Surgery, engineering, and industry collaborate on
THE HOSPITAL OF THE FUTURE
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About the cover...

The University of California, Los Angeles (UCLA), plans to open a new hospital in July. An artist's rendering of a portion of the building's facade is on the cover, but even more exciting elements of the new hospital will be housed within the structure. The article on page 12 gives readers an inside look at how the UCLA University Hospital will combine input from engineering, medicine, and industry to deliver state-of-the-art care to surgical patients.
### NEWS

**April 24-27, 2004:**
32nd Spring Meeting will convene in Boston

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Nominations sought for the Board of Regents

---

Nominations sought for ACS Surgical Volunteerism Award

---

College announces new logo for Fellows

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Young surgical investigators conference to be held in March

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Fellows and facts

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NTDB™ data points: Same cover, but new version 3.0
by Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

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Letters

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National residency end-of-life care training project recruiting participants

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of the American College of Surgeons

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From my perspective

So often these days surgeons speak of the many socioeconomic challenges facing their profession, their practices, and their patients. Generally, these discussions focus on discouraging subjects, such as declining reimbursements, the growing medical liability crisis, unreasonable regulatory and administrative burdens, and other issues that are making the practice of surgery so difficult. Nevertheless, at this time of year when it’s common to reflect on what has been accomplished and to make plans for the future, I find myself feeling very positive about the progress we’ve made and our prospects for the future.

Surgery has, in fact, increased its public profile and is beginning to emerge as an effective force with regard to advocacy. This progress is due partly to new programs implemented by the College and by other specialty societies. But, in large part, it is also due to the greater personal investment individual surgeons are making by keeping themselves informed and by participating actively as their own advocates.

For the College’s part, there is no question that our outlook has changed and that we are committing greater resources toward advocacy efforts. From past mistakes, we learned that divisions among physician groups serve only to harm our effectiveness on Capitol Hill. As a result, we are devoting considerable effort toward promoting closer collaboration and coordination among medical and surgical groups on our common issues. Our Health Policy Steering Committee is one vehicle that helps us to accomplish this goal in a proactive way. We have made new grassroots advocacy tools available for our Fellows to use. And, we have established an affiliated organization—the American College of Surgeons Professional Association—with a more flexible 501(c)6 tax status that allows surgery to participate in a wider range of lobbying efforts as well as in political activities. We’ve also restructured the staffing of our former Chicago-based Department of Socioeconomic Affairs and have created a primarily Washington-based Division of Advocacy and Health Policy. As a result, the College is able to devote more “shoe leather” to lobbying the halls of Congress than all but the very largest health care organizations can.

As important as all these steps have been, what’s most impressive is the tremendous response we have had from our members. As has been said frequently over the years, the College’s status in Washington as an organization representing more than 60,000 surgeons means little if the membership cannot be mobilized in a grassroots effort that demonstrates its strength.

The College’s status in Washington as an organization representing more than 60,000 surgeons means little if the membership cannot be mobilized in a grassroots effort that demonstrates its strength. I’m happy to report that this past year, surgeons have proven their commitment and their muscle.

For example, the College’s e-mail system has been used frequently to send legislative alerts to our Fellows on such critical issues as medical liability reform and Medicare’s dysfunctional physician payment system, and surgeons have responded by the thousands. In one week before Congress adjourned for the holidays, more than 6,000 e-mail messages were sent by surgeons to their legislators asking them to address the physician payment issue before the end of the year. Congress responded
by providing a modest, two-year period of relief from the downward payment spiral.

Last summer, the College activated a network of surgical specialty societies that co-host a Surgery State Legislative Action Center to allow their members to write to selected members of the National Conference of State Legislators (NCSL) about medical liability reform. At NCSL’s meeting in San Francisco, I was able to personally deliver paper copies of more than 11,000 letters that had been faxed to these state policymakers over a single weekend using this new grassroots activation tool.

Earlier in the summer, the annual Leadership Conference for Chapter Officers and Young Surgeons was held for the first time in Washington, DC. Attendance at this meeting was about 50 percent higher than is usual for this annual event, and all participants had the opportunity to meet individually with their legislators and staff on Capitol Hill. In fact, the meeting was so successful, we plan on holding it in Washington again this year.

In the fall, each of our members received sample copies of a College-developed patient education brochure on the medical liability crisis, along with an invitation to order more copies at cost to make available in their waiting rooms. Six weeks after this mailing was sent, over 12,500 copies of the brochure had already been ordered.

These activities and more occurred during just the last six months of 2003. Perhaps a sign of our troubled times—but also, I believe, an indication of greatly heightened awareness—this kind of broad-based, grassroots participation by surgeons simply would not have occurred just a year or two ago. Clearly, our profession is assuming more responsibility for its socioeconomic fate and becoming more activist.

Of course, many of our greatest policy challenges remain, despite these efforts. Nonetheless, I am optimistic about the future. Surgeons have demonstrated that they are knowledgeable about the issues and that they are a force to be reckoned with. Policymakers who fail to appreciate our perspective may now find themselves an uncomfortable target of a focused educational campaign. On the other hand, those policymakers who do share our views are beginning to appreciate that our support is meaningful and makes a valuable contribution to the effort.

So, despite the intransigence of many of the issues confronting us, surgery has reason to celebrate its recent accomplishments and to anticipate growing influence in the future. All of us owe a debt of thanks to those Fellows who have made the commitment to become involved. As for the rest, I encourage you to join your colleagues and help us make a difference.

Editor’s note

To ensure the timeliness of our messages and to make it easy for our members to participate in these activities, we send most of the College’s legislative alerts via e-mail. To optimize the effectiveness of these efforts, Fellows who have not yet done so are encouraged to provide us with their current e-mail address, by going to the College’s home page at www.facs.org and clicking on the “Members Only” link at the top of the page. You will need your ACS ID number or password, if you have chosen one, when you log on. Or you may e-mail rtornhout@facs.org; please include your Fellowship ID number in your note.

Thomas R. Russell, MD, FACS

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

Are you wondering why your 2004 dues payment should be made out to the American College of Surgeons Professional Association (ACSPA) rather than the American College of Surgeons? ACSPA, the College’s 501(c)6 tax-exempt affiliate, was created last year to provide more flexibility so that the College can offer a broader range of activities and services to benefit the surgical profession and its patients, including an expanded legislative action program. The establishment of this corporation requires that dues be paid to ACSPA, which, in turn, finances the activities of the College. Further information about ACSPA and its relationship to the College can be viewed on the ACSPA Web site, at http://www.facs.org/acspa/about.html.

On December 8, President Bush signed the Medicare prescription drug legislation into law. The signing ceremony was witnessed by a number of physicians, including Thomas R. Russell, MD, FACS, Executive Director of the College, who received a special invitation to attend the event. To read the President’s speech at the ceremony, visit the White House Web site at http://www.whitehouse.gov/news/releases/2003/12/20031208-2.html.

Abstracts are being sought for the 2004 Owen H. Wangensteen Surgical Forum and may be submitted online at http://www.facs.org/sfabstracts/index.html. Accepted abstracts will be presented at the Owen H. Wangensteen Surgical Forum during the 90th Annual Clinical Congress, October 10-14, 2004, in New Orleans, LA. All authors of accepted abstracts will also be considered for the Excellence in Research Award. The Surgical Forum Committee will recognize a select group of authors whose abstracts are outstanding in the areas of originality of concept, quality of methodology, and impact of the science. The deadline for submissions is 5:00 pm (CST), March 1, 2004. For further information, contact Kathryn Koenig-Matousek, at 312/202-5336.

The College has developed a patient information brochure that explains correct-site surgery and how patients can take an active role in their preoperative planning to ensure their personal safety. The brochure can be viewed online at http://www.facs.org/public_info/correctsite.html. Single copies of the brochure are available for free by ordering online at http://www.facs.org/commerce/2003/pubinfo.html. Information on quantity discounts for members of the College is also provided.
President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act on December 8, 2003, marking the largest benefit expansion in the Medicare program’s history. In addition to reversing the physician payment cut announced by the Centers for Medicare & Medicaid Services (CMS) in November (and discussed in the article on page 8 of this issue), the new law contains other provisions of interest to surgeons, including:

- **Rural providers.** Medicare will pay a 5 percent bonus to physicians providing care in scarcity areas from 2005 through 2007. In addition, geographic adjusters in the physician fee schedule for 2004 through 2006 have been changed to increase Medicare payments in areas where reimbursement for physician work is less than the national average.

- **Graduate medical education.** The indirect medical education (IME) adjustment factor is increased from 5.5 to 6.0 percent for the last half of fiscal year (FY) 2004, 5.8 in FY 2005, 5.55 in FY 2006, 5.35 in FY 2007, and 5.5 percent for FY 2008 and thereafter. In addition, unused resident positions will be redistributed, giving priority to rural/small urban area hospitals.

- **Specialty hospitals.** The “whole hospital” exception to physician self-referrals limits is amended to exclude, for 18 months, facilities with physician owners that are devoted primarily to cardiac, orthopaedic, surgical, or other designated specialties. This provision does not affect specialty hospitals in operation or under development as of the date of enactment. The bill also asks the Medicare Payment Advisory Commission (MedPAC) to conduct a study of physician ownership of specialty hospitals.

- **Ambulatory surgery centers (ASCs).** The bill alters the payment rate for services provided in ASCs. Next year, they will be updated by the percent increase in the Consumer Price Index for all urban consumers (CPI-U), less 3 percent. Starting in the fourth quarter of 2005 and extending through 2008 the updates will be frozen. In addition, the General Accounting Office (GAO) will study ASC payments.

- **Average wholesale price (AWP) reform.** The bill decreases the reimbursement rate for drugs administered in a physician’s office from 85 percent of the AWP in 2004 to the Average Sale Price plus 6 percent in 2005. It also initiates competitive bidding as a physician choice beginning in 2006 and increases practice expense reimbursements for drug administration.

- **Thoracic surgery practice costs.** MedPAC will conduct a study on whether Medicare payments for thoracic and cardiac procedures adequately reflect the cost of physician-employed clinical staff who provide services in the hospital setting.

- **Emergency care.** The bill appropriates $250 million for each fiscal year beginning with 2005 through 2008 for allotments to the states to pay providers for emergency services furnished to undocumented aliens. Two-thirds of this money will be distributed to states based on the number of undocumented alien residents.

- **Quality initiatives.** The bill establishes a five-year demonstration program to examine health delivery factors that improve patient
care, including the provision of incentives to enhance quality and safety and promote the appropriate use of best practices. In addition, the bill mandates that the Institute of Medicine issue a report on leading health care performance measures used in the public and private sectors and options to implement policies aligning performance with payment in the Medicare program.

- Systemic interoperability. The bill provides for the establishment of an 11-member commission on systemic interoperability to develop a comprehensive strategy for adopting and implementing health care information technology standards, including a timeline and an agenda for implementation.

The text of the legislation is available online at http://thomas.loc.gov/cgi-bin/query/C?c108:./temp/~c108A6zaOo.

Survey of Fellows indicates troubling trends

Preliminary results of the College’s Workforce Access Survey, published in the December issue of the Bulletin, suggest that many Fellows plan to make changes in their practices to compensate for current socioeconomic pressures. For example, more than 40 percent of the respondents as of press time said they had stopped performing high-risk procedures, and about one-third said they may stop performing them within the next two years. About one-third also indicated that they had already limited the number of Medicare patients they see, and 7 percent said they had stopped accepting Medicare patients altogether.

This summary is based on approximately 750 responses. Of course, more input from surgeons is needed to illustrate the need for regulatory and legislative changes to improve the practice climate and maintain widespread access to care. Fellows who have not yet participated in the survey are encouraged to complete the online questionnaire, which can be accessed at http://www.facs.org/ahp/workforcesurvey/index.html.

CMS releases Medicare improper payment rate for 2003

CMS estimates that the national Medicare payment error rate for fiscal year 2003 was 5.8 percent or $11.6 billion, an amount comparable to last year. As shown by the new detail in this year’s report, the provider types that had the most errors nationally were chiropractors (11.3%), physical therapists (18.2%), and internists (13.5%). Providers with the lowest errors were ambulance services (4.7%), podiatrists (4%), and urologists (5.3%). The findings also indicate that contractors have a large number of providers that submit improper claims. For more information go to: http://www.cms.gov/media/press/release.asp?Counter=905.
On November 7, 2003, the Centers for Medicare & Medicaid Services (CMS) published a final rule implementing Medicare physician payment policy changes that became effective January 1, 2004. By and large, the regulations put into practice regulatory modifications described in a notice of proposed rulemaking that was published in August. Then, on January 7, 2004, a second regulation was published to incorporate further fee schedule changes mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173. Following are answers to questions surgeons may have about these important regulatory changes, some of which will have a significant impact on Medicare payments for surgical services in 2004.

Throughout the year, it has been predicted that all physician services will be subject to a significant across-the-board payment reduction. Did this occur?

Ultimately, no. The conversion factor that is used to translate fee schedule relative value units (RVUs) into actual payment amounts would have been reduced by 4.5 percent in 2004 under the November regulation. However, P.L. 108-173 included a provision that establishes positive fee schedule conversion factor updates of at least 1.5 percent in both 2004 and 2005. As a result, the new conversion factor for 2004 is $37.3374.

While the congressional intervention is certainly good news, it seems that every year, Medicare physician payments continue their downward spiral. Why? Will this trend ever end?

The source of the problem lies in high rates of growth in total Medicare spending for physician services—despite recent reductions in payment for each unit of service—combined with low rates of economic growth and a flawed, “unforgiving” formula for determining the annual fee schedule updates.

The updates reflect the rate of inflation in the cost of providing Medicare services (known as the Medicare Economic Index, or MEI), growth of beneficiary enrollment in the fee-for-service program, and, importantly, an update adjustment factor that is determined by comparing actual rates of Medicare physician spending to a prospectively determined “allowable” rate of growth known as the Sustainable Growth Rate (SGR). The SGR encompasses a number of factors, including the rate of gross domestic product (GDP) growth.

A key problem with the current update system is its cumulative nature. Each year, the comparison between actual and allowed spending growth extends back to April 1996—so that years in which total spending exceeds the SGR have a negative impact on updates for many years to come. Certain changes in the formula were legislated by Congress earlier this year, and CMS recently made some important adjustments in the way it calculates the MEI. However, unless Congress legislates a new update system, recent periods of slow economic growth and unanticipated high rates of growth in Medicare service volume will produce negative fee schedule updates for several years to come.

Targeted expenditures for Medicare physician services in 2003 were $71.7 billion, while the estimated actual spending was $77.8 billion—an excess of $6.1 billion, or 8.5 percent. Cumulatively, allowed spending for the period between April 1, 1996, and December 31, 2002, was $454.2 billion, while actual spending amounted to $462 billion.

See Table 1 on page 9 for a history of the Medicare conversion factors that have been applied under the SGR system.

What is the MEI for 2004?

CMS calculated the 2004 MEI to be 2.9 percent. This rate reflects a number of changes in the data.

The 2004 Medicare fee schedule
by Cynthia A. Brown, Director, Division of Advocacy and Health Policy
used to calculate this annual inflation figure for Medicare physician spending. For example, more recent wage and cost data were used, and revisions were made in certain cost categories and price proxies. Of particular interest to surgeons, the data reflect more recent malpractice premium increases, which, in turn, resulted in greater weight being given to these costs in the MEI calculation.

