research Fellowship will be withdrawn. It is the responsibility of the recipient to notify the Scholarships Administrator of the ACS of competing awards.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant's research effort should be submitted. This approval would involve a commitment to the acceptance of the research fellow and the availability of facilities for research.

- The applicant's mentor should be an active investiga-

tor in the area of the proposed research who will directly supervise the applicant's research. The mentor must document the availability of staff, research support, and facilities for high-quality research training.

- The applicant must submit a detailed research plan and propose a budget for the two-year period of the research, even though renewed approval is required for the second year. The applicant is also required to submit a cover letter of approximately 400 words that describes the career objectives, how these career objectives will be achieved, and how the research protocol furthers the applicant's career development. The applicant is expected to devote a minimum of 40 hours per week to his/her research training project.

- The review criteria depend upon an assessment of the applicant's previous academic and research performance and potential to become an important contributor to surgical science; an assessment of the quality of the training environment and the qualifications of the mentor for the proposed research training project; the merit of the proposal itself and its relationship to the applicant's career plans; and the value of the fellowship as it relates to the applicant's requirements for a career as an independent researcher.

- It is desirable that the fellowship period should be held during a leave of absence, so that the applicant has a known position to which to return afterwards.

- The awardee is expected to attend both the Annual Meeting of the Royal College of Surgeons of England and the Clinical Congress of the American College of Surgeons (October 7-11, in New Orleans, LA) in 2007 to present

reports to the ACS Scholarships Committee and RCS representatives.

- The American College of Surgeons and the Royal College of Surgeons require a research progress report after one year. A summary of research progress and information regarding current academic rank, sources of research support, and future plans at the conclusion of the research period is also required.

The closing date for receipt of applications is May 1, 2004. A fellow and an alternate will be selected and notified by July 1, 2004, and the fellowship will begin January 1, 2005. Application forms may be obtained upon request from the Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or from the College's Web site at www.facs.org.

GAO issues report on assistants at surgery

In January, the General Accounting Office (GAO) issued a report entitled *Medicare: Payment Changes Are Needed for Assistants-at-Surgery* (GAO-04-97). Written in response to a directive by Congress to report on the potential impact of allowing Medicare fee schedule payments for certified registered nurse first assistants, the report concludes that Congress may wish to consider consolidating *all* Medicare payments for assistant at surgery ser-

vices under the hospital inpatient prospective payment system.

This provision would include assistant at surgery services by all provider types, both physician and nonphysician, without regard to employment status. Because Medicare's Part A hospital payments are intended to cover assistant-at-surgery services that are provided by hospital employees—and those payments are not reduced when a Part B payment to an

assistant at surgery is made under the physician fee schedule—the GAO believes that the program may be paying too much for some hospital surgical care.

The College and other surgical and nonsurgical specialty organizations have already begun educating Congress about the very serious implications of such a radical policy change. To view the full report online, visit <http://www.gao.gov/new.items/d0497.pdf>.



Change your address online!

Just visit www.facs.org
and go to the "Members Only" tab

Profiles in Leadership

Pon Satitpunwaycha, MD, FACS

Fellow of the American College of Surgeons since 1973. Recipient of the 2001 Fellows Leadership Society Distinguished Philanthropist Award. A practicing community surgeon in Houston, TX.

"I share the vision of the College, which consistently speaks out on the issues facing our profession. For the 30 years that I have been a member, I have benefited tremendously from the College's efforts. Therefore, I believe that it is my obligation to give financial support to ensure that future surgeons will have the same opportunities.

"A gift to the College is an investment in the future of surgery through research, education, and the welfare of the patients we serve.

"I am the major beneficiary of the College, along with thousands of my patients. I enjoy the ongoing surgical education and professional activities. These benefits started when I was in training and have continued throughout my professional life. More importantly, I believe that the College speaks for me as a surgeon."

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

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



**We invite you to consider joining
Dr. Pon Satitpunwaycha
in the Fellows Leadership
Society of the American
College of Surgeons.**



International Guest Scholarships available

The American College of Surgeons offers International Guest Scholarships to competent young surgeons who have demonstrated strong interests in teaching and research. The scholarships, in the amount of \$8,000 each, provide the scholars with an opportunity to visit clinical, teaching, and research activities in North America and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons' Clinical Congress.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, FACS(Hon), former College Director. More recently, a bequest from the family of Abdol Islami, MD, FACS, and gifts from others to the International Guest Scholarship endowment have enabled the College to expand the number of scholarship awards.

The scholarship requirements are as follows:

- Applicants must be graduates of schools of medicine.
- Applicants must be at least 35 years old, but no older than 44, on the date that the completed application is filed.
- Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
- Applicants must have demonstrated a commitment to teaching and/or research *in accordance with the standards of the applicant's country.*
- Applicants whose careers are in the developing stage are deemed more suitable than those who are serving in senior academic appointments.
- Applicants must submit a fully completed application form provided by the College, either from the Web site or in paper format. The application must be typewritten and in English. Submission of a curriculum vitae only is not acceptable.
- Applicants must provide a list of all of their

publications and must submit, in addition, three complete publications (reprints or manuscripts) of their choice from that list.

- Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment, or a Fellow of the American College of Surgeons residing in their country. The chair's or the Fellow's letter is to include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted in envelopes sealed by the recommenders. These letters are to be submitted with the completed application form.

- Applicants may submit a curriculum vitae of no more than 10 pages.
- Applicants may submit a photograph. (Passport size is preferable.)
- The International Guest Scholarships must be used in the year for which they are designated. They cannot be postponed.
- Applicants who are awarded scholarships are expected to provide a full written report of the experiences provided through the scholarships upon completion of their tours.
- An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

The scholarships provide successful applicants with the privilege of participating in the College's annual Clinical Congress in October, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses plus admission to all lectures, demonstrations, and exhibits, which are an integral part of the Clinical Congress. Assistance will be provided in arranging visits, following the Clinical Congress, to various clinics and universities of their choice.

In order to qualify for consideration by the selection committee, all of the above requirements must be fulfilled.

Formal American College of Surgeons Interna-

tional Guest Scholar application forms may be obtained from the College's Web site (www.facs.org) or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, USA.

Completed application forms for the International Guest Scholarships for the year 2005 and all of the supporting documentation must be received

at the office of the International Liaison Section prior to **July 1, 2004**, in order for an applicant to receive consideration by the selection committee. All applicants will be notified of the selection committee's decision in November 2004. Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing.

2005 Australia and New Zealand Chapter Travelling Fellowship available

The International Relations Committee of the American College of Surgeons announces the availability of a travelling fellowship, the Australia and New Zealand (ANZ) Chapter of the American College of Surgeons Travelling Fellowship.

Purpose

The purpose of this fellowship is to encourage international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships.

Basic requirements

The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:

- Has a major interest and accomplishment in basic sciences related to surgery.
- Holds a current full-time academic appointment in Canada or the U.S.
- Is under 45 years of age on the date the application is filed.
- Is enthusiastic, personable, and possesses good communication skills.

Activities

The Fellow is required to spend a minimum of two or three weeks in Australia and New Zealand.

- To attend and participate in the Annual Scientific Congress of the Royal Australasian College of Surgeons, which will be held in Perth, Western

Australia (May 9-13, 2005).

- To participate in the formal convocation ceremony of that congress.
- To attend and address the ANZ Chapter meeting during that congress.
- To visit at least two medical centres in Australia and New Zealand before or after the Annual Scientific Congress of the Royal Australasian College of Surgeons to lecture and to share clinical and scientific expertise with the local surgeons.

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and the President or designated representative of the Australia and New Zealand Chapter of the American College of Surgeons. The surgical centres to be visited would depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Australia and New Zealand.

His or her spouse is welcome to accompany the successful applicant. There will be many opportunities for social interaction, as well as these professional activities.

Financial support

The Australia and New Zealand Chapter and the College will provide the sum of \$12,000 U.S. to the successful applicant, who will also be exempted from registration fees for the Annual Scientific Congress. He must meet all travel and living expenses. Senior chapter representatives will consult with the Fellow about the centres to be visited in

Australia and New Zealand, the local arrangements for each centre, and other advice and recommendations about travel schedules. The Fellow is to make his own travel arrangements in North America, as this makes available to him reduced fares and travel packages for travel in Australia and New Zealand.

The American College of Surgeons' International Relations Committee will select the Fellow after review and evaluation of the final applications. A personal interview may be requested prior to the final selection.

Applications for this travelling fellowship may

be obtained from the College's Web site at www.facs.org or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is **April 1, 2004**.

The successful applicant and an alternate will be selected and notified by August 2004. The formal announcement of the recipient will be made during the 2004 Clinical Congress of the American College of Surgeons in New Orleans, LA, October 10-14.

ACS Traveling Fellowship to Japan available

The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Japan.

Purpose

The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America.

Basic requirements

The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:

- Has a major interest and accomplishment in clinical and basic science related to surgery.
- Holds a current full-time academic appointment in Canada or the U.S.
- Is under 45 years of age on the date the application is filed.
- Is enthusiastic, personable, and possesses good communication skills.

Activities

The Fellow is required to spend a minimum of two weeks in Japan.

- To attend and participate in the annual meeting of the Japan Surgical Society, which will be held in Nagoya, Japan, May 11-13, 2005.

- To attend the Japan ACS Chapter meeting during that congress.

- To visit at least two medical centers (other than the annual meeting city) in Japan before or after the annual meeting of the Japan Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons.

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and designated representatives of the Japan Surgical Society and the Japan ACS Chapter. The surgical centers to be visited would depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Japan.

His or her spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction, in addition to professional activities.

Financial support

The College will provide the sum of \$7,500 U.S. to the successful applicant, who will also be exempted from registration fees for the annual

meeting of the Japan Surgical Society.