The agency also made adjustments in total fee schedule RVUs for the three service components—physician work, practice expense, and malpractice expense—to match the new MEI weights. Table 2 (this page) shows the old and new weights assigned to the fee schedule components.

Although still accounting for a relatively small proportion of total fee schedule RVUs, the malpractice component increased so significantly that it has produced higher base payments for specialties that provide services with relatively high malpractice RVUs. According to CMS, payments for services provided by cardiac and thoracic surgeons, neurosurgeons, orthopaedic surgeons, and vascular surgeons were adjusted most significantly.

**Table 1: Fee schedule conversion factors under The SGR system**

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Conversion factor</th>
<th>% change from previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>$37.34</td>
<td>1.5%</td>
</tr>
<tr>
<td>2003</td>
<td>36.79</td>
<td>1.6</td>
</tr>
<tr>
<td>2002</td>
<td>36.20</td>
<td>-5.4</td>
</tr>
<tr>
<td>2001</td>
<td>38.26</td>
<td>4.5</td>
</tr>
<tr>
<td>2000</td>
<td>36.61</td>
<td>5.4</td>
</tr>
<tr>
<td>1999</td>
<td>34.73</td>
<td>-5.3</td>
</tr>
<tr>
<td>1998</td>
<td>36.69</td>
<td>-10.4</td>
</tr>
<tr>
<td>1997</td>
<td>40.96*</td>
<td></td>
</tr>
</tbody>
</table>

*Beginning in 1998, the sustainable growth rate system replaced the former Medicare volume performance standard system under which separate fee schedule conversion factors were calculated for surgical services, primary care, and all other physician services. The 1997 conversion factor shown was for the category of surgical services. It was the largest conversion factor ever applied to the Medicare fee schedule.

**Table 2: Old and new weights assigned to fee schedule components**

<table>
<thead>
<tr>
<th></th>
<th>2003 weights (based on 1996 data)</th>
<th>2004 weights (based on 2000 data)</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician work RVUs</td>
<td>54.5</td>
<td>52.5</td>
<td>-3.7%</td>
</tr>
<tr>
<td>Practice expense RVUs</td>
<td>42.3</td>
<td>43.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Malpractice RVUs</td>
<td>3.2</td>
<td>3.9</td>
<td>21.9</td>
</tr>
</tbody>
</table>

**What else has CMS done to account for the escalating malpractice premium costs that surgeons and other physicians have experienced?**

To account for regional variations in malpractice premium growth rates, CMS revised the geographic practice cost index (GPCI) for the malpractice component of the Medicare fee schedule. (Each of the three fee schedule components—physician work, practice expense, and malpractice expense—is adjusted locally to reflect geographic variations in cost of living, practice overhead, and malpractice premiums, respectively.) The malpractice cost component is the most “volatile” of the three indices with relatively large variations from year to year and among geographic payment areas. The agency factored these variances into its revisions.

- Rather than basing the index on the most recent malpractice premium data available (2002), CMS used three-year premium averages. In addition to using actual data from 2001 and 2002, projected rates of increase for 2003 were calculated and included in the average. (The 2003 projections, in turn, were based on four years of actual data going back to 1999.)
- The agency also applied a so-called modulating factor of 0.5 to the GPCI changes. In other words, the difference between new and previ-
ous malpractice GPCIs for each geographic area was reduced by 50 percent.

Because the law requires CMS to phase in any GPCI adjustments when more than one year has elapsed since the most recent revision, changes in the malpractice index will occur over two years, with one-half of the revision appearing in the 2004 fee schedule. The revision will be completed in 2005.

Table 3 on this page compares Medicare payments for a sample service, inguinal hernia repair, in the Medicare payment localities with the highest (Detroit, MI) and lowest (Idaho) malpractice GPCI adjustments.

Clearly, Medicare payments are not keeping up with the annual increase in medical liability insurance premiums. Does the agency plan to take other steps to address this crisis, and, if so, when?

According to the rule, CMS will continue to monitor local malpractice markets, work with state insurance departments, and collaborate with the American Medical Association/ Specialty Society Relative Value Update Committee (RUC) to obtain the most current and valid malpractice premium data possible. Responding to suggestions from specialty societies, the agency has committed to col-

### Table 3: Impact of malpractice GPCI changes:
**Payment comparison between high- and low-cost malpractice localities**

**CPT 49505: Repair Inguinal Hernia**

<table>
<thead>
<tr>
<th>Locality name</th>
<th>Work RVUs</th>
<th>GPCI work</th>
<th>PE RVU</th>
<th>GPCI PE</th>
<th>MP RVU</th>
<th>GPCI RVU</th>
<th>Total Adjusted RVUs</th>
<th>2004 CF</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idaho</td>
<td>7.59</td>
<td>1.00</td>
<td>3.87</td>
<td>0.881</td>
<td>0.78</td>
<td>0.478</td>
<td>11.38</td>
<td>$37.34</td>
<td>$424</td>
</tr>
<tr>
<td>Detroit</td>
<td>7.59</td>
<td>1.043</td>
<td>3.87</td>
<td>1.038</td>
<td>0.78</td>
<td>2.741</td>
<td>14.08</td>
<td>$37.34</td>
<td>$525</td>
</tr>
<tr>
<td>Difference in payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$65.71</td>
<td></td>
<td>$101</td>
</tr>
</tbody>
</table>

Table 4: Comparison of national average Medicare payments for key surgical services, 2003-2004

<table>
<thead>
<tr>
<th>CPT/descriptor</th>
<th>2003 average payment</th>
<th>2004 scheduled payment</th>
<th>2004 actual payment</th>
<th>% change 2004-2003 actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984/ Remove cataract, insert lens</td>
<td>$ 607</td>
<td>$ 645</td>
<td>$ 684</td>
<td>12.7%</td>
</tr>
<tr>
<td>27447/ Total knee replacement</td>
<td>1,446</td>
<td>1,390</td>
<td>1,476</td>
<td>2.1</td>
</tr>
<tr>
<td>35301/ Rechanneling of artery</td>
<td>1,074</td>
<td>1,044</td>
<td>1,113</td>
<td>3.6</td>
</tr>
<tr>
<td>52601/ Prostatectomy (TURP)</td>
<td>675</td>
<td>647</td>
<td>687</td>
<td>1.8</td>
</tr>
<tr>
<td>44140/ Partial removal of colon</td>
<td>1,177</td>
<td>1,132</td>
<td>1,204</td>
<td>2.3</td>
</tr>
<tr>
<td>63047/ Removal of spinal lamina</td>
<td>1,010</td>
<td>970</td>
<td>1,030</td>
<td>2.0</td>
</tr>
<tr>
<td>49505/ Repair inguinal hernia</td>
<td>451</td>
<td>430</td>
<td>457</td>
<td>1.3</td>
</tr>
<tr>
<td>33512/ CABG, vein, three</td>
<td>1,922</td>
<td>1,864</td>
<td>2,012</td>
<td>4.7</td>
</tr>
<tr>
<td>19240/ Removal of breast</td>
<td>970</td>
<td>921</td>
<td>979</td>
<td>0.1</td>
</tr>
</tbody>
</table>

2004 “scheduled payments” are those that would have taken effect under terms of the November 7, 2003, final rule, had Congress failed to take action.
lecting malpractice premium data annually. And, as these data are obtained, it will review, propose changes to, and revise the GPCIs as appropriate.

Are there any plans to revise the GPCIs for physician work and practice expense?

Both GPCIs were scheduled for revision in 2004. But, because they rely primarily on special tabulations of U.S. Census data that are not yet available, the usual periodic changes in these indices have been delayed until 2005.

However, P.L. 108-173 included some legislated changes to the GPCIs that were not planned when the November 7 regulation was issued. Most importantly, the new law established a “floor” of 1.0 for the work geographic adjuster for all services provided between January 1, 2004, and January 1, 2007. As a result, those largely rural locales with typically a lower cost of living will experience payment increases. Puerto Rico (13.5%) experienced the most significant work GPCI increase as a result of this provision. For the state of Alaska, the new law further legislated specific increases in both 2004 and 2005 through revisions in the work, practice expense, and malpractice GPCIs, bringing those figures to a uniform 1.67.

Were any significant changes made in work RVUs?

CMS received work RVU recommendations from the RUC for approximately 130 new and revised CPT codes and, as is typically the case, accepted about 95 percent of them. The agency also accepted changes that the RUC recommended for three anesthesia codes.

Reports on the proposed fee schedule rule issued last summer noted that changes were being considered for the work RVUs assigned to codes for the excision of benign and malignant skin lesions. Were those changes implemented?

In 2003, the CPT descriptors for these service codes were changed significantly, so that they are now reported according to the diameter of the excision rather than the size of the lesion. In August, CMS proposed to revise the work RVUs assigned to these services to base them on the excised diameters and involved body area only, making no distinction between benign and malignant lesions. However, because so many organizations, including the College, argued against this change, the agency decided to maintain the 2003 values as interim for another year and provide an opportunity for the specialties to collect additional data on these codes.

Were any significant changes made in the practice expense RVUs?

The practice expense advisory committee (PEAC), a subcommittee of the RUC, has been providing CMS with recommendations for refining direct practice expense inputs since 1999. In 2002, the PEAC submitted recommendations on practice cost data refinements for more than 1,200 codes covering almost every major specialty. The agency reviewed and accepted all of those recommendations. Comments were invited in December 2002, and the agency finalized its decision to accept the PEAC recommendations in the current rule.

The agency also extended by two years the deadline that was established for specialty societies to submit supplemental practice expense survey data that may be used in refining practice expense RVUs.

Where can I obtain more detailed information on the 2004 fee schedule changes?

Table 4 on page 10 shows the total impact of RVU changes and the reduced fee schedule conversion on average Medicare payments for a number of high-volume surgical services. Additional information regarding the physician fee schedule and pricing files is available on the CMS Web site. The data can be accessed at http://cms.hhs.gov/physicians/, or by visiting the home page at http://cms.hhs.gov, and selecting “physicians” in the drop-down menu that appears when the cursor is placed over the word “professionals” in the blue area near the top of the page.
UCLA introduces state-of-the-art surgical suites

by Karen Sandrick, Chicago, IL
When the new surgery suites at the University of California-Los Angeles (UCLA) hospital open in July 2004, surgeons will no longer have to sidestep tangled webs of electrical cords from fluoroscopes, ultrasound units, and image-guided systems. They will not have to maneuver between surgical carts crowded with cameras and high-intensity light sources, electrocauteries, and cutting devices or crane their necks to view clinical images or physiological monitoring data on bulky cathode ray tubes (CRTs). They will not have to call out instructions and wait while OR nurses wend their way around the room to dim the lights or turn off the insufflator.

When the new surgery suites open, surgeons will find a clean environment. Jumbled networks of cables will be housed within ceiling-mounted booms that can be pushed into position or pulled out of the way. Each piece of surgical equipment, whether it’s an Aesop surgical robot or BrainLAB image-guided software system, will be plugged into the same audiovisual management system. Bulky CRTs will be gone, replaced by sleek, flat-panel monitors suspended from articulating arms that bring endoscopic images of the surgical field in line with the surgeons’ hands or eyes at the head or the foot or the side of the operating table.

In the new suites, surgeons will be able to control the intensity of the light source, the pressure of insufflation, or the diameter of the camera iris through a touch panel display or voice command. They will be able to select images from picture archiving and communication systems, endoscopic cameras, or network information processing addresses and route them to a plasma screen on a wall or to an auditorium, conference room, nurses’ station, or physician’s office.

Surgeons at UCLA will be operating in the largest integrated OR project built to date using the most advanced surgical concepts. While several hospitals around the country have one or two, or perhaps as many as six, integrated surgical suites, UCLA will have 28. All the surgical suites, other than the neurosurgery suite with its open magnetic resonance imaging unit and the cardiac surgery room with a heart-lung machine, will be within the “red zone” and have a sterile environment, including those destined for cardiac catheterization, interventional radiology, minimally invasive surgery, or open procedures. Every surgical suite also will have the biplanar imaging devices and other accoutrements associated with angioplasty or embolization; so any interventional or invasive procedure can be performed in any room.

Surgeons at UCLA and across the country also will reap the benefits of a unique collaboration between surgery, engineering, and industry based at the university—the Center for Advanced Surgical and Interventional Technology (CASIT). The center is exploring innovative surgical approaches for the future, such as microelectromechanical systems located at the tips of endoscopic instruments to detect tissue density or Doppler blood flow, microrobotics to operate endoscopically without tremor in cramped anatomic regions, and data mapping with a surgical robot to simulate an operation preoperatively.

“The future of surgery will be dictated by three groups: engineers, physicians, and industry. Independently, each of them has done its part to get us where we are today. What we’re doing at UCLA is to try to improve the efficiency of collaboration. So if surgeons come up with an idea, how do they take that to fruition? Or if industry wants to test an innovation, what do they need to do? We’re integrating all three components to have cross-fertilization of ideas,” said Peter Schulam, MD, codirector of CASIT, chief of endourology and laparoscopy, and associate professor of urology at UCLA.

This article describes the design and development of the surgical suites at UCLA. It also explains how surgeons, engineers, and vendors are shaping the surgical suites of tomorrow through CASIT.

Beginnings

UCLA’s current operating theaters are similar to most university-based surgical programs, most of which were built more than 45 years ago. UCLA’s facilities are more than 50 years old, and although the operating suites have withstood the
test of time, they and the hospital as a whole have become increasingly expensive to maintain. The department of surgery, therefore, took advantage of the opportunity to reinvent its surgical suites when the university decided to replace the hospital after the 1994 Northridge earthquake.

When planning began in 1998, several OR turnkey products for integrating surgical equipment and audiovisual technology were being marketed. However, only about 400 integrated surgical suites had been installed across the country, and most were scattered in pockets of one or two as a hospital replaced a few of its existing operating rooms. No hospital had completely transformed its surgical facility to create state-of-the-art, technologically advanced, fully integrated operating suites, which would allow an orthopaedic surgeon to do arthroscopy on Monday, a neurosurgeon to perform ventriculoscopy on Tuesday, and a general surgeon to complete a robotically assisted Nissen fundoplication on Thursday—all in the same room.

UCLA chose to locate all traditional operating rooms, interventional radiology and cardiac catheterization suites, and medical procedure units in the same geographic area to consolidate space for preoperative preparation, postoperative facilities, and nursing care and factor in design flexibility. If in 2010 the hospital needs more standard operating suites, it can convert rooms commonly used for cardiac catheterization or interventional radiology, and vice versa, without affecting bricks and mortar.

Underlying such practical considerations was the recognition of the changing face of surgery. “Both medical and surgical disciplines have operated basically as cylinders, with each discipline in its own space scattered throughout an institution. As we tried to envision the care of patients over the next 50 years, we saw a blurring of many disciplines,” said James B. Atkinson, MD, FACS, professor of
surgery and chief of pediatric and general surgery at the UCLA School of Medicine and an ACS Governor.

Already, Dr. Atkinson pointed out, vascular surgeons are using intravascular techniques to deliver devices through catheters and along guide wires and correct an aneurysm from within the lumen of the blood vessel. These are the same types of techniques interventional radiologists use to intraarterially manage strokes, uterine fibroids, or varicose veins.