He must meet all travel and living expenses. Senior Japan Surgical Society and Japan ACS Chapter representatives will consult with the Fellow about the centers to be visited in Japan, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his own travel arrangements in North America, as this makes available to him reduced fares and travel packages for travel in Japan.

The American College of Surgeons International Relations Committee will select the Fellow after

review and evaluation of the final applications. A personal interview may be requested prior to the final selection.

Applications for this traveling fellowship may be obtained from the College's Web site, www.facs.org, or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is June 1, 2004.

The successful applicant and an alternate will be selected and notified by November 1, 2004.

Trauma and Critical Care 2004 to be held in May

The Eastern States Committees on Trauma will present Trauma and Critical Care 2004: Point/Counterpoint XXIII, May 24-26, in Atlantic City, NJ. The Hilton Casino Resort will be the site for the program, which will examine the latest developments in the care of the injured patient.

Course topics include: Let's Take Another Look at Liver Trauma; Teaching and Learning Trauma Care; Trauma Surgery Today, Trauma Surgery Tomorrow; Difficult Case Management


Panel; Avoiding Tragedies in Patient Transfers; Optimizing Trauma Care in Special Populations; Limitations of Bedside Diagnostics and Minimally Invasive Procedures; Cutting Edge—How I Do It: Point/Counterpoint; Contemporary Trauma Care—The Survivor Game; Emerging Role of Evidence-Based Medicine in Trauma Care; and Critical Decisions in Critical Care.

The scientific program committee consists of Kimball I. Maull, MD, FACS, Course Chair;

Charles C. Wolferth, MD, FACS; L.D. Britt, MD, MPH, FACS; David V. Feliciano, MD, FACS; Rao R. Ivatury, MD, FACS; Lenworth M. Jacobs, Jr., MD; MPH, FACS; and Michael Rhodes, MD, FACS.

Complete course information can be viewed online at: <http://www.facs.org/dept/trauma/cme/traumtgs.html> <http://www.traumapointcounterpoint.com>. For further information, contact the ACS Trauma Office at 312/202-5342.

SOCIOECONOMIC TIPS, from page 20

these areas is to make a monthly meeting a priority. Prepare a written agenda that includes reports on goals established in the retreat, performance against budget, and time to address issues of personal interest at the confluence of practice interests. The best meetings involve good listeners who are prepared with the information ahead of time and are active participants in productive dialogue. 

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

CALL FOR SUBMISSIONS

The Committee for the Forum on Fundamental Surgical Problems
The American College of Surgeons

For the 2004 Owen H Wangensteen 59th annual Surgical Forum
Journal of the American College of Surgeons

Accepted abstracts
will be presented at:*

•
American College
of Surgeons
Clinical Congress

•
October 10-14, 2004
New Orleans, LA



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

Who

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

What

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

When

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

Where

-
- Online submissions ONLY: <http://www.facs.org/sfabstracts/>.

- *Final Decision:* May 2004 (principal author will be contacted).
- *Format:* Follow Author Instructions, Online Submission.
- *Questions:* kkoenig@facs.org or: 312.202.5336.

The Excellence in Research Awards Program has been established by the Surgical Forum Committee to recognize excellence in research performed by surgical residents and Fellows, further increase the visibility of the Surgical Forum as a venue for resident research presentation, facilitate and encourage attendance of residents and Fellows at the Forum sessions, encourage residents and Fellows to participate in research during their training period, and contribute to the overall quality of the Annual Meeting of the American College of Surgeons. The committee will consider all accepted abstracts for the award and will present awards during a special session at the Clinical Congress.

Contributions sought for 2004 Clinical Congress

Paper sessions

The Program Committee and the Division of Education would like to invite submissions of abstracts for clinical paper sessions at the ninetyeth annual Clinical Congress to be held October 10-14, 2004, in New Orleans, LA. These paper presentations include clinical work that has not been previously presented or published elsewhere. *The Program Committee will consider only those abstracts where the principal author or a coauthor is a Fellow of the College.* The following instructions should be strictly adhered to:

1. The abstract should provide adequate information and objective data to evaluate the abstract properly.

2. The abstract must be limited to one 8-1/2" x 11" page, with 1" top and bottom margins and a left margin of 1-1/2". (It is permissible to single-space the abstract.)

3. At the top of the page please include the full title of the abstract and complete names and academic degrees of all authors, and indicate a surgical category based on the list below that best represents the overall topic of the paper.

- Adrenal Surgery
- Bariatric Surgery
- Breast Surgery
- Cardiac Surgery
- Colon and Rectal Surgery
- Esophageal Surgery
- Gastric and Duodenal Surgery
- Liver, Biliary Tract, Pancreas Surgery
- Minimal Access Surgery
- Neurological Surgery
- OB/GYN Surgery
- Ophthalmic Surgery
- Orthopaedic Surgery
- Otolaryngology-Head and Neck Surgery
- Pediatric Surgery
- Perioperative and Critical Care Surgery
- Skin, Plastic and Reconstructive Surgery
- Small Intestinal Surgery
- Surgical Education

- Surgical Oncology
- Thoracic Surgery
- Thyroid and Parathyroid Surgery
- Transplantation
- Trauma Surgery
- Urologic Surgery
- Vascular Surgery
- Other

4. At the bottom of the page, a footnote should be included to provide the principal author's mailing address, telephone number, e-mail, fax number, and, where pertinent, medical school affiliation and other institutions from which the work originates.

5. The original and one copy of the abstract should be submitted.

6. Photographs *should not* accompany the abstract.

7. The deadline for the receipt of abstracts is Monday, March 1, 2004. They should be mailed to: Camille Kidd Moses, Program Committee, Division of Education, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Quality of the paper and a balanced program remain the committee's principal criteria for evaluating the abstracts received. Because of the competitiveness of the scientific program, it is unlikely that an author would be selected to present his or her work in two successive years. Questions regarding the submission process should be directed to Ms. Moses at 312/202-5325.



Disciplinary actions taken

In June 2003, the Board of Regents suspended the Fellowship of Shagufta Parvin Khan of San Diego, CA. This surgeon had her California license to practice medicine suspended and then placed on probation for seven years after being found to have aided and abetted the unlicensed practice of medicine.

The following disciplinary actions were taken by the Board of Regents at their October 18, 2003 meeting:

- Full Fellowship privileges were restored to a general surgeon from Rio Rancho, NM, after having been on probation since February 1998. This Fellow had been placed on probation after being charged with violation of Article VII, Section 1(b) of the ACS *Bylaws* in July 1997. His medical license in the state of Colorado had been placed on probation for five years after being found to have a higher than average number of anastomotic leaks from surgical intestinal resections. His license has been restored to full and unrestricted status.

- A plastic surgeon from Edina, MN, had his Fellowship restored to full status after being suspended in June 2000. This surgeon had been charged with violation of Article VII, Sections 1(b) and (I) of the College *Bylaws* in February 2000. His license had been conditioned and restricted based upon allegations and findings of false advertising, unprofessional conduct, and improper management of medical records.

- Richard G. Manning, a general surgeon from Camp Hill, PA, was expelled from the College after being immediately temporarily suspended and charged with violation of Article VII, Sections 1(a), (b) and (f) of the *Bylaws* following the June 2003 Board of Regents' meeting. Dr. Manning's medical license in the state of Pennsylvania was revoked on December 17, 2002, after he pled guilty to three counts of indecent assault on three patients within the course of his medical practice.

- A general surgeon from Wilson, NC, was placed on probation until he has a full and unrestricted medical license, has full and unrestricted surgical privileges in an accredited hospital, and his practice pattern has been reviewed and approved by the Central Judiciary Committee (CJC). This surgeon voluntarily surrendered his license to practice medicine in the state of North Carolina on July 12, 2002, until such time as the board reissues his license. He has entered into a contract with the North Carolina Physicians Health Program (PHP).

- A general surgeon from Constantine, MI, was placed on probation until such time as: he has a full and unrestricted medical license; he has full and unrestricted surgical privileges in an accredited hospital; and his practice pattern has been reviewed and approved by the CJC. This surgeon's license to practice medicine in the state of Michigan was placed on proba-

tion in December 2002, following a finding of negligence and incompetence.

- A neurosurgeon from Tarrytown, NY, was placed on probation until such time as he has a full and unrestricted medical license; until he has full and unrestricted surgical privileges in an accredited hospital; and until his practice pattern has been reviewed and approved by the CJC. This surgeon's license to practice medicine in the state of New York was suspended for one year and then placed on probation for three years with the requirement that he only practice surgery with a practice monitor present. This action was taken following a finding of gross negligence.

Correction

A recent Dateline: Washington story entitled "CMS releases revisions to EMTALA" (October 2003, p. 6) should have stated that "CMS has *no rule* stating that whenever there are at least three physicians in a specialty, the hospital must provide 24-hour/7-day coverage in that specialty." That means that there are *no specific requirements that hospitals must provide 24/7 coverage in a specialty* where there are three or more surgeons on staff.

NTDB™ data points

The graying of America

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

The National Trauma Data Bank™ (NTDB) currently contains almost three quarters of a million records from 268 trauma centers in the 36 states, territories, and the District of Columbia. Less than one year ago, we reported on the success of the second annual report, which included records from 130 trauma centers located in 22 states and territories. In less than 12 months, the NTDB has grown in size and in representation with a greater than 50 percent increase in both the number of trauma centers providing trauma records as well as in the number of states they represent. As evidenced by the figure on this page, it will not be long until the entire map is shaded gray.