“We felt that co-locating the space for all the procedural disciplines would allow physicians and surgeons to work more closely together,” he said.

Efficiency, control, and connectivity

The design of the operating suites also exemplifies a vision for surgery that more effectively uses space, gives surgeons more control over the operating environment, and adds connectivity. Following are some examples of how these improvements are achieved.

• Space efficiency. “In the past, in the operating room, the tools were all hand-held. All you needed was a light and a table. But now we’re using many other devices that have to be brought in on carts and plugged in via wall outlets. And it’s difficult to roll a cart from one end of the OR to the other without having to contend with 10 different cords. So the idea was to integrate all these devices and technologies in a way that is space-efficient,” Dr. Schulam said.

Instead of running electric cords along the floor to different outlets, the new surgical suites collect all the wires in booms that move within a large radius around the OR during surgery and can be docked away from the table when they’re not needed. In keeping with the overall design concept, “any case in any room,” every piece of
equipment is powered from the ceiling through the booms; all the booms are positioned to the left of the patient to be as unobtrusive as possible; and every room can be reconfigured for whatever type of operation will be performed.

Every surgical suite has clear space above the patient and the operating table to add headroom and improve lighting, explained Jeff Dunkley, project director from Berchtold Corporation, Charleston, SC. “Why for years architects designed lights directly over the operating table, we’re not sure. Placing lights in the center of a room is logical for a bedroom or dining room, but not in ORs. In the surgical suites at UCLA, we’re mounting lights in flat metal arms laterally to the patient, which in actuality gives a better leverage point,” Mr. Dunkley said.

Taking other departures from standard OR design, Berchtold is providing eight feet of space for anesthesia, positioning doors so they streamline the patient’s path to the table, and adding a nurse’s station within the OR.

- Control. So surgeons will be able to control the sterile environment, the operating suites will have built-in touch panels and voice-activated command systems for all devices. Through an 18-inch touch-screen display within surgical field or voice commands, surgeons can turn lights up or down, move the operating table, adjust the cautery machine, connect with a telephone or fax, and bring up radiological images from the archives.

- Connectivity. All the data collected during a procedure, including voice recordings, radiology scans, patient data, and images from endoscopic cameras within patients, overhead surgical field cameras, and peripheral OR cameras, can be displayed on any monitor within the operating room for what Dr. Schulam calls “intra-room connectivity.” The same images can be transmitted between other areas of the hospital or other facilities worldwide. Four of the operating rooms will be able to project broadcast-quality, digital pictures captured from several room cameras and a boom camera mounted directly over the operating field as well as digital outputs from endoscopic cameras. “Surgeons will be able to assemble a live broadcast from four of the operating rooms with high-definition capability,” Dr. Atkinson said.

Select didactic facilities within the hospital will be able to display data information from OR input devices so medical students, residents, nurses, and visiting surgeons can remotely observe surgeons while they perform procedures and communicate with them through Duplex audio.

Surgeons also will have the ability to telestrate on the operative screen to add yet another layer of OR connectivity and increase communication. “We can take the information within the operating room and move it around to another room or bring information from another room into ours. We can go to other facilities in the world and send our data out for teaching or consultation purposes. Connectivity means the operating room is not an island,” Dr. Schulam said.

CASIT is a 3,500-square-foot facility that houses d-y lab facilities and conference and office space for industry, research fellows, and faculty.
Industry involvement

When surgeons at UCLA were designing integrated surgical suites for the university’s replacement hospital, they realized that, with existing technology, minimally invasive surgery probably had evolved as far as possible. They also recognized that at least one factor that was restraining surgical advancements was the proprietary nature of medical technological development and engineering.

Gordon Bell, senior researcher for Microsoft’s Medical Presence Relations Group, put it all together for Dr. Atkinson. When Bell spoke at a conference in Santa Barbara, CA, in 2000, he explained that other technologically complex environments, such as the aircraft and auto industries, share technological developments over an open architecture. In the medical industry, however, companies compete by developing new products and making them incompatible with everyone else’s. In order to use a medical product, a hospital has to buy the manufacturer’s disposable accessories and the devices that make it work, and because surgeons can’t plug one manufacturer’s device into another’s monitor, they have to wheel around surgical carts for each company’s product lines.

To pursue the next level in minimally invasive surgery, Dr. Atkinson and his colleagues at UCLA created an academic neutral ground for industry to partner with the medical school and engineering department to fashion seamless linkages among existing technologies and test innovative concepts, ideas, and products.

As the university began working with vendors to construct the integrated surgical suites, it distinguished between firms that saw UCLA only as a customer for products and consumable supplies and those that were willing to participate in an ongoing relationship.

First to come on board in 1999 was Computer Motion, the Mountainview, CA, manufacturer of surgical robots. Soon to follow were Berchtold Corp., the Charleston, SC, creator of the Berchtold Surgical Room of the Future, and Karl Storz, Culver City, CA, supplier of endoscopic equipment and instruments.

With CASIT serving as a foundation, the three vendors are now building relationships that cut across proprietary lines. In the construction of the integrated surgical suites, Berchtold Corporation is removing much of the bulk from the rooms, installing common electrical and communications connections for all devices, and creating the infrastructure that supports Computer Motion’s surgical robots and Karl Storz’s systems. Karl Storz is integrating products from several vendors, including media recording devices, lighting systems, and medical equipment, in one user interface so surgeons can reconfigure a room for general or vascular surgery or urology and adjust the fine details of the operating room milieu.

These companies and the university members of CASIT also are beginning to collaborate on the next tier of surgical technology, such as new robotic platforms for pediatric and other types of surgery performed in small anatomical spaces, surgical simulators, and microelectromechanical systems.

Robotic platforms

One of the future applications for robotics in surgery is in minimally invasive procedures that are difficult or impossible with standard instrumentation because they involve tiny, delicate structures or complex navigation, such as pediatric surgery.

Because endoscopic instruments are rigid and straight and translate the movements of the human hand over a considerable distance, they induce tremor. Because the instruments do not have the same degree of articulation as a human wrist, they are clumsy in confined anatomical areas. To address these issues, Computer Motion is working through CASIT to develop robotic techniques that will expand minimally invasive technology to pediatric surgery by adding precision to endoscopic procedures. Applying the same principles, the company is looking at robotic methods for intracardiac surgery, endoscopic prostatectomy, and robotic suturing after endoscopic aortic aneurysm repair, said Joseph Devivo, president.

Robotics also may have a role in enhancing existing endoscopic procedures by accelerating operative time or expanding the capabilities of surgeons, thereby becoming a true surgeon ex-
The UCLA building project

UCLA is replacing the tertiary and quaternary university hospital on its Westwood campus as well as the primary and secondary Santa Monica Community Hospital and constructing three new research towers. All the buildings in the $1.4 billion project, which is being funded partially by the Federal Emergency Management Agency (FEMA), must withstand an earthquake of a magnitude of 8.3 on the Richter scale and be able to function independently from any outside resources for three days. The buildings consequently will be structural behemoths. The university hospital will use 20,000 tons of structural steel and 3,500 tons of reinforcing steel, 1.7 million pounds of ductwork, and 44,7000 cubic yards of concrete.

Designed by I. M. Pei, the university hospital is being made with travertine marble, the same marble quarried for the Getty Center. One of the largest construction projects ever in the state of California, the UCLA university hospital will have 524 beds and 3,514 rooms covering 1.1 million square feet and 23 acres of floor area.

The hospital will incorporate advanced technology from the surgical suites to the food service areas. It will provide Internet access at the patient’s bedside and wireless connections to laboratory results. Every room will have a single bed, which can be converted from standard medical/surgical to intensive care.

Although a building of this magnitude typically takes three or four years to design, the hospital had only about 18 months to complete the planning process because of FEMA regulations. Under the direction of Dr. Atkinson, the design of the surgical suites went through seven phases, including programming, schematics, blueprints, and mockups.

During the design process, Dr. Atkinson headed a committee that worked with architects to identify the functions the building should serve, convert programming needs and concepts into physical space requirements, and draw plans. In the last stage, Dr. Atkinson focused on OR users. The design team and architects took over a vacant building and actually built operating rooms so surgeons and residents could walk around the table, stand among the flat panels, and envision a surgical procedure.

“Some of the things in the building are unique to the earthquake environment of Southern California, which led to the rather massive engineering and structural design,” said Dr. Atkinson. “But many of the operational and technological aspects of the building are related to our vision of the future in surgery and medicine.”

An artist’s rendering of the UCLA/Santa Monica replacement hospital, which will carry the additional technology in the community.
tender, Dr. Atkinson said. Computer Motion is testing robotic prototypes for making minimally invasive procedures easier, faster, and more efficient by adding functions that are impossible to perform with a couple of standard instruments in the surgeons' hands, DeVivo added.

**Simulations**

Surgical simulation has great potential for providing hands-on guidance when training future surgeons and for eliminating some of the uncertainty when preoperatively planning a procedure.

Computer Motion and UCLA, in fact, are contemplating a surgical simulation system that places two robotic consoles next to each other—one for a surgical resident who is learning how to perform a procedure, the other for the surgeon teacher. “For teaching and mentoring, we’ve been developing a workstation so a surgeon can watch a student perform standard suturing or dissection but also take control from students and guide them to the appropriate motion and method of performing the operation,” Mr. DeVivo explained. “Something like drivers’ education where you have a student driving a car and the teacher in the passenger seat with a steering wheel and brake so he can take control of the car at any time.”

Because surgical robots are driven by computers, it is conceivable that surgeons one day could map three-dimensional imaging data into a surgical simulator to plan an operation based on a patient’s own anatomy. There’s nothing more frustrating for surgeons than setting up a surgical robot and figuring out where to place the arms on the table only to find that the arms keep banging into one another during a procedure, Dr. Atkinson said. But if surgeons could use a surgical simulator to decide where to place ports ahead of time, they could test the geometry of the arms with the movement of the robot before they approach a patient, he added.

Surgeons might use a surgical robot as a projector for viewing a patient’s imaging scans and making a dry run through an intended procedure. According to Mr. DeVivo, surgeons would be able to put a camera inside the three-dimensional data set of the patient’s body and find the gallbladder and liver. They’d be able to decide where to place the left and right arm trocars right on the monitor and use them to grasp, lift, and remove tissue.

“They’d be doing all this actually sitting in a chair, using the handles of the robot, interfacing with the patient’s data, and planning an operation on a patient’s particular anatomy,” Mr. DeVivo said.

Imaging data also may be used intraoperatively with surgical robots to identify markers that direct surgeons to locations that are blind to the na-
It’s not inconceivable for a surgical system to synchronize a patient’s imaging data set with a robot, identify specific anatomical coordinates, and send a robotic arm precisely to that spot, said Mr. DeVivo. “Imagine if we took an X ray. Imagine if we knew exactly where to isolate where a tumor was embedded deep in the liver. We might be able to tell the robot to go exactly to the X, Y, and Z coordinates, place a probe at the dead center of the lesion, and then use radiofrequency to ablate the tissue. The accuracy would be unparalleled,” Mr. DeVivo added.

Microelectromechanics

Relationships between surgeons and engineers at UCLA are spurring research in nanotechnology. Working through CASIT, the department of urology is collaborating with the biomedical engineering division of UCLA on surgical microelectromechanical systems (MEMS), Dr. Schulam said. Dr. Schulam explained that MEMS are devices about the size of a grain of pollen to produce micro-sized gears. MEMS currently are used to operate inkjet printers, deploy airbags, and control the mirrors that display light in digital projection television sets. Dr. Schulam and Carlo Montemagno, PhD, chair of the biomedical engineering division in the UCLA School of Engineering, are exploring how they might employ MEMS technology in surgical instrumentation, such as laparoscopic graspers.

“When I put a laparoscopic grasper in a patient, I can palpate and touch and squeeze tissue, but it’s not as good as having my hand in there. We’re thinking about putting MEMS devices on the ends of surgical instruments that will be able to detect tissue density or have Doppler ultrasound capabilities for generating a mechanical signal to distinguish arteries from veins,” Dr. Schulam said.

CASIT is laying the groundwork for these and other advancements in surgical technology. For industry, CASIT is replacing traditional professional relationships with individual physicians and surgeons in individual locations with a collective, multidisciplinary, and formal partnership for developing and testing new devices. For the surgical subspecialties and other clinical and professional disciplines within UCLA, CASIT is overcoming barriers to technological innovations. “We’ve all become islands. We work on projects and think about novel technologies, new ways of doing things, but we don’t know what any of the other surgeons or radiologists or cardiologists are doing in the hospital,” said Dr. Schulam.

“The idea of CASIT is to bring everyone around the table regardless of discipline to share their thoughts, ideas, research projects, technologies, and techniques so we can learn from one another,” he added. “The key to CASIT is that it will be an independent program. So it will not be owned by anyone but shared by all.”

Ms. Sandrick is a freelance writer in Chicago, IL.
The most important change in the Current Procedural Terminology (CPT) for general surgeons this year is the complete revision of central venous access procedures. This article covers that change first and then moves on to other codes in numerical procedure code order.

First, though, a reminder that the general rule for Medicare’s acceptance of old codes is that carriers will accept either CPT 2003 or CPT 2004 for claims received during January, February, and March. Beginning April 1, carriers will reject procedure codes deleted in CPT 2004.

CVA procedure codes

The section containing central venous access (CVA) procedures codes (36555-36597) has been extensively rewritten and expanded to more accurately reflect the increasing variety and complexity of procedures that surgeons perform. A total of 27 codes are in the new section, including 24 new codes and three existing codes that were relocated; 10 old codes were deleted. The codes are grouped into five categories that describe insertion, repair, partial replacement, complete replacement, and removal of a CVA.

The internal tip of the catheter must be within the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium to qualify as a CVA device. The actual device may be a catheter, port, or pump. The external end of the device may be either on or under the skin. The codes recognize CVA catheters that are inserted either centrally or peripherally and may be tunneled or non-tunneled. Subcutaneous ports may be implanted either centrally or peripherally, while pumps are only implanted centrally. There is no distinction related to catheter size or whether the vein entry was achieved percutaneously or by cutdown. The age distinctions for CVA devices have been raised from equal to or more than two years to equal to or more than five years; a modifier indicating that the patient was a neonate or infant up to 4 kg in weight (modifier -63) may be added to the procedure code.

Two repair codes and one partial replacement code may be used for the catheter portion of the device. Two codes apply to the removal of the entire device, and six codes indicate complete replacement of a CVA device through the same access site. If complete replacement is performed at a new site,

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CPT changes in 2004

by
John T. Preskitt, MD, FACS, Dallas, TX,
Albert Bothe, Jr., MD, FACS, Chicago, IL,
and
Jean A. Harris, Associate Director, Division of Advocacy and Health Policy, Washington Office
use the appropriate new insertion code, along with the relevant removal code for the device being replaced. When reporting the repair, replacement, or removal of a multi-catheter device, use the appropriate code to describe the procedure with a frequency of two.

The codes are summarized in Table 1 on this page. Additional versions of the table, sorted by procedure code and by device (such as insertion, repair), are available on the College’s Web site at http://www.facs.org/fellows_info/bulletin/2004/cvacodes.xls.