In taking a closer look at the breakdown of the 268 reporting hospitals, 83 percent (223) meet the American College of Surgeons Committee on Trauma criteria to be verified as a trauma center. Sixty-nine are verified as a Level I trauma center, which represents 35 percent of all the Level I trauma centers in the U.S. There are 71 Level II, 34 Level III, and 49 Level IV/V representing 26 percent, 13 percent, and 11 percent, respectively, of all trauma centers. University hospitals account for 24 percent of the reporting trauma centers, while the majority (54%) are community teaching hospitals.



States and U.S. territories from which one or more hospitals have submitted to the NTDB are shown in gray. States whose data are in the process of being added to the NTDB are shown in black.

This diverse cross-section of trauma centers embodies all levels of trauma care, transcends geographic boundaries, represents academic as well as community institutions, and contains urban along with rural populations of trauma patients.

Such diversity will allow researchers to perform epidemiological analyses. As the number of trauma records in the NTDB continues to grow at such a pace, benchmarking with a subset of trauma records from institutions similar in size, location, urban versus rural, and adult or pediatric populations will soon be possible. The NTDB will become an invaluable tool for both researchers and individual trauma

centers and their trauma center directors alike. How often are you asked at your trauma center, “How do we compare with other trauma centers like us?” Soon you will not only be able to respond to this question but the answer you give may only be a few mouse clicks away.

Throughout the year we will be highlighting these data through brief monthly reports in the *Bulletin*. For a complete copy of the NTDB *Annual Report 2003*, visit us at <http://www.facs.org/trauma/ntdbannualreport2003.pdf>. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.



Highlights of the ACSPA Board of Directors and the ACS Board of Regents meeting

October 18-19, 23, 2003

*by Paul E. Collicott, MD, FACS,
Director,
Division of Member Services*

American College of Surgeons Professional Association (ACSPA)

At its June meeting, the Board of Regents voted to dedicate significant financial resources toward addressing the medical liability crisis that is having such a severe effect on surgeons and their patients. In September, the American College of Surgeons Professional Association (ACSPA) sent educational material to all its members for distribution to their patients, who could communicate with their senators about the need for strong medical liability reform. The ACSPA also helped to create a new coalition called Doctors for Medical Liability Reform, the purpose of which is to increase public awareness about the need for medical liability reform.

With regard to the ACSPA-SurgeonsPAC, the organization has raised approximately \$160,000 from more than 720 College members. The Board of Directors has continued to raise funds through venues such as the Leadership Conference and chapter meetings. In 2003, the ACSPA-SurgeonsPAC contributed to 38 federal candidates and committees.

American College of Surgeons (ACS)

Bylaws change

The Board of Regents approved a change in the *Bylaws* that will allow all Regents who fill unexpired terms to serve a full three-year term. In the past, Regents who filled such seats served only until the expiration of the term of their respective predecessors. This change is consistent with a *Bylaws* change regarding unexpired terms for the Board of Governors that the Board of Regents approved at its June meeting.

College logo

In response to member requests for a symbol they might use for individual business purposes, the College has developed a special logo for its Fellows. At its June meeting, the Board of Regents approved in principle a proposal regarding a "slogan logo" that Fellows may use

to indicate membership in the College. At its October meeting, the Board of Regents approved the final logo design and the guidelines governing its use. To access the guidelines and an electronic copy of the logo, visit <http://www.facs.org/members/sloganlogo/disclaimer.html>.

Development Program

As of September 16, 2003, the College received gifts totaling \$778,261. This figure represents an increase over the same period during the previous year.

Case statement

The Board of Regents approved a capital campaign case statement. The case statement, "Surgery in the 21st Century: Leading the Challenge to Meet the Need," highlights three general purposes for which funds will be sought:

- To strengthen and expand research and optimal patient care.
- To ensure surgical patient safety.
- To provide gold-standard surgical education through scholarships, fellowships, courses, and programs.

Statement on nursing workforce

The Board of Regents approved a statement on the nursing shortage that was developed by the Health Policy Steering Committee. The Statement in Support of a Sustainable, Competent, and Diverse Nursing Workforce was prepared following a request from the Association of periOperative Nurses (AORN), who asked the College to participate in advocacy efforts aimed at addressing the growing shortage of nurses. The statement was published in the January 2004 *Bulletin*, page 31.

Office-based surgery

The Board of Regents approved a document outlining 10 core patient safety principles that should govern office-based procedures involving moderate sedation, deep sedation, or general anesthesia. The statement was a collaborative effort of more than 35 organizations.

Both the ACS and the AMA have formally adopted these patient safety principles. The core principles are posted on the ACS Web site at http://www.facs.org/patientsafety/patient_safety.html.

Revised statements

The Board of Regents approved a revised Statement on the Surgeon and HIV Infection. The statement was initially developed in 1991 by the Governors' Committee on Surgical Practice in Hospitals Subcommittee on AIDS. The statement was previously revised in 1998 by the Governors' Committee on Blood-borne Pathogens.

The Board of Regents also approved a revised Statement on the Surgeon and Hepatitis. Initially developed in 1994 by the Governors' Committee on Blood-borne Pathogens, the statement was previously revised in 1999 to include Hepatitis C.