**Vascular coding**

Four new codes were added to report upper extremity arterial bypass grafts using vein. All four codes include procurement of suitable autogenous conduit, either saphenous or arm vein. Table 2 on

### Table 1:

**Central venous access codes by procedure**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Entry site</th>
<th>Device</th>
<th>Tunneled</th>
<th>Age</th>
<th>Example</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Insertion</td>
<td>Extremity</td>
<td>Catheter</td>
<td>&lt;5</td>
<td></td>
<td>PICC</td>
<td>36568</td>
</tr>
<tr>
<td>Insertion</td>
<td>Extremity</td>
<td>Catheter</td>
<td>&gt;=5</td>
<td></td>
<td>PICC</td>
<td>36569</td>
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<tr>
<td>Insertion</td>
<td>Extremity</td>
<td>Port</td>
<td>&lt;5</td>
<td></td>
<td></td>
<td>36570</td>
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<td>Port</td>
<td>&gt;=5</td>
<td></td>
<td></td>
<td>36571</td>
</tr>
<tr>
<td>Insertion</td>
<td>Torso</td>
<td>Catheter</td>
<td>No</td>
<td>&lt;5</td>
<td></td>
<td>36555</td>
</tr>
<tr>
<td>Insertion</td>
<td>Torso</td>
<td>Catheter</td>
<td>No</td>
<td>&gt;=5</td>
<td></td>
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</tr>
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<td>Insertion</td>
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<td>Catheter</td>
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<td>&lt;5</td>
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<td>Catheter</td>
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<td>&gt;=5</td>
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<td>&lt;5</td>
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<td>36560</td>
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<td>Port</td>
<td>Yes</td>
<td>&gt;=5</td>
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<td>36561</td>
</tr>
<tr>
<td>Insertion</td>
<td>Torso</td>
<td>Pump</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Insertion</td>
<td>Torso</td>
<td>Dual catheter</td>
<td>Yes</td>
<td></td>
<td>Tesio-Type</td>
<td>36565</td>
</tr>
<tr>
<td>Insertion</td>
<td>Torso</td>
<td>Port w/ 2 catheters</td>
<td>Yes</td>
<td></td>
<td></td>
<td>36566</td>
</tr>
<tr>
<td>Repair</td>
<td>Extremity</td>
<td>Catheter</td>
<td></td>
<td></td>
<td></td>
<td>36575</td>
</tr>
<tr>
<td>Repair</td>
<td>Torso</td>
<td>Catheter</td>
<td></td>
<td></td>
<td></td>
<td>36575</td>
</tr>
<tr>
<td>Repair</td>
<td>Extremity</td>
<td>Port/pump</td>
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<td></td>
<td></td>
<td>36576</td>
</tr>
<tr>
<td>Repair</td>
<td>Torso</td>
<td>Port/pump</td>
<td></td>
<td></td>
<td></td>
<td>36576</td>
</tr>
<tr>
<td>Replace catheter</td>
<td>Extremity</td>
<td>Port/pump</td>
<td></td>
<td></td>
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<td>36578</td>
</tr>
<tr>
<td>Replace catheter</td>
<td>Torso</td>
<td>Port/pump</td>
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<td>36578</td>
</tr>
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<td>Complete replacement</td>
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<td></td>
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</table>
this page provides an overview of the four new codes.

A new code has been established to report an elective open bypass graft and ligation procedure for patients suffering from steal syndrome related to hemodialysis access. It is code 36838, Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome).

A new add-on code has been created for reporting reimplantation of the visceral artery (that is, inferior mesenteric, accessory renal) during either aortic aneurysm repairs or aortic bypass procedures. Code 35697, Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery, is reported one time for each infrarenal artery reimplanted during the procedure. There is a cross-reference directing the reader not to report code 35697 with code 33877, Repair of thoracoabdominal aortic aneurysm, since all subsequent infrarenal implantations are included in code 33877.

An existing category III CPT code for reporting aorto-uniliac or aorto-unifemoral endovascular repair of an infrarenal abdominal aortic aneurysm or dissection has been converted to a category I code. It is code 34805, Endovascular repair of an infrarenal abdominal aortic aneurysm or dissection; using aorto-uniliac or aorto-unifemoral prosthesis. A note indicates it is permissible to report open arterial exposure (for example, codes 34812 or 34820) with code 34805. In addition, all introductory remarks related to the endovascular aortic aneurysm repair family of codes, as well as rules related to component coding, are relevant when reporting code 34805.

There is a new note after code 35572, Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure, indicating that modifier -50 should be used when performing this procedure bilaterally.

Two new codes were created to report stab phlebectomy of varicose veins. Code 37765, Stab phlebectomy of varicose veins, one extremity; up to and including 20 incisions, is used to report 10 to 20 stab incisions in one leg. Code 37766 is used to report more than 20 stab incisions in one leg. The unlisted vascular surgery service code 37799 should be used to report this service when fewer than 10 stab incisions are performed.

Gastric tube placement

Code 43752 has been revised to clarify that the code is to be reported only in those rare instances when a physician performs naso- or orogastric tube placement under radiologic guidance. The language specifies that the service includes fluoroscopic guidance, consisting of fluoroscopy, image documentation, and a report.

Living donor hepatectomies

To reflect the growing sophistication of living donor hepatectomies, three new codes have been added to report the removal of different portions of the liver. These include code 47140 to report the removal of the left lateral segment (segments II and III), code 47141 to report a total left lobectomy (segments II, III, and IV), and code 47142 to report a total right lobectomy (segments V, VI, VII, and VIII).

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Table 2: New venous bypass graft codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Bypass graft</th>
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<tr>
<td>35510</td>
<td>Carotid-brachial</td>
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<td>Subclavian-brachial</td>
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<tr>
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<td>Axillary-brachial</td>
</tr>
<tr>
<td>35525</td>
<td>Brachial-brachial</td>
</tr>
</tbody>
</table>

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Dr. Preskitt is a general surgeon at Baylor University Medical Center, Dallas, TX, and a Regent of the College.
Code 47134, the old code for a partial lobectomy from a living donor, has been deleted. There is a cross-reference directing that all hepatectomies that were reported using code 47134 be reported using code 47140. That is certainly true for partial left lobectomies, but it is not true for total right or total left lobectomies. Full or formal (“total”) lobectomies should be reported as code 47141 or 47142.

**Starred procedures**

You will remember that several surgical procedures (such as code 47000, Biopsy of liver, needle; percutaneous, and code 46500, Injection of sclerosing solution, hemorrhoids) had a star or an asterisk next to them. The star meant that the service included only the surgical procedure; pre- and post-operative services, including complications, were reported separately.

The stars have become obsolete due to the recognition of zero and 10-day global services and the creation of a modifier for a significant, separately identifiable evaluation and management (E/M) service on the same day as a procedure (modifier –25). Therefore, the stars are being deleted, but, of course, the procedure will remain. Code 99025, for a visit by a new patient at the time a starred procedure is performed, also was deleted. One of the usual E/M services should be reported if necessary.

**Category II and III**

CPT has added category II codes for performance measurement this year. They represent activities that normally are carried out as part of an E/M service and are widely believed to indicate high-quality care if performed on eligible patients. Examples are blood pressure measurement and the prescription of beta blockers. Because these codes are a part of an E/M service, they do not have assigned relative values. However, in the near future, some payors may begin using these codes to pay an incentive for high-quality performance over the course of a year. The category II codes appear after the end of the category I codes. Presently, none of the measures applies to surgery.

Surgeons are expected to be familiar with and use category III codes when the procedure they perform is described by one of these codes. The category III designation is assigned for emerging technology procedures or for procedures involving devices that are not yet approved by the Food and Drug Administration (FDA). Once a device gains FDA approval, conversion to a category I CPT code requires a minimum of 15 months, but the category III designation is maintained throughout that interval of time. For the Medicare program, decisions about coverage for category III codes, and a determination of the payment amount for most category III codes, have been delegated by the Centers for Medicare & Medicaid Services to the local carriers. Surgeons should discuss coverage and, if necessary, the payment amount with their carriers in advance of performing the procedures if they believe payment is indicated. This year, codes 0045T-0061T have been added. Breast, thoracic, and orthopaedic surgeons should review the new codes.

**Acknowledgement**

The authors thank Robert M. Zwolak, MD, FACS, for reviewing this article.

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**Dr. Bothe** is professor of surgery and compliance officer at the University of Chicago (IL).
no-fault compensation system is a possible alternative to our current tort-based professional liability system. This concept has been under discussion in the U.S. for a number of years, and it has a certain appeal. While most physicians would be happy to see our present lottery system replaced, there always has been a concern that a no-fault system would result in a rapid escalation in the number of cases brought and, as a result, in overall costs.

To understand how such a system might work we might look to Sweden. The Michigan State Medical Society did just that in 1989, when it organized a trip to Sweden. Joining the medical society were representatives of the Michigan Hospital Association, the two Michigan physician-owned insurance companies, the trial lawyers association, and the Michigan legislature. The trip was led by Marilynn M. Rosenthal, professor of sociology at the University of Michigan, Dearborn, and author of Dealing with Medical Malpractice: The British and Swedish Experience.* There, the delegation studied the earlier Swedish Patient Insurance Fund, the Medical Responsibility Board (“MRB”) and the Swedish health care system.

Embedded within the Swedish social system, the earlier Patient Insurance Fund was the no-fault alternative to the tort system until 1996, when the Patient Torts Act (PTA) replaced it. In reality, however, the PTA also is a no-fault system, even though

it does require all medical and health providers to obtain liability insurance. The question we pose in this article is whether a similar no-fault system for compensating injured patients could be adapted to meet the needs of patients in the U.S. The answer will depend on whether we in the U.S. can replicate the elements of the Swedish social and legal system that underpin the success of this alternative.

Sweden’s earlier Patient Insurance Fund operated in the context of a public health care system that is part of an extensive welfare state. Sweden guarantees full employment, extensive entitlement programs, and legislated social programs. The state funds all hospitals, and all but 5 percent of the physicians are employees of the state. Financial responsibility for health care services is distributed among the national government, 23 county councils, and three large municipalities. The municipalities take primary responsibility for social welfare services. Health care accounts for more than two-thirds of each county’s budget. County councils operate hospitals and outpatient services.

Other social insurance systems also compensate certain medical injuries. These include public insurance, workers’ compensation, collective agreement sick-leave insurance, security insurance, no-fault traffic insurance, no-fault medical drug insurance, the General Torts Act, and compensation for victims of crime.

Sweden first introduced the country’s no-fault Patient Insurance System in 1975. Within this system, a Patient Insurance Fund was established, funded by county tax revenue and by organizations representing private practice doctors, dentists, and physiotherapists. A consortium of private Swedish insurance companies administered the system. Three years later, a similar insurance system was introduced for injuries caused by, or clearly related to, pharmaceuticals.

The Patient Insurance System did not require a showing of fault or malpractice in order to compensate a claim against a health care practitioner. The Medical Responsibility Board processed complaints alleging physician incompetence. This function was and still is entirely separate from the system that compensates patients for injuries. In 1997, it became a legal obligation for every health care authority to provide compensation for injuries sustained in the course of clinical procedures, regardless of fault.

In a 1983 study of the Patient Insurance System, Carl Oldertz, vice-president of Skandia, showed that 60 percent of the injuries were considered eligible for compensation. Of these, about 75 percent of the claims involved procedures. Mr. Oldertz said, “Our philosophy is compensation should be paid if it’s possible to have avoided a particular medical injury. And that fault is an irrelevant factor.”

The Patient Insurance Fund provided compensation according to a predetermined schedule, adjusted by percentage of full or partial disability and by expected duration. It covered most injuries due to diagnostic errors, new or unproved methods of treatment or their complications, hazardous interventions performed in order to avoid a threat to life or permanent disability, injuries that could have been avoided by choosing a different treatment, and most mistakes in diagnosis. Exclusions included minor injuries requiring 30 days of sick leave from work and a minimum of 10 days in the hospital, cases of psychological or “unavoidable” injury, or “accidental” injury. It only covered infections in clean cases, excluding infection of the respiratory or gastrointestinal tract. If an expert medical advisor held that “accepted” medical treatment was used, the injury was not compensated. Injuries due to pharmaceuticals were covered through a separate program. Fault, except in rare instances, was not a necessary factor.

Loss of income was paid when the child’s future opportunities could be assessed. Pain and suffering were paid with strict limitations. Economic damages were paid in a structured settlement. The statute of limitations was three years, with the equivalent of the collateral source rule, taking into account other types of insurance payments. In the case of a death no payments were made for non-economic damages. Experienced claims adjustors used objective criteria to determine awards.

The only lawyers involved in the procedures under the Patient Insurance System were the insur-
ance company staff or individuals who assisted
patients in writing out claims. The system had an
18 percent overhead, and the whole award went
to the patient. Compensation was 100 percent for
economic losses, with noneconomic losses paid ac-
cording to a fee schedule. Noneconomic losses ac-
counted for two-thirds of the payments. The aver-
age claim was settled within two months and most
of the rest in less than six months, although some
took up to two years.

Appeals went to a government-appointed claims
panel with six permanent members, including one
medical expert from the government. These ap-
peals were free of charge. Approximately 20 cases
could be heard in a month. The panel reversed
about 10 percent of the cases.

Arbitration was available but rarely used. The
chair of the arbitration panel was a governmental
appointee, usually a judge, and medical experts
advised the panel. In 1989, only a handful of cases
had been taken to court. In general, these were in
cases where the Patient Insurance Fund had ex-
cluded payment, and the lawyers argued that the
case should be covered. A series of cost-cutting
maneuvers had reduced the schedule of awards,
strengthening those arguments.

The American trial lawyers with us who looked
at this system predicted that Swedish lawyers
would soon bring more of these cases to court,
but the Swedes explained that American trial
lawyers should recognize that the mentality of
U.S. and Swedish lawyers are poles apart.
Swedes generally do not believe in “a right” to
economic compensation for all imperfections or
defects, and Swedish case law provides very low
damage awards. Indeed, the lawyers who had
brought cases to court found the damage awards
under the general Torts Act to be lower than
the fixed benefit schedule the Patient Insurance
Fund used.

Feedback from the Patient Insurance System
was returned to hospitals, physicians, and the
chief of the hospital clinical service. The physi-
cian could not be fired for this reason alone, but
he or she could be either reassigned or sent for
additional training. All case reports went to a
risk management/quality assurance database.
Complaints of physician fault or malpractice also
could, and still can, be filed with the Medical
Responsibility Board.

The Medical Responsibility Board (MRB) is a gov-
ernment agency resembling a court. A patient, close
relative, or legal representative may claim malprac-
tice or allege that medical practitioners have acted
incorrectly. The remedies include disciplinary
warning, admonition, or removal of the practitio-
ner from the health register.

Medical practitioners are thus held responsible
for their actions in a process that is separate from
the system for compensating injured patients.

Although the number of complaints filed annu-
ally has varied, it has been fairly consistent. In
1994, 2,417 complaints were filed, and this num-
ber grew slowly to 3,250 in 2001. In 1994, the board
judged 2,053 cases, increasing to 3,132 cases in
2001. Thus, the board clears its dockets fairly effi-
ciently, avoiding undue procedural delay.

The MRB decides all matters associated with dis-
ciplinary sanctions. This body consists of a chair
and eight government-appointed members. In
1989, they included members of parliament, rep-
resentatives from each of the three large health
occupation unions, and a representative from the
Federation of City Councils. The chairman must
be a lawyer and should have experience as a prac-
ticing judge. In certain situations, the chair may
decide cases independently of the panel.

In 1994, the chairman independently judged 684
cases, and the panel judged 902. This ratio has
gradually reversed, until 2001, when the chair in-
dependently judged 1,733 cases and the panel 723
cases.

Patients, health care professionals, hospitals, a
parliamentary entity, or the National Board of
Health and Welfare may submit complaints in writ-
ing, using forms that are widely available in all
hospitals. If a plaintiff cannot file a complaint per-
sonally, a proxy may do so. Administrative staff
reviews all submitted complaints, screening out 30
to 40 percent as frivolous.

The MRB assigns investigation of the complaint
to a physician in the same discipline. The physi-
cian considers written testimony from the named
physician, the complaining patient, and other in-
terested parties, as well as the hospital records. A
staff lawyer writes up the physician’s summary, and
the physician presents it to the MRB.

The opinions and recommendations of this physi-
cian are granted considerable weight in the MRB’s discussion, but the MRB’s ruling typically is unanimous. The MRB’s nonphysician majority gives the public confidence that physicians are not covering up for each other, and the physician experts give the panel credibility and validity. The MRB normally accords these physicians great deference.

The proceedings are conducted in writing, though portions may be verbal. The MRB thoroughly examines the factual findings of all complaints, considering all relevant records and associated documents. The practitioner under investigation must respond within a set time limit, indicating whether he or she accepts or rejects the allegations, and giving the basis for this position.

The appropriate city or district administrative court does have subject matter jurisdiction to order a hearing or issue an injunction.

Disciplinary sanctions may be imposed on health and medical practitioners who, intentionally or negligently, fail to discharge their duties or other obligations in accordance with Swedish law. The 1994 Health and Medical Personal (Duties) Act (replaced in 1999 by a new law with essentially the same content on this subject) is the controlling law. A complaint must be filed within five years of the alleged offense.

MRB sanctions may include warnings, admonitions, restriction of prescribing authority, or withdrawal of licensure, which latter must be requested by the National Board of Health and Welfare. Warnings are issued in some 20 percent of the cases. These admonishments are taken extremely seriously. The Michigan delegation was told that one admonished physician committed suicide.

Investigations usually last 18 months, but for license revocations they usually are completed in five to six months. The MRB usually issues a sanction for substance abuse or for mental incapacity, less often for professional incompetence. The MRB has complained of inadequate funding and insufficient staff.

The total number of warnings or admonitions varies. In 1994, the MRB warned 150 practitioners and admonished 112 practitioners. This rose to 226 warnings and 184 admonitions in 1996. In 2001, the MRB warned 120 practitioners and admonished 157.

A license to practice medicine may be revoked for incompetence, when a practitioner is shown to be clearly unfit to continue in practice, or because of illness. A practitioner may receive an injunction requiring a medical examination. A license to practice may be temporarily withdrawn pending the final outcome of the examination or if the practitioner has failed to comply with the injunction within one year. In the European Union, revocation of a license to practice in any other member state also bars that person from practicing in Sweden.

License revocations are uncommon for doctors, dentists, or nurses, and only a few have been issued for other health care personnel. In 1994, of 48 filed complaints, the MRB revoked 20 licenses from seven doctors, two dentists, and 11 nurses. Number of complaints filed increased to 80 in 1998, with the MRB revoking 26 licenses from 16 physicians, one dentist, seven nurses, and two other personnel. In 2002, of 60 filed complaints, the MRB revoked 19 licenses from six physicians, one dentist, and 12 nurses.

Final decisions of the Medical Responsibility Board may be appealed to an administrative court within three weeks. In addition to the plaintiff and defendant, the National Board of Health and Welfare may appeal. The parliamentary ombudsman and the Chancellor of Justice may also appeal certain decisions. All parties are entitled to legal counsel. Few judgments have been appealed to the administrative court since July 1995, averaging 23 to 29 per year.

The 1996 Patient Torts Act requires that patients take their liability claims to court and that health care providers carry liability insurance. Whether the bill was passed because of perceived deficiencies in the previous Swedish Compensation Fund or primarily in response to pressure from the European Convention on Human Rights is a matter of conjecture. We do know that Article 6 of the Convention states, “In the determination of his civil rights and obligations...everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law.” We also know that Sweden’s governmental and quasi-governmental administrative systems have been criticized in Europe on this basis.
The PTA compensates injuries caused by health care practitioners, including conditions that are the result of the diagnosis and treatment of disease, medical research, organ or tissue donations, transportation of patients, and dental care.

The burden of proof is lower than it is under the general Torts Act in Sweden. The plaintiff must show "by a reasonable certainty" that the health care practitioner's conduct caused the alleged injury. There is no need to prove proximate cause; that is to say, that the injury was within the scope of foreseeable risk.

Under the PTA, the "but for" test may be used, meaning that the injury would not have occurred "but for" the physician's act or omission. Also, the defendant's conduct is considered the cause if it was a "substantial factor" in causing the injury.

Claims under the PTA may involve procedures, medical devices, diagnoses, infections, accidents, and pharmaceuticals. Compensation is paid if a different procedure or method could have prevented the injury or if the injury resulted from defective devices or products or from their incorrect use. Injuries are compensated if they result from transmission of infection, from accidents in the course of diagnosis or treatment, or from pharmaceuticals prescribed or given contrary to directions. The standard of care is that of a skilled specialist or any other skilled professional within the field.

Compensation is not offered for injuries that are unavoidable, for injuries resulting from a procedure that is necessary to diagnose or treat a disease, for life-threatening injuries, or for treatments without which there would be severe disability. This includes emergency care. If the only available treatment was provided, an injury is not compensated. Under the PTA, a claim must be filed within three years from the time that the patient recognized the injury and within 10 years from the time of injury.

Calculation of medical expenses, other expenses, loss of income, funeral costs, loss of services, and damages for pain and suffering usually are the same under the PTA as under the general Torts Act. Because the public health care system funds the hospitals and employs most physicians, actual medical expenses tend to be low.

The PTA compensates only necessary expenses, not so-called comfort expenses. There is compensation for loss of future income when an injury leads to permanent harm. The general Torts Act provides the following criteria for these calculations: type of work, previous education and occupation, retraining requirements, age, and residence.

Compensation for acute and permanent pain and suffering takes into account the length of hospitalization or sick leave, and it is generally very low in Sweden. The courts usually rely on the Traffic Injury National Board tables as a template for these calculations.

Under the PTA, approximately $180 is deducted from patient compensation. A cap on patient compensation for economic and noneconomic damages is set at an amount that presently is about $730,000. If several patients are injured through the same conduct, the total amount paid is capped at about $3.6 million. If this amount does not fully compensate patients for their respective injuries, payment for each individual is reduced.

When negligence can be proven, a plaintiff may file under the general Torts Act, thus avoiding the PTA deductible and the cap on compensation. The burden of proof in the no-fault PTA system requires "reasonable certainty," a lower burden of proof of causation in comparison with the general Torts Act, which requires "probable cause."

Damage awards under the general Torts Law generally would not exceed those under the PTA. Courts usually are very unwilling to award high noneconomic damages to any plaintiffs. In criminal law, for example, awards to victims of serious crimes are very low in comparison to those in the U.S. This appears to be a cultural difference, rather than a legal difference.

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To evaluate whether the U.S. should change to a no-fault patient compensation system, we need to consider whether the key elements of the Swedish system could be applied under the current U.S. health care system. The questions are whether the U.S. public would accept restrictions on the types of events that are compensated, and whether they would accept a limited compensation schedule. In Sweden, these two points explain why the number of cases and overall costs remain under control.

In legal terms, the obstacle is that compensation in Swedish medical liability cases is determined in the same way as it is in all other types of cases under Sweden’s general tort law, and all these awards are low. In the U.S., awards in all types of tort cases are much higher, and this has caused the U.S. public to expect correspondingly high levels of compensation for medical liability cases.

We also need to recognize major cultural differences between the Swedish legal system and the American system. Sweden does not have jury trials. At the district court level, a judge and three laymen decide the case, and they all have an equal vote. The crucial difference in comparison to the U.S. is that Swedish case law allows judges and laymen to decide on patient compensation, including noneconomic damages, in accord with strict guidelines. Again, this is a cultural difference. Case law has been able to develop in this way because the public is satisfied with these lower levels of patient compensation and noneconomic damages. The Swedish public does not believe that any plaintiff would have the right to $20 million in damages for any injury. The PTA cap of approximately $730,000 sounds high enough to them. Of course, because Sweden’s social system subsidizes many of the plaintiff’s costs, their lower awards reflect in part a lower need.

Although the Swedish system of socialized medicine is markedly different from our U.S. system, these differences may be less relevant to this discussion than are the differences in legal environment. Medicine is virtually free of cost within the public system in Sweden, but there is a small private system that provides a significant amount of care in some fields. In contrast, although we have a primarily private system, we too have a large public system. Medicaid now covers 47 million Americans, and Medicare is not far behind.

To build a case for change to a no-fault system, we would have to answer the trial lawyers’ charge that the tort system protects the public from “bad doctors.” In Sweden, the system is clearly bifurcated, and patient compensation is entirely separate from disciplinary actions against doctors who perform poorly or are unqualified. If we were to have a no-fault compensation system in the U.S., the public would likely demand something like the Swedish Medical Responsibility Board, to feel that their interests were being protected. Although we do have boards of medicine in each state, these bodies have come under attack, and they have not maintained the credibility with the public that the Medical Responsibility Board has in Sweden. We would need to carefully study this trade-off.

In summary, the Swedish system is ideally suited to Sweden. Any attempt to adopt it, in whole or in part, in the U.S. would encounter a number of problems. The trial lawyers would oppose it, and the political climate would be problematic. If awards were to be markedly higher here than they are in Sweden, overall costs might be too high, and we would have to figure out who should bear these costs. These questions demand rigorous legal and economic analysis.

References and source material for this article may be obtained from Dr. Adelman, 29820 Woodland Dr., Southfield, MI 48034; e-mail susanadelman@hotmail.com.

Ms. Westerlund is an attorney with RydinCarlsten in Stockholm, Sweden.
Nursing supply and demand

Registered nurses form the largest segment of the U.S. health care professional workforce. Nonetheless, the number of nurses is shrinking steadily and has not kept pace with the demands of a growing and aging American population. In 2000, the number of full-time equivalent registered nurses was estimated at 1.89 million, while demand was estimated at 2 million—a shortage of 6 percent. This shortage is expected to grow steadily to 12 percent in 2010, when it will accelerate, increasing to 20 percent in 2015 and 29 percent in 2020.\(^1\)

Factors driving the growth in demand include population growth, a larger proportion of elderly Americans requiring more care, and medical advances that increase the need for highly trained clinical staff. Further, the nursing workforce itself is aging, averaging a little over 47 years.\(^2\) Of particular interest to surgeons, only about 4 percent of the licensed registered nurses are perioperative nurses, whose average age is slightly higher. In addition, about 20 percent of perioperative nurses are expected to retire within the next five years.\(^3\)

It takes an average of 90 days to fill vacancies for clinical care in hospitals where the demand is greatest for nurse specialists, including perioperative nurses. To cope, many hospitals are creating in-house training programs to develop their own pool of perioperative nurses. Unless these trends are reversed, it has been predicted that the expanding nurse shortage will be felt acutely by surgeons in such areas as emergency departments, critical care units, and in the operating room.

Driving forces and trends

Many factors contribute to the short supply of registered nurses:

- An aging workforce has resulted from a decline in the overall number of nursing school graduates, the higher average age of recent graduating classes, and the aging of the existing pool of licensed nurses. As a result, the professional career of registered nurses has shortened, and increased rates of retirement can be expected in coming years.\(^1\)
- Fewer nurses are being trained. Declines in nursing graduates are seen across all types of programs—diploma, associate degree, and baccalaureate. While the trend appears
to be reversing for associate and baccalaureate programs, the change may not be sufficient to meet projected needs.

- **Relative earnings have declined** for nurses in recent years, and salaries play a role in recruitment and retention. While actual earnings for registered nurses increased steadily from 1983 to 2000, when adjusted for inflation, average salaries have remained relatively flat since 1991.¹

- **Cost containment** strategies implemented by hospitals over the past two decades have seriously affected the industry’s ability to retain and recruit qualified workers. Job satisfaction continues to be a problem, with low staffing levels and heavy workloads among the problems cited most often.

**Impact on patient care**

Evidence is growing that a shortage of nurses affects the quality and safety of patient care. For example, nurse researchers at the University of Pennsylvania found that in hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted mortality and failure-to-rescue rates. Further, nurses working in these environments are more likely to experience job “burnout” and dissatisfaction.

In a report issued by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in August 2002, the authors examined the shortage of nurses in U.S. hospitals and found that low nursing staff levels were a contributing factor in 24 percent of 1,609 hospital reports of patient deaths or injuries since 1996.

A study, published in the *New England Journal of Medicine* in May 2002, examined 799 hospitals in 11 states, and found that the number of hours of care provided by registered nurses each day in hospitals is associated with patient outcomes. Among surgical patients, a higher proportion of care provided by registered nurses was associated with lower rates of urinary tract infections, and more hours of care per day were associated with decreased fail-to-rescue rates.

**College views**

Surgeons view nurses as partners—on the patient care units and in the perioperative area, and especially in the critical care units and operating room. Our patients’ best interests lie in the education and retention of nurses as members of the surgical care team. Emphasis must be placed on the positive relationship that exists between surgeons and the nurses with whom they work by promoting a professional workplace environment and an atmosphere of mutual respect.

The American College of Surgeons strongly supports a variety of approaches to induce promising men and women, including those from minority populations, to pursue careers in nursing. We urge hospitals to develop and promote career pathways in which nurses are rewarded financially and participate in policy development.

To increase the number of nurses, schools of nursing should increase the number of qualified faculty and expand student clinical experiences. Additional educational opportunities and the flexibility and financial resources to pursue them should be made available to allow nurses to attain advanced education, skills, and status. The American College of Surgeons supports federal efforts to improve understanding of the supply and demand issues involved and new legislation to enhance our nation’s investment in nurse education and training.

**References**


2. American Hospital Association Commission on Workforce for Hospitals and Health Systems.

3. Association of periOperative Registered Nurses.
The American College of Surgeons invites you to attend its 32nd annual Spring Meeting, which will take place April 24-27 at the Marriott Copley Place, Boston, MA. The theme of this year’s program will be Embracing the Surgical Revolution: Enhancing Knowledge, Skills, and Performance.

To emphasize its strong commitment to and support of general surgery, the American College of Surgeons devotes its annual Spring Meeting to the interests and needs of the practicing general surgeon. The objective of the Spring Meeting is to provide practicing surgeons with knowledge and skills that they may apply to enhancing the care of surgical patients.

The Advisory Council for General Surgery has planned a program for the 2004 Spring Meeting that the College anticipates will be of interest to all general surgeons. The Assembly for General Surgeons: A Town Meeting will focus on important evolving practice-related issues on quality and outcomes that are affecting surgical practice today.

The 2004 Excelsior Lecture, “Optimizing Results in Pancreatic Surgery,” will be presented by Andrew L. Warshaw, MD, FACS.