Volunteerism award

The Governors' Committee on Socioeconomic Issues developed criteria for a surgical volunteerism award. The award recognizes individuals who or organizations that are making significant contributions to surgical care through organized volunteer activities. The College presented the first awards of this type to Lowell B. Furman, MD, FACS, Boone, NC, and Juan M. Montero II, MD, FACS, Chesapeake, VA, at the Annual Meeting of Fellows during the Clinical Congress.

ACS Traveling Fellowship to Japan

George K. Gittes, MD, FACS, of Kansas City, MO, was designated the Japan Traveling Fellow. The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America.

NSQIP

The Board of Regents approved a business plan that will allow the ACS to expand the National Surgical Quality Improvement Pro-

gram (NSQIP) into additional private sector hospitals—96 within the first year. The NSQIP has operated within the U.S. Department of Veterans Affairs for the past 11 years. NSQIP performs the following functions: (1) collects patient risk data, intraoperative data, and postoperative outcomes on all patients undergoing major surgery at participating surgical services; (2) provides risk-adjusted outcomes to the participating surgical services so they can compare their outcomes to others on an anonymous basis; (3) evaluates high outliers through medical record reviews and site visits; and (4) provides best surgical practices of low outliers to other services in the system. This program supports the College's mission of promoting the highest standards of surgical care through the evaluation of surgical outcomes in clinical practice and promises to improve the quality of surgical care.

Inguinal Hernia Project

The Board of Regents approved the creation of a patient follow-up registry for the Inguinal Hernia Project. The purpose of this proposal is to develop a registry to follow approximately 2,500 patients currently enrolled in two randomized controlled multicenter inguinal herniorrhaphy trials cosponsored by the American College of Surgeons.

HEALTHeCAREERS

The ACS has contracted with HEALTHeCAREERS Network for the purpose of providing expanded job opportunities and a resume data bank. The network integrates job information from dozens of the most prestigious health care associations. It provides a unique online recruiting resource for thousands of health care employers, recruiters, and millions of candidates. A full-service application service provider for health care association career centers, the Network provides advanced electronic recruiting solutions and services for the medical association market. It can be accessed at <http://www.healthcareers.com/>.

JACS

As of September 19, 2003, a total of 5,464 Fellows participated in the *Journal of the American College of Surgeons (JACS)* CME-1 online/print program. *JACS* has provided 35,369 CME-1 credits. *JACS* is available on the Web at www.journalacs.org.

Communications/media relations

Current events and their implications for surgical care in the future continue to spur media calls to the College. Media interviews were arranged between reporters and College representatives on the following topics:

- Surgical infections and prevention efforts.
- Measurement of surgical quality.
- The predicted shortage of surgeons.
- Medical liability reform.
- Medicare reimbursement.
- Health systems reform.
- Funding and trauma care systems.
- The College's work regarding systems-based practice.
- Ethical considerations in separating conjoined twins.

The College has developed a patient information brochure called *What Is Correct-Site Surgery?* The initial print run was limited pending the announcement of its availability. For a copy of this brochure, contact us at 312/202-5000 or postmaster@facs.org. For a copy of the related statement, visit our Web site at www.facs.org.

CAS-ACS News, a quarterly newsletter for the Candidate and Associate Society, is in its first year of publication. The newsletter is distributed electronically, and feedback from the members indicates that it is being well received.



Residency Assist Page (RAP)

[Home Page](#)

[Members Only](#)

[Table of Contents](#)

[Search This Site](#)

[Contact Us](#)

[Site Index](#)

The Division of Education
of the American College of Surgeons presents the
Residency Assist Page (RAP)

The RAP addresses a spectrum of issues related to the restrictions on the duty hours of residents that were implemented July 1, 2003. Developed by the College's Division of Education, this online resource will be specific to surgery and will serve as a unique tool for surgery program directors and others as they consider changes in residency programs to ensure optimum educational outcomes under the new guidelines.

The RAP includes articles, editorials, examples of practical solutions, and select references. The goal of the editors is not to be prescriptive, but to offer helpful suggestions that may be adapted to meet the specific needs of individual programs.

<http://www.facs.org/education/residencyassist.html>



Letters

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

Trauma

After reading Adrienne Robert's article on trauma in the December 2003 *Bulletin*, I could not help but wonder why she did not address the ever-increasing demands of physicians to be paid for "covering" emergency facilities throughout the country. Until a solution to that problem is developed, completing the trauma system in any state will not be possible.

When I started my orthopaedic practice in 1966, the granting of hospital privileges was attended by a requirement that I would cover the ER on the nights/weekends assigned by a departmental chief. In my community, that rule applied to all physicians, including those in such specialties as radiology, psychiatry, and dermatology. After all, their MD designations and state licensure allowed them to practice medicine, not specialties per se. When on call, the supersub doctors had backup on the specialties they needed to consult so the fear of covering the ER did not exist.