A number of skills-oriented postgraduate courses are scheduled, including: Breast Imaging for the General Surgeon; Breast Ultrasound; Ultrasound in the Acute Setting; Stereotactic Breast Biopsy; Bariatric Surgery Primer; Bedside Procedure Workshop; Mobile and Wireless Computing: Practical Application; and Mastering Surgical and Office-Based Coding. General sessions on vascular access, genetics and cancer, and endolaparoscopic approaches to esophageal disease will be complemented by core didactic courses in abdominal trauma and vascular surgery.

The Spring Meeting in Boston will provide surgeons with high-quality educational and networking opportunities, so make plans to attend this valuable meeting. Information regarding the general sessions, postgraduate courses, and registration information will be mailed to Fellows in February. Registration will be available online and posted on the ACS Web site at www.facs.org.
Preliminary program

Program is subject to change.

General Sessions

Saturday, April 24

1:00–5:00 pm
Welcome and Opening Remarks
A Town Meeting: Facing the Inevitable: Surgical Quality and Outcomes Made Public
MODERATOR: Shukri F. Khuri, MD, FACS, West Roxbury, MA

Sunday, April 25

8:00–9:30 am
Laparoscopic vs. Open Tension-Free Inguinal Hernia Repair: Principal Outcomes of Veterans Affairs’ Cooperative Study
MODERATOR: Leigh Anne Neumayer, MD, FACS, Salt Lake City, UT

Monday, April 26

8:00–9:30 am
Update on Surgical Oncology for General Surgeons
MODERATOR: David P. Winchester, MD, FACS, Chicago, IL

ACS Advisory Council for General Surgery

CHAIR: Mark A. Malangoni, MD, FACS, Cleveland, OH
VICE-CHAIR: J. Patrick O’Leary, MD, FACS, New Orleans, LA

Linda M. Barney, MD, FACS, Dayton, OH
Kenneth E. Chandler, MD, FACS, Decatur, AL
Joseph B. Cofer, MD, FACS, Chattanooga, TN
Thomas H. Cogbill, MD, FACS, La Crosse, WI
James A. Edney, MD, FACS, Omaha, NE
David V. Feliciano, MD, FACS, Atlanta, GA
Richard J. Finley, MD, FACS, Vancouver, BC
Michael J. Hart, MD, FACS, Seattle, WA
Nathalie Johnson, MD, FACS, Portland, OR
A. Letch Kline, MD, FACS, Biloxi, MS
John K. MacFarlane, MD, FACS, Vancouver, BC
Fabrizio Michelassi, MD, FACS, Chicago, IL
Juan C. Paramo, MD, Miami Beach, FL
Victor E. Pricolo, MD, FACS, Providence, RI
Charles F. Rinker II, MD, FACS, Bozeman, MT
A. Frederick Schild, MD, FACS, Miami, FL
Jose L. Sorrentino, MD, FACS, San Juan, PR
Marc K. Wallack, MD, FACS, New York, NY

STAFF:
Paul E. Collicott, MD, FACS, Chicago, IL
Director, Division of Member Services
Mark Peterson, Chicago, IL
Administrator
10:00–11:30 am  
Open Abdomen in General Surgery: How Do You Close the Abdomen When You Can’t?  
**MODERATOR:** David V. Feliciano, MD, FACS, Atlanta, GA

1:00–2:30 pm  
Important Issues in the Management of Inguinal Hernias in Infants and Children  
**MODERATOR:** Richard G. Azizkhan, MD, FACS, Cincinnati, OH

3:00–4:30 pm  
Surgical Education: The Effect of the Resident 80-Hour Workweek on the Practicing Surgeon  
**MODERATOR:** Richard E. Welling, MD, FACS, Cincinnati, OH

Tuesday, April 27

8:00–11:30 am  
Spectacular Cases from Residents  
**MODERATORS:** A. Fredrick Schild, MD, FACS, Miami, FL  
Juan C. Paramo, MD, FACS, Miami Beach, FL

8:00–9:30 am  
What's New in Diverticulitis  
**MODERATOR:** Robert D. Fry, MD, FACS, Philadelphia, PA

10:00–11:30 am  
New Techniques in Endocrine Surgery: Is Minimally Invasive Better?  
**MODERATOR:** Christopher R. McHenry, MD, FACS, Cleveland, OH

1:00–5:00 pm  
Surgical Jeopardy  
**MODERATOR:** Mark W. Bowyer, MD, FACS, Burke, VA

1:00–5:00 pm  
Surgical Palliation of Advanced Cancer: What's New? What's Helpful?  
**MODERATOR:** Blake Cady, MD, FACS, Providence, RI

**Postgraduate Courses**

The Spring Meeting offers a wide variety of postgraduate courses from which to choose. This year, we have several skills-oriented courses (SCs) and didactic courses (PGs).

Skills-Oriented  
Breast Imaging for the General Surgeon  
Saturday, April 24, 8:00 am–12:30 pm  
**CHAIR:** Philip Z. Israel, MD, FACS, Marietta, GA

This course is designed to provide the practicing surgeon with increased imaging skills in the analysis of both mammographic and breast sonographic images. Emphasis will be placed on correlating normal breast anatomy to both mammographic and sonographic images. The pathology of breast disease will be highlighted by analyzing sonographic and mammographic images and correlating the pathophysiology presented to the image seen. The course will be presented in an interactive fashion.

Skills-Oriented  
Mastering Surgical and Office-Based Coding  
Saturday, April 24, 8:00–11:30 am and 1:00–4:30 pm  
**CHAIR:** John T. Preskitt, Sr., MD, FACS, Dallas, TX

The objective of this course is to build on the key concepts discussed in the ACS basic coding course. This course will introduce cases using surgical modifiers, followed by hands-on coding scenarios. Evaluation and management scenarios will be introduced, and attendees will code cases identifying the appropriate category of codes and appropriate modifiers in various scenarios. At the conclusion of the advanced coding program, participants will be able to: (1) understand when to apply modifiers to surgical procedures and office encounters; (2) analyze physician profiles and identify profiles that may pose risk to the physician or practice; (3) understand the American Medical Association's definition of the surgical package and Medicare's definition of the global surgical package; and (4) identify the types of explanation of benefits that are important for the physician to review.


Skills-Oriented  
Stereotactic Breast Biopsy  
Sunday, April 25, 8:00 am–12:00 noon (lectures) and 1:00–5:15 pm (workshop)  
**CHAIR:** Richard E. Fine, MD, FACS, Marietta, GA

The objective of this course is to introduce surgeons to the principles and practice of stereotactic biopsy as a minimal-access means of obtaining tissue samples for
diagnosing indeterminate or suspicious mammographic lesions. An overview of radiation safety issues as related to stereotaxis, as well as the technical efficacy and cost-effectiveness of stereotactic biopsy and its alternatives, will be presented.

Skills-Oriented

**Bedside Procedures**

Sunday, April 25, 8:00–11:30 am (lectures) and 1:00–5:30 pm (workshop)

**Chair:** George C. Velmahos, MD, PhD, FACS, Los Angeles, CA

The objective of this workshop is to teach surgeons how to perform three bedside procedures: percutaneous dilational tracheostomy, percutaneous endoscopic gastroscopy, and percutaneous vena caval filter placement. Bedside procedures have been shown to be safe, convenient, teachable, and cost-effective. Reimbursement rates are significant. Surgeons will be called on to perform these procedures with increasing frequency in the near future. Other specialists treating critically ill patients, such as medical intensivists, pulmonologists, cardiologists, and anesthesiologists, will compete with surgeons in this field. Surgeons should be adequately prepared to take an early lead in performing procedures by the bedside.

Skills-Oriented

**Mobile and Wireless Computing: Practical Applications**

Sunday, April 25, 1:00–4:30 pm (lecture)

Monday, April 26, 8:00 am–12:00 noon (workshop)

**Or**

Monday, April 26, 1:00–4:30 pm (workshop)

**Co-Chairs:**

David A. Krusch, MD, FACS, Rochester, NY

Ronald B. Hirschl, MD, FACS, Ann Arbor, MI

The lecture in this postgraduate course will highlight the role of personal digital assistants (PDAs) and the use of interactive information for the surgeon’s daily practice. The workshop session, designed for beginners who have never owned or used a PDA, will feature a hands-on demonstration of the use and function of the devices. A PDA will be provided to participants. Participants are required to attend the lecture session and select one workshop session.

Skills-Oriented

**Breast Ultrasound**

Monday, April 26, 8:00 am–12 noon (lectures) and 1:00–5:00 pm (workshop)

CO-CHAIRS:

Eric B. Whitacre, MD, FACS, Ellicott City, MD

Patrick W. Whitworth, MD, FACS, Nashville, TN

(Prerequisite: Ultrasound for Surgeons: The Basic Course)

The objective of this course is to introduce the practicing general surgeon to a focused module in diagnostic and interventional breast ultrasound. The program will consist of lectures and hands-on skill stations using a variety of ultrasound equipment. Live models and phantom breast moulages will be used to develop skills in breast ultrasound imaging and ultrasound-guided breast biopsy.

Skills-Oriented

**Bariatric Surgery Primer**

Monday, April 26, 8:00 am–12:05 pm (lectures and panel discussion), 1:30–4:40 pm (lectures and panel discussion), and 6:30–8:45 pm (lectureship and dinner)

Tuesday, April 27, 8:00–9:50 am (lectures and interactive presentations) and 10:10 am–5:30 pm (live interactive closed circuit TV presentations and panel discussion)

**Chair:** Henry Buchwald, MD, PhD, FACS, Minneapolis, MN

**Associate Chair:** Sayeed Ikramuddin, MD, Minneapolis, MN

This intense, two-day course will feature didactic presentations, panels, and live, interactive closed-circuit TV sessions to provide a broad overview of bariatric surgery. Participants will be able to describe the epidemiology, etiology, and incidence of morbid obesity and outline the physiologic basis for bariatric surgery. Criteria for identification of appropriate surgical candidates will be outlined, and various bariatric surgical procedures—such as laparoscopic adjustable gastric banding, vertical banded gastroplasty, gastric bypass, and duodenal switch—will be presented. The pre-, intra-, and postoperative care associated with each procedure will be described, along with the pos-

Over 50 companies will display products and services related to the art and science of surgery.

CO-CHAIRS:

Eric B. Whitacre, MD, FACS, Ellicott City, MD

Patrick W. Whitworth, MD, FACS, Nashville, TN

(Prerequisite: Ultrasound for Surgeons: The Basic Course)

The objective of this course is to introduce the practicing general surgeon to a focused module in diagnostic and interventional breast ultrasound. The program will consist of lectures and hands-on skill stations using a variety of ultrasound equipment. Live models and phantom breast moulages will be used to develop skills in breast ultrasound imaging and ultrasound-guided breast biopsy.
sible postoperative complications and their appropriate management and prevention strategies. In addition, principles underlying a multidisciplinary approach to bariatric surgery and the consequences of postbariatric weight loss will be discussed. Six live, interactive, closed-circuit TV operations, primarily featuring laparoscopic techniques, will be performed by world-renowned surgeons. The course will also include presentations regarding insurance, billing, coding, and liability issues related to bariatric surgery, as well as the ethical perspectives on elective surgery for metabolic disease. The special evening presentation by an international expert and dinner are included as part of the course.

**Skills-Oriented**

**Ultrasound in the Acute Setting**  
Tuesday, April 27, 8:00–11:15 am (lectures) and 1:00–5:00 pm (workshop)  
**Chair:** Amy C. Sisley, MD, FACS, Baltimore, MD  
*(Prerequisite: Ultrasound for Surgeons: The Basic Course)*  

The objective of this course is to familiarize the participant with areas of ultrasound frequently used by general surgeons to evaluate patients with acute surgical problems. Participants will learn focused ultrasound examinations through individual hands-on experience and will acquire an understanding of the essentials of ultrasound technology and physics.

**Didactic Course**  
**Minimal Access Surgery**  
Saturday, April 24, 8:00–11:30 am and 1:00–4:30 pm  
**Chair:** Nathaniel J. Soper, MD, FACS, Chicago, IL

The objectives of this course are: (1) to increase participants’ awareness of the current status of minimal access surgery; and (2) to expose participants to new techniques and technologies in minimal access surgery.

**Didactic Course**  
**What’s New in Vascular Surgery: 2004**  
Monday, April 26, 8:00–11:30 am and 1:00–4:30 pm  
**Chair:** Michael Belkin, MD, FACS, Boston, MA

The objective of this course is to review current strategies and recent advances in the management of patients with peripheral vascular disease. The major focus will be on carotid artery occlusive disease, limb salvage procedures and interventions, aortic aneurysmal disease, and venous insufficiency.

**Didactic Course**  
**Charting a Sound Course for Surgical Practices**  
Monday, April 26, 8:00 am–12:00 noon and 1:00–5:00 pm  
**Co-Chairs:** Charles D. Mabry, MD, FACS, Pine Bluff, AR  
Frank G. Opelka, MD, FACS, Boston, MA

The objective of this course is to discuss improvements in the management and efficiency of surgical practice. It will include discussion of business practices and overall components of operations. Instructors will provide insights into solving real-life practice management problems.

**Didactic Course**  
**Abdominal Trauma: Beyond Initial Care**  
Tuesday, April 27, 8:00–11:30 am and 1:00–4:30 pm  
**Chair:** Scott A. Dulchavsky, MD, PhD, FACS, Detroit, MI

This course will provide the surgeon with guidelines in interventions following the initial treatment of the trauma patient. Topics to be covered include timing of repeat operations and critical interventions, methods and challenges of nutritional support, advances in the management of short bowel syndrome, appropriate use of antimicrobial agents, diagnosis and therapeutic options of intraabdominal infection, management of intestinal fistula, evaluation and management of suspected vascular graft infection, and management of the open abdomen.

The Spring Meeting will conclude at 5:00 pm on Tuesday, April 27, 2004.

The American College of Surgeons sponsors this conference to promote advances in surgery and other areas of science. The information presented through the programs and exhibits is not verified or endorsed by the American College of Surgeons. Presenters and exhibitors are solely responsible for content.

Make plans now to attend this important meeting. Information regarding the general sessions, postgraduate courses, and registration information will be mailed to Fellows in February. Registration will be available next month online at www.facs.org.
Registration information

Individuals who pay the registration fee will receive a name badge, access to all general sessions, and one exhibit hall reception ticket. Registered attendees may purchase postgraduate course tickets based on availability. Advance registration is strongly encouraged and is open to all physicians and individuals in the health care field.

Payment of all applicable fees must accompany your registration. Visa, MasterCard, or American Express payment must be submitted at the time of registration. Purchase orders are not accepted. Checks should be made payable to the American College of Surgeons. Your registration will not be processed without the appropriate payment information. You may register by one of the following methods:

Online Register online at www.facs.org.

By fax: Complete the registration form (see pages 41-42) and fax it to 800/682-0252 or 312/202-5003. If you submit your registration by fax, you do not need to mail the original registration form from this program.

By mail: Complete and mail the registration form (see pages 41-42) and check to: American College of Surgeons, Attn: Registration Services, PO Box 92340, Chicago, IL 60675-2340.

The deadline for advance registration is March 22, 2004. Registrations received and postmarked after March 22 will be billed according to the fees indicated on the registration form.

Formal, written confirmation will be mailed to all advance registrants upon successful processing. Before the meeting, each advance registrant will receive an official name badge, attendance verification card, and postgraduate course tickets (if applicable). Postgraduate course syllabi will be distributed on site in Boston.

If you are unable to register in advance, bring the completed registration form with proper credentials and payment information to the on-site registration area of the Boston Marriott Copley Place.

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<td>Commercial representative</td>
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<td>420</td>
</tr>
</tbody>
</table>

*Guest physicians: The ACS will apply $150 of your registration fee toward the Fellowship application fee. An application for Fellowship will be sent to you upon receipt of your registration. Simply complete the application and return it by June 28, 2004, and you will be on your way to becoming a member of the American College of Surgeons, enjoying the many benefits of membership.

†The American College of Surgeons is pleased to offer discounted registration fees for residents and medical students. Please submit a letter verifying your educational status with your completed registration form to expedite processing. Residents should obtain a letter from their program directors, and students should contact their department chairs.
Cancellation: Registration fees will be refunded if a written request is received at the College and postmarked no later than March 22. A $50 handling fee will be retained. **Cancellations received after March 22 will not be eligible for refunds.**

No substitution of one individual for another is allowed.

**Registration location and hours**

All advance and on-site registration activity will occur at the Boston Marriott Copley Place.

- **Saturday, April 24** .......... 7:30 am–5:00 pm
- **Sunday, April 25** .......... 7:30 am–7:00 pm
- **Monday, April 26** .......... 7:30 am–5:00 pm
- **Tuesday, April 27** .......... 7:30 am–1:00 pm

**Visa information**

International Fellows, guest physicians, and meeting attendees: Please be aware that the process of obtaining a visa to attend meetings in the U.S. takes much longer than in the past. You are strongly urged to apply for a visa as early as possible, preferably at least 60 days before the start of the meeting.

You may request a letter welcoming you to the meeting from the College if you feel that this will be helpful by contacting the International Liaison Section by e-mail at: postmaster@facs.org or by fax at: 312/202-5001.

**General session attendance**

The registration fee includes admittance to the general sessions. In order for the College to provide participants with a comfortable meeting environment, please take a moment to indicate which general sessions you plan to attend.

**Postgraduate course fees and cancellation information**

Course tickets may only be purchased by registered meeting attendees. Each course requires a ticket for admission. Tickets may only be exchanged for another course prior to the beginning of your ticketed course. Seating is limited.

Postgraduate course fees will be refunded if a written request is received at the College and postmarked no later than March 22. A $50 handling fee will be retained. Cancellations postmarked after March 22 will not be eligible for refunds. Cancellations made on site will not be eligible for refunds.

The American College of Surgeons reserves the right to cancel any regularly scheduled session before the start of the meeting.

**Technical exhibits**

To enhance the educational value of the meeting, more than 50 companies will display products or services related to the practice of surgery. Your registration includes a reception on Sunday, April 25, 5:00–7:00 pm, in the exhibit hall. Spouses/guests will receive a ticket for the reception if they register under the appropriate registration category. Technical exhibits will be open:

- **Sunday, April 25** .......... 12:00 noon–3:30 pm
- ................................. 5:00–7:00 pm (reception)
- **Monday, April 26** .......... 10:00 am–3:30 pm

**Social Program**

A Social Program will be offered during the Spring Meeting in Boston. A nonrefundable fee is required for participation; the fee entitles you to purchase event tickets, attend scientific sessions, view technical exhibits, and attend the Sunday evening Exhibit Hall Reception. Registered Social Program spouses and guests also will receive a travel tote bag.

This year, we will be offering the following tours: A Cooking Demonstration and Wine Tasting at B&G Oysters; A Jazz Brunch; “Art in Bloom” and Special Exhibit “Gauguin Tahiti” at the Museum of Fine Arts; Colonial Newport; The Mansions Along Bellevue Avenue; A Private Tour of Doris Duke's Home “Rough Point” and a Winery Tour; and a Tour of Private Homes on Beacon Hill.

Because tour capacities are limited, advance registration is strongly encouraged. For further information, please visit the ACS Web site at [www.facs.org](http://www.facs.org).

**Children**

The ACS policy regarding children is as follows:
- Under 12: not permitted on Social Program tours.
- Under 16: not permitted on exhibit floor or in scientific sessions.
- 16 and over: must have a badge to enter exhibit area or meeting rooms.

This policy includes infants in strollers and arms.

**Accreditation**

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

**CME credit**

The American College of Surgeons designates this educational activity for a maximum of 35 Category I credits toward the AMA Physician’s Recognition Award.
Each physician should claim only those hours of credit that he or she actually spent in the educational activity.

**Compact discs**

Selected postgraduate courses, general sessions, and named lectures will be recorded live and will be available for purchase on compact disc. Additional information will be available onsite in Boston at the National Audio Video booth near the registration area.

**Meeting location and accommodations**

In Boston, the host city of this meeting, historic landmarks share the skyline with soaring skyscrapers. Boston is storied for its role in the American revolution, but there is far more to Boston than just Revolutionary history. From museums to pro sports, from fresh seafood to Italian cuisine, Boston has something for everyone. Fenway Park, Faneuil Hall, Quincy Market, Boston Garden, the U.S.S. Constitution, and Paul Revere’s House are just some of the unique places to visit during your stay in this great city.

The meeting venue is the Boston Marriott Copley Place, located just 15 minutes from Logan International Airport and in the heart of Boston’s Back Bay area. All tastefully appointed guest rooms feature individual climate control, two phones, voice mail, computer dataports, hairdryers, and irons/ironing boards. The hotel features an indoor pool, health club with exercise room, whirlpool/saunas, 24-hour room service, four restaurants and lounges, concierge service, and a business center.

Reservations may be made by calling the hotel directly at the numbers listed below. Please indicate that you will be attending the ACS Spring Meeting in order to obtain the special group rates. Reservations can also be made online through the Spring Meeting section of the ACS Web site, www.facs.org.

**Hotel information:**

Boston Marriott Copley Place
110 Huntington Avenue
Boston, MA 02116
Phone: 617/236-5800
ACS Group Rate: $219 single/double

Reservations made after the housing deadline of April 1, or after the room block fills, are subject to space and rate availability. A deposit of one night’s stay is required when making your reservation, payable via check or credit card. The deposit is refundable if your reservation is cancelled by 6:00 pm on the day of arrival. Please also verify your checkout date when checking into the hotel.

**Transportation**

Special meeting saver airfares are available on United and Delta airlines. Choose from the following savings options:

- Receive a 5 percent discount off the lowest applicable domestic published fares.
- Receive a 10 percent discount off the published unrestricted coach fares.
- Obtain a 5 percent additional discount on the above fares if tickets are purchased at least 30 days in advance on United and 60 days in advance on Delta.

Area/zone fares based on geographic location are also available with no Saturday night stay required. Minimum stay two nights, varies by airline; seven-day advance purchase required. (Zone fares are not available through online ticket purchase; please call the numbers below).

These special discounts are available by calling either official airline directly (independently or through a travel agent). Be sure to indicate the name of the meeting to which you will be traveling, and refer to the ACS file numbers to obtain the special fares.

**United Airlines**

800/521-4041
8:00 am–10:00 pm (ET)
ACS File 501CR

**Delta Air Lines**

800/241-6760
8:00 am–11:00 pm (ET)
ACS File 201428A

**Car rental**

Avis is designated as the official car rental company for the 2004 Spring Meeting. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

**Avis Reservations**

800/331-1600
Web site: www.avis.com
AWD number: B169699

In February, you will be able to register online at www.facs.org.
**Scientific Registration Form**

**American College of Surgeons**

32nd Annual Spring Meeting
April 24–27, 2004
Marriott Copley Place
Boston, MA

Deadline for advance registration is March 22, 2004. Payment must accompany registration. Please see page 16 for additional registration information. Avoid additional fees. Register early!

<table>
<thead>
<tr>
<th>Membership ID Number</th>
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<tr>
<td>Fellow of the American College of Surgeons</td>
<td>$195</td>
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<td>ACS Candidate Group</td>
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<td>$25</td>
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<td>Guest Physician–U.S. and International</td>
<td>$370</td>
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<td>(includes Fellowship application fee)</td>
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| Postgraduate Course Fees: Please Indicate Selection(s) Clearly | 101 | SC01 Breast Imaging for the General Surgeon | $250 |
|                                                               | 102 | SC02 Mastering Surgical and Office-Based Coding | $350 |
|                                                               | 103 | SC03 Stereotactic Breast Biopsy | $750 |
|                                                               | 104 | SC04a Mobile and Wireless Computing Lecture Sun PM, Workshop Mon AM | $325 |
|                                                               | 105 | SC04b Mobile and Wireless Computing Lecture Sun PM, Workshop Mon PM | $325 |
|                                                               | 106 | SC05 Bedside Procedures Workshop | $850 |
|                                                               | 107 | SC06 Breast Ultrasound* | $1,000 |
|                                                               | 108 | SC07 Bariatric Surgery Primer | $850 |
|                                                               | 109 | SC08 Ultrasound in the Acute Setting* | $750 |
|                                                               | 201 | PG09 Minimal Access Surgery | $400 |
|                                                               | 203 | PG11 Charting a Sound Course for Surgical Practices | $450 |
|                                                               | 204 | PG12 Abdominal Trauma: Beyond Initial Care | $325 |

Please check course dates and times prior to registering to avoid scheduling conflicts!

* Additional information about prerequisite courses can be found in the postgraduate course section.

Please see page 16 for additional registration information. Avoid additional fees. Register early!

| Registration Fee | $ ______________ |
| Registration Fee | $ ______________ |
| Postgraduate Course Fee | $ ______________ |
| Total Due | $ ______________ |

(form continues on back)
### General Sessions – All sessions included in registration fee.

Please assist us with planning meeting room space by indicating which sessions you plan to attend.

**Saturday, April 24**
- 1:00–5:00 pm G501 Welcome and Assembly for General Surgeons
  - Facing the Inevitable: Surgical Quality and Outcomes Made Public

**Sunday, April 25**
- 8:00–9:30 am G502 Vascular Access
- 9:45–11:15 am G504 Genetics and Cancer: Implications for Surgeons
- 11:15 am–12:15 pm G505 Excelsior Lecture: Optimizing Results in Pancreatic Surgery
- 1:00–2:30 pm G506 Surgery of the Carotid Artery: Current Status
- 1:00–2:30 pm G507 Practical Aspects for Management of Solid Organ Injuries
- 3:00–4:30 pm G508 Endolaparoscopic Approaches to Esophageal Disease
- 3:00–4:30 pm G509 Training: Who Is Your Next Partner and How Are They Trained?
- 7:00–9:00 pm G510 Highlights from the 2003 Clinical Congress
  - Video-based Education Sessions in Chicago, IL

**Monday, April 26**
- 8:00–9:30 am G511 Update on Surgical Oncology for General Surgeons
- 10:00–11:30 am G512 Open Abdomen in General Surgery: How Do You Close The Abdomen When You Can’t?
- 1:00–2:30 pm G513 Important Issues in Management of Inguinal Hernias in Infants and Children
- 3:00–4:30 pm G514 Surgical Education: The Effect of the Resident 80-Hour Workweek on the Practicing Surgeon

**Tuesday, April 27**
- 8:00–11:30 am G515 Spectacular Cases from Residents
- 8:00–9:30 am G516 What’s New in Diverticulitis
- 10:00–11:30 am G517 New Techniques in Endocrine Surgery: Is Minimally Invasive Better?
- 1:00–5:00 pm G518 Surgical Jeopardy
- 1:00–5:00 pm G519 Surgical Palliation of Advanced Cancer: What’s New, What’s Helpful

### Surgical Specialty
(Please Indicate)
- General Surgery
- Thoracic Surgery
- Colon and Rectal Surgery
- Gynecology and Obstetrics
- Neurological Surgery
- Ophthalmic Surgery
- Orthopaedic Surgery
- Otolaryngology
- Pediatric Surgery
- Plastic Surgery
- Urological Surgery
- Vascular Surgery
- Other:

### Cancellation Policy
Registration fees will be refunded if a written request is received at the College and postmarked no later than March 22, 2004. A $50.00 handling fee will be retained. Registrations postmarked after March 22, 2004, will not be eligible for refunds.

### Payment Information
Payment must accompany your registration. Make checks payable in U.S. funds to: American College of Surgeons
- Check (enclosed)
- If paying by credit card, please complete and ensure legibility.

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Signature

### Americans with Disabilities Act
- Check here if special services are required due to a disability.

Please specify ________________

An ACS staff person will contact you.
Please provide a daytime phone number or e-mail address:

Phone (_______) __________________

E-mail _________________________
Nominations sought for the Board of Regents

The 2004 Nominating Committee of the Board of Governors has the task of selecting nominees for seats on the Board of Regents that will need to be filled during the 2004 Clinical Congress. The following suggested guidelines are used by the Nominating Committee when reviewing the names of potential nominees for election to the Board of Regents.

• Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.
• Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.
• Recognition of the importance of their representing all who practice surgery.
• Also to be taken into consideration are geography, surgical specialty balance, and academic or community practice.
• The College encourages consideration of women and other underrepresented minorities.

Nominations sought for the Board of Regents

• Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the Board of Regents.
• The surgical specialty that should be given priority consideration is ophthalmic surgery.

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Please submit nominations to memberservices@facs.org. The deadline for submitting nominations is February 27, 2004.

Nominations sought for ACS Surgical Volunteerism Award

A recent survey by the ACS Board of Governors’ Committee on Socioeconomic Issues, conducted by the Institute for Health Policy of the Massachusetts General Hospital, Boston, MA, determined that approximately 30 percent of American and Canadian surgeons actively participate in more than 250 different volunteer domestic and international organizations. The American College of Surgeons is seeking to identify and formally recognize those individual surgeons and volunteer programs.

Last year, the College honored two surgeons with the inaugural Surgical Volunteerism Award. Lowell B. Furman, MD, FACS, received the award for his 20 years of domestic volunteer medical services in the Eastern Shore region of Virginia. The inaugural award plaques presented by ACS President Claude H. Organ Jr., MD, FACS, read, “In recognition of those surgeons committed to giving something of themselves back to society by making significant contributions to surgical care through organized volunteer activities.”

The Committee on Socioeconomic Issues is seeking nominations for this year’s award. We are looking for individuals or organizations making a significant contribution to surgical care through volunteer actions. Candidates for this award may practice their surgical volunteerism either in a domestic, international, or military setting. All surgical subspecialties are eligible for consideration.

Nominations should be limited to 500 words, briefly describing the nature of the surgical activity, location, scope and number of patients served, status of the volunteer surgeons (active, retired, military active duty or reservist), frequency of service, funding sources, and relation to the ACS, other professional organizations, or charitable institutions.

Please consider an estimate of the impact of the program upon patients, continuing care, the area served and local medical providers.

Nominations must be received by February 27, 2004. Please send nominations to Robert V. Stephens, MD, FACS, Chair, B/G Committee on Socioeconomic Issues, 370 E. Virginia, Phoenix, AZ 85004; fax: 602/241-1201, e-mail: physsurg@aol.com.
Claims coding reference and education database

ACS CodingToday features:

- Complete CPT, HCPCS Level II, and ICD-9 codes.