In contrast, many supersub doctors (foot/ankle/ophthalmology/etc.) claim that they have not maintained enough general knowledge to serve patients in the ER. Thus, they are either refusing to provide that service or have resigned their hospital privileges and work only in five-day-week surgicenters. In Georgia, these type of circumstances have led to changes in several hospitals' classification as trauma centers or their potential for designation of same. If they don't use that excuse, the other major factor for not covering ERs is that they demand to get paid for taking call, whether it be from home

or actually working in the facilities. Some are demanding flat fee payments from their hospitals as high as over a thousand dollars per shift. Needless to say, as inferred by Ms. Roberts, states and/or hospitals are underfunded in so many respects to meet the doctor's demands for subsidies.

She also did not address the issue of how doctors in regional hospitals feel about all the smaller hospitals or doctors in surrounding counties "dumping" unwanted patients on their hospitals. When faced with that situation and a vote is taken to decide if a hospital is to participate in the trauma system, statements are made, such as "We don't want their trash sent to us."

Despite the above omissions, Ms. Roberts has addressed many of the factors that have placed barriers on the road to developing trauma programs in the US. Even though she states that trauma systems are underfunded, she primarily centered her comments on the development of (or lack of) the systems administration and data gathering, rather than those related to the grassroots coverage in every hospital city in the country. Until those problems are addressed and solved, trauma systems will not go as far as needed to provide optimum care.

**Charles B. Gillespie,
MD, FACS**

The business of surgery

Dr. Russell, I read your lament in the November [2003] *Bulletin* regarding business pressures on surgeons. You specifically mentioned Medicare and the steadily declining reimbursements from that program. You suggested some potential solutions but did not specifically mention one very important one.

When in negotiations with another party, one should have in mind a "walk away position." In my opinion, surgeons reached that point a long time ago with Medicare. Nevertheless, organizations

such as the College continue to counsel working things out with the federal government. As a consequence, a lot of PAC money is spent (wasted) every year trying to convince members of Congress to reverse the annual decline in Medicare reimbursement. However, federal bureaucrats long ago learned that they can ignore the pleadings and rational arguments of the College and others, and diminish reimbursement for surgical services without consequence.

Instead, the College should advise its members of a "walk away" alternative. Surgeons do not *have* to participate in Medicare. They can opt out and provide care under private contracts. The patient pays the surgeon's fee and Medicare pays the rest. If more surgeons did this, a number of salutary outcomes would result, not the least of which would be a halt to annual rounds of diminishing reimbursement.

The next time you comment on Medicare, I urge you to mention opting out as an alternative to the ongoing abuse by the federal government.

Bruce E. Van Dam, MD, FACS

Medical liability crisis

Dr. Russell, thank you for helping out the average surgeon. We have just been notified that our group of four surgeons, who for the year of 2003 were paying \$80,000 in premiums for all four surgeons, will probably be paying somewhere in the area of \$150,000 to \$180,000 come April 2004.

Our small state of Delaware had been shielded from the medical liability crisis for some time. Obviously, the crisis has now reached our state.

If there is anything I can do in order to help you fight for the average surgeon concerning medical liability reform, I would certainly be glad to help.

Thomas P. Barnett, MD, FACS

Chapter news

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

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

South Texas to meet April 1-2

In a departure from its regular schedule, the South Texas Chapter plans to meet April 1-2, just before the meeting of the Texas Surgical Society. The meeting will take place at the Omni Hotel in Houston. Along with presentations from members of the chapter, the education program will feature presentations on clinical and basic science research completed by residents from the various training programs in the chapter. The chapter leaders are also using this opportunity to evaluate members' needs, especially with regard to expanding the chapter's educational programs. For more information about these new initiatives, the CME meeting, and other activities, contact the chapter's President, Mary L. Brandt, MD, FACS, at brandt@bcm.tmc.edu.

Brooklyn-Long Island hosts clinic day

The Brooklyn-Long Island Chapter (BLIC) hosted its annual clinic day on December 3, 2003, in conjunction with the Nassau Surgical Society (NSS). The program also included a keynote address by Max Gomez, MD, a medical reporter for NBC in New York City. The title of Dr. Gomez's presentation was "Medicine in the Media. Good Idea? Bad Idea?" A photo of Dr. Gomez and the BLIC and NSS leaders appears on this page.

Utah addresses mandatory interpreter requirements

The Utah Chapter leadership presented the following resolution to the Utah Medical Association's house of delegates. The resolution directs the American Medical Association to seek federal funding for mandatory interpretive services for patients who have hearing impairments



Brooklyn-Long Island Chapter, left to right: Robert F. D'Esposito, MD, FACS, BLIC President; Michael O. Bernstein, MD, FACS, BLIC Vice-President; Dr. Gomez; Michael Setzen, MD, FACS, BLIC Program Chair; and David J. Chalif, MD, FACS, NSS President.

or who do not speak English. The Utah Chapter's resolution was adopted and reads as follows:

Resolution 1 - Medical Interpreters

RESOLVED, That the Utah Medical Association direct our delegation to the American Medical Association to introduce a resolution in the AMA House of Delegates commending the AMA for its efforts to obtain federal funding for medical interpretive services, to reaffirm its policy as stated in H-385.928 and to direct the AMA to redouble its efforts to remove the burden from physicians for the cost of medical interpretive services; and be it further

RESOLVED, That the resolution direct the AMA to urge the administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; and be it further

RESOLVED, That the Utah Medical Association inform the Utah congressional delegation of its concerns regarding the interpretation of Title VI of the Civil Rights Act of 1964 and request that they contact the administration and urge them to reconsider this interpretation.

Chapter anniversaries

Month	Chapter	Years
January	Northern California	52
	Louisiana	52
February	Arizona	52
	Australia-New Zealand	19
	South Florida	50
	Iowa	36
	Italy	18
	Lebanon	41
	Montana-Wyoming	39
	Eastern Long-Island, NY	36
	Peru	27
	South Korea	17
Washington State	52	

Uruguay Chapter reestablished

The Uruguay Chapter has been reestablished. The officers of the reformed chapter include: Roberto Rubio, MD, FACS, President; Luis Alberto Carriquiry, MD, FACS, Vice-President; Luis Alberto Ruso Martinez, MD, FACS, Secretary; and Gonzalo Estape Carriquiry, MD, FACS, Governor.

Ohio initiates PAC

The Ohio Chapter recently began funding its Surgeons Political Action Committee (S-PAC). With the intention of advancing the goals of the profession, the Ohio Chapter plans to form relationships with legislators who are supportive of the concerns and needs of surgeons and their patients. For more information about S-PAC, contact Brad Feldman, Executive Director, at 877/677-3227, or via e-mail at ocacs@ohiofacs.org.

New York plans lobby day in Albany

On March 16, the New York Chapter will host a legislative day in Albany. All ACS members who reside in the state are invited to participate. For more information, or to schedule a visit

with elected officials, contact Heather Bennett, JD, Executive Director, at 518/433-0397, or via e-mail at bennett@bennettfirm.com.

Lebanon conducts education program

Last September, the Lebanon Chapter, in conjunction with the Lebanon-based specialty societies for plastic surgery and head and neck surgery, hosted the X Clinical Congress. More than 400 surgeons from the Middle East and Europe attended the four-day education program, held in Beirut. Michel Daher, MD, FACS, President-Elect, and Whibi ShuAyb, MD, FACS, Governor, coordinated the education event.

Chapters continue to support College funds

During 2003, 22 chapters contributed a total of \$28,365 to the College's endowment funds. The chapters' commitments to the various funds support the College's pledge to surgical research and education.

Chapters may contribute to several different funds, including the Annual Fund, the Fellows Endowment Fund, or the Scholarship Fund. Chapters that contribute at \$1,000 annually are named members of the Fellows Leadership Society (FLS)—the distinguished donor organization of the College. Chapter that have contributed \$25,000 are FLS Life Members. Chapters that contributed in 2003 include:

Life Members of the FLS: Arizona, Southern California, Louisiana, Maryland, Nebraska, Brooklyn-Long Island (NY), Ohio, South Carolina, North Texas, and Illinois.

Annual Members of the FLS: Alabama, Florida, South Florida, Georgia, Hong Kong, Metropolitan Chicago, Indiana, Michigan, North Carolina, Oregon, Metropolitan Philadelphia, Southwest Pennsylvania, South Dakota, Virginia, Washington State, West Virginia, and Japan.

Contributors: Hawaii, Missouri, Southwest Missouri, Montana-Wyoming, and New York.

Leadership conference scheduled for May 16-18

The 2004 Leadership Conference for Chapter Officers and Young Surgeons will take place May 16-18, at the Hyatt Regency Hotel in Washington, DC. For the second year in a row, chapter officers, young surgeons, and administrators will have an opportunity to attend a congressional reception and to meet with their members of Congress on Capitol Hill. A preliminary schedule follows:

Sunday, May 16: *Afternoon*: Three concurrent sessions: Special session for young surgeons, special session for chapter officers, and special session for chapter executives. *Evening*: Welcoming reception for chapter officers, young surgeons, chapter administrators, spouses, and guests.

Monday, May 17: *All Day*: Plenary and special education program sessions. *Evening*: Congressional reception.

Tuesday, May 18: *Morning*: Breakfast and briefings, visits with members of Congress. *Afternoon*: Debriefings, lunch, and adjournment.

Next month in JACS

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

Original Scientific Articles

- Vascular Invasion in Well-Differentiated Thyroid Cancer
- Management of Duodenal Ulcers

Surgical Forum

- Quality of Life after Transurethral Prostate Resection

What's New in Surgery

- Plastic and Maxillofacial Surgery
- General Surgery: Transplantation