- Current Medicare Correct Coding Initiative bundling edits, national and local fee schedules, and Medicare policy information.

- Medicare information on global fee days and modifier usage.

- Automatic calculation of fees by geographic locality.

- Full text: Local Medical Review Policies, fall 2003.

The only coding database that contains ACS billing and coding tips!

Special discount pricing: Only $199 for the first user, $50 for each additional user—a $590 value!
College announces new logo for Fellows

Over the years, the American College of Surgeons has had many requests from Fellows who would like to use the ACS seal on their letterhead, business cards, Web sites, and even office walls. The College has had to deny those requests because the seal is a registered trademark and, as such, can be used only on official materials produced by the College itself.

In an effort to be responsive to its members’ requests for a symbol they might use for individual business purposes, the College has developed a special mark for its Fellows. The new “slogan logo” underscores the fact that ACS members are “committed to excellence” and is now available online. Only Fellows of the American College of Surgeons may use this symbol, and they must abide by the guidelines that have been developed to govern its use. To access the guidelines and an electronic copy of the logo, visit http://www.facs.org/members/sloganlogo/disclaimer.html.

Young surgical investigators conference to be held in March

Registration is now open for the Young Surgical Investigators (YSI) Conference, March 5-7, 2004, at the Lansdowne Resort Conference Center in Leesburg, VA. Sponsored by the College’s Surgical Research Committee, this conference is designed to introduce young surgeon-scientists to the process of obtaining extramural, peer-reviewed grant support. YSI includes intensive exposure to National Institutes of Health (NIH) programs and policies, grant-writing strategies, mock study section review of model grants, information from the NIH institutes, and workshops on hypothesis testing, methodology, background and significance, and renewals.

Additional information and a registration form are available at http://www.facs.org/oeps/src/youngsurg.html. Further information may be obtained by contacting Mary Fitzgerald via e-mail at mfitzgerald@facs.org, or by calling 312/202-5319.
John R. Benfield, MD, FACS, a thoracic surgeon at the University of California, Los Angeles and Davis, was elected president of the Thoracic Surgery Foundation for Research and Education (TSFRE). In the past, Dr. Benfield has served as president of the Western Thoracic Surgical Association, the Thoracic Surgery Directors Association, and the Society of Thoracic Surgeons. TSFRE supports research and education initiatives to increase knowledge and enhance treatment of patients with cardiothoracic diseases and to develop the skills of cardiothoracic surgeons, surgeon scientists, and health policy leaders.

The Mexican Board of Surgery elected Jorge Cervantes, MD, FACS, to serve as its vice-president and president-elect. Dr. Cervantes is a former ACS Governor and Past-President of the Mexico Chapter. He is a general surgeon on staff at the American British Cowdray Hospital, Mexico City, Mexico.

The American Spinal Injury Association has honored Jerome M. Cotler, MD, FACS, with the organization’s Lifetime Achievement Award. He also recently received the Alumni Award from Ursinus College, Collegeville, PA. Dr. Cotler is the Everett J. and Marian Gordon Professor of Orthopaedic Surgery at Thomas Jefferson University's Jefferson Medical College, Philadelphia, PA, where he continues to teach in the department of anatomy.

Vascular surgeon Paul J. DiMuzio, MD, FACS, assistant professor of surgery and radiology, Jefferson Medical College, was named the 2003 Wylie Scholar in Academic Vascular Surgery for his research into innovative treatments for cardiovascular disease. The Wylie Scholarship is awarded by the Pacific Vascular Research Foundation to surgeon scientists who are pursuing independent research projects, which could lead to improved treatment or cures for vascular disease. Each honoree receives a $150,000 multi-year grant.

Michael S. Goldrich, MD, FACS, was elected chairman of the American Medical Association’s Council on Ethical and Judicial Affairs. The council handles judicial review of cases of physicians who have allegedly violated the code of medical ethics. Dr. Goldrich is an otolaryngologist in New Brunswick, NJ, and is the director of the Voice Center of New Jersey.

The University of Minnesota, Rochester, has established a new scholarship honoring H. Bryan Neel III, MD, PhD, FACS. The endowed scholarship was announced at a special reception marking his retirement from the University of Minnesota Board of Regents after serving two consecutive six-year terms. The scholarship will be awarded exclusively to university students. Dr. Neel is a professor of otolaryngology at the Mayo Medical Center, is a Past-Treasurer of the College, and has served on the Board of Governors.

The new director of the UConn Cancer Center at the University of Connecticut Health Center, Farmington, is Carolyn D. Runowicz, MD, FACS, a gynecologic oncologist. Dr. Runowicz also serves as director of women’s health services at the center.

India’s President, A.P.J. Abdul Kalam, has appointed Devendra S. Saksena, MBBS, FACS, to the honorary rank of surgeon commodore in the armed forces medical services. Dr. Saksena is a thoracic surgeon.

The Ohio State Medical Association elected William C. Sternfeld, MD, FACS, to serve as the organization’s president this year. Dr. Sternfeld is a general surgeon on staff at several hospitals in the Toledo area. He is a former Governor of the College and served on the Board of Governors’ Committee to Study the Fiscal Affairs of the College.
The American College of Surgeons and the National Ultrasound Faculty have developed “Ultrasound for Surgeons: The Basic Course” for surgeons and surgical residents on CD-ROM.

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

- Replaces the basic course offered by the American College of Surgeons.*
- A printable CME certificate is available upon successful completion.
- CD will install the necessary software (PC or Mac).
- The learner is offered two attempts to pass a multiple-choice exam with a minimum score of 80% at the completion of the program.
- Residents must submit a letter from their director/chair to document residency status.
- Only one user per CD is allowed. Online access is needed to register the CD and to take the exam.
- $300 for nonmembers
- $225 for Fellows of the College
- $125 for residents with letter proving status
- $90 for Candidate and Associate Society members
  (Additional $16 for shipping and handling of international orders)

The CD can be purchased online at www.facs.org or by calling Customer Service at 312/202-5474.

For additional information, contact Dawn Pagels, tel. 312/202-5185, e-mail dpagels@facs.org

*The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this educational activity for a maximum of 4 Category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity. The American Medical Association has determined that physicians not licensed in the U.S. who participate in this CME activity are also eligible for AMA PRA Category 1 credit.
NTDB™ data points

Same cover, but new version 3.0

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

The third annual report of the National Trauma Data Bank™ (NTDB™) is an updated analysis of the largest aggregation of trauma registry data ever assembled. The NTDB currently contains 731,824 records from 268 trauma centers in 36 states, territories, and the District of Columbia. This represents an increase of 301,267 records from the 2002 report.

The significant increase in trauma records has made this the first year that the NTDB has achieved its long-term goal of focusing the report on a sliding five-year time frame. The analyses in this report are based on data from 1997 to 2002, totaling 548,735 records. This allows subsequent data analyses and trauma center benchmarking to remain contemporary as opposed to using data that may be skewed by changes in practice patterns, management methods, or environment.

Along with the current year of the report on the cover there is also a version number. Researchers requesting data and publishing studies will be able to refer to the version number which will directly relate to the data set that the study was based upon.

Another new direction that we have taken this year is that this report marks the beginning of our transition to the use of the external cause of injury codes. The usual tables based on E-code ranges used in previous reports are also included. The previous E-code system was based on groupings that were clinically relevant and predictive of the care and resources patients need. Both E-code systems can be found in the appendix to this report. Stay tuned as the NTDB Annual Report 2004 will be based exclusively on the CDC’s external cause of injury codes.

Throughout the year we will be highlighting these data through brief monthly reports in the Bulletin. For a complete copy of the NTDB Bank Annual Report 2003, visit us on the Web 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.
The American College of Surgeons' Division of Education is pleased to make available the content of 15 postgraduate courses on a CD-ROM, Syllabi Select 2003. This CD-ROM is able to run in the PC and Mac environments and offers you the ability to word-search throughout the CD, along with the convenience of accessing any of the courses when you want, and where you want.

These syllabi can be purchased by calling 312/202-5474 or through the College's Web site at http://secure.telusys.net/commerce/current.html.

The 2003 Syllabi Select CD-ROM is priced at $79. There is an additional $16 shipping and handling charge for international orders.
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

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.

Accepted abstracts* will be presented at:

American College of Surgeons
Clinical Congress
October 10-14, 2004
New Orleans, LA

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.

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.

FACS(Hon)

I want to commend the ACS on its electing Dr. Catherine Hamlin to Honorary Fellowship in the American College of Surgeons. From my 33 years of work in the “developing world,” I know very well the problems she faced in developing a new surgical procedure under what must have been difficult circumstances. (When I did my first operation in India, a pulmonary lobectomy, my anesthetist was an orthopaedic surgeon, and the electricity went off for three hours, and we had no generator.) Again, congratulations to the ACS for an outstanding choice.

Forrest C. Eggleston, MD, FACS

Dr. Russell, I want to thank you so much for all you did during the Clinical Congress in Chicago, IL, to help me and to arrange for me to receive this great recognition from your College.

This time in America will be stamped on my memory forever! I have never received such kindness and wonderful hospitality. Please give my thanks to all in your office who were so kind to me. I have such happy memories of my days in Chicago! And meeting my old friends and making new ones added to the pleasure I experienced there.

The (Convocation) ceremony on Sunday evening was just so wonderful. I shall never forget the reception I was given and know it will do good for the sad, sweet patients we treat. I shall have lots to tell our staff when I get back. Now I am on my way to Australia and am greatly looking forward to the trip.

Thank you again for all you have done for me. With warmest greetings,

Catherine Hamlin, MB, FACS(Hon), DRCOG

Crisis in health care

Dr. Russell, I am a (relatively) young pediatric surgeon in an academic practice in Southern California. I have tremendous respect for you and always look forward to the Bulletin in order to read your monthly editorials.

I have to say that I am somewhat confused by the October and November 2003 editorials. In October, you admirably paid significant attention to the “Proposal of the Physicians Workgroup for Single Payor National Health Insurance.” In your commentary, you noted that “tremendous administrative costs and competition between plans that have a for-profit mentality have resulted in an arcane and costly system, which diverts money from patient care and breeds the corporate mindset that has become pervasive in the medical profession.” I could not agree more. But a few lines later you stated that you “do not believe that the crisis in health care has reached a threshold that would command such a startling transformation.”

In your November editorial, you lamented the “transformation of American surgery from a profession to a business.” But sadly you seem resigned to it. The same issue of the Bulletin reports the number of U.S. uninsured has risen to 43.6 million. The number of underinsured is unknown.

What more do we have to wait for before we push for this “startling transformation” in our health care system? As a pediatric surgeon, I witness on a weekly basis the sacrifice of children, our weakest and most fragile patients, on the altar of corporate medicine. It comes in the form of denied services, referral to nonpediatric surgeons to cut costs, inadequate care to “patch” the problem, control of patient choice of physician, to name but a few evils. I am happy when I have a publicly insured patient, because I know I can give them appropriate care without limitation or micromanagement.

Just yesterday, I saw a 17-year-old girl with a thyroid mass the size of a lemon. For an entire year, the only care (if you can call it that) she could get was from sporadic ER visits. She finally had to be admitted emergently for an appropriate work-up. Unfortunately, this story is not an anecdote. I see it repeated weekly in many different forms. The crisis in our health care system may be below the threshold only because we keep elevating the threshold.

Our great country is crying out for leadership in health care crisis, leadership with a vision, leadership that can bring the facts to life and allay the unfounded fears. How great it would be if the American College of Surgeons, one of the greatest medical organizations of all time, provided that vision and that leadership. Instead, we are choosing to toe the line and follow the crowd. How so very sad!

Sherif Emil, MD, CM, FACS

Regarding Dr. Russell’s comments in the November 2003 issue of the Bulletin—it is unfortunate that the practice of surgery today is as much a business as it is a science and an art. Lamentable indeed, but there are still some knotty professional issues to be addressed, not the least of which is the reluctance of the surgeon community to look into the matter of major surgeries being performed by surgeons with limited experience with particular procedures, such as esophagectomy and pancreatectomy.

Irving Rudman MD, FACS

I read with pleasure the articles each month in the Bulletin, and they serve as a guiding light to me.
I am a rural surgeon, by choice, in Wisconsin, and feel connected to academia each time I read your articles.

Regarding “a lot of finger pointing”... why can’t we as physician/scientists publish data in the form of the scientific method, to prove our hypothesis that capitalization works? Here in Wisconsin, they have a “PCF”—a “patient’s compensation fund,” which is basically a slush fund (each MD contributes on average $8,000 per year to the fund. The governor recently tried to raid the fund of $2 million and was stopped by a grassroots push from physicians (and the Wisconsin Medical Society) that allows insurance companies to offer lower premiums due to less risk. When a claim comes in above the physician’s coverage, the slush fund kicks in and the insurance company has limited indemnity. So far, all that is cited is anecdotal evidence—that is, MICRA from California. Like any problem we choose to solve in medicine, we apply the standard of the scientific method. We also are held accountable for our actions and outcomes. We need to influence the Senate to make political choices that have some sort of science to back up their decisions, and we need to focus on the results of their choices and outcomes.

We have 50 beautiful states that can become 50 political science/geopolitical labs, and social issues can be tested in a few states, like California, and if a hypothesis is created, and works, it can then be applied regionally, then nationally. No amount of political influence or money can dispute the results of the study; and we can take this information to the public and show them the results of their elected officials’ actions on big issues. This is the political tool we need to take toward getting the Senate to pass national capitation laws. The House has passed reforms, so we must take aim at the Senators—there are only 50. We can handle that.

I feel proud to fight for our profession. We enter the profession for altruistic reasons, then we are confronted with the political reality, we are forced to think financially and legally, not medically like we’ve been trained, and now, after all these long years of pain and suffering to obtain this beautiful body of medical knowledge, we can’t relax. We now have to confront the business and political world. Those of us true to the profession will suffer whatever it takes to maintain the dignity this profession deserves.

I am 37 and have no regrets. I love what I do and am ready to fight for the rights of the profession of medicine. This recent attack by politicians and lawyers is nothing more than a modern version of a medieval battle, with full body armor and swords, and is white collar warfare. We deserve the fruits of our labor, not the lawyers, administrators, or insurance executives.

Once this malpractice crisis is tackled, we then need to focus on why insurance premiums are so high. The average middle-class family pays $8,000 to $15,000 per year, causing anger from society that is directed toward physicians. Yes, we need to take control of the situation, and I am glad we have people—like Dr. Thomas R. Russell—who have the knowledge, commitment, care, and concern to protect this wonderful profession.

Darrin Antonelli, MD, FACS

Training future surgeons

I read in the November 2003 Bulletin about the travails of the Second FSSB, a MASH-type unit in the Iraq desert. The travels from the U.S. did not permit much sleep except in layovers, but I saw in the article that they worked for 72 hours without a let-up. The author wrote about being drained physically by this frenzy.

What on earth would prepare the doctors for such intensive work? Certainly not the training they are getting under the new set of rules by the ACGME! How can physicians train for the care of their own critical patients, when they give up their care to an associate who will cover for them? I believe this to be more deleterious than continuing care by an interested surgeon.

As a surgeon who was trained under old methods, who worked on average every other night, in addition to daily work, I must confess that at Bellevue Hospital I never lacked adequate rest. I never hallucinated or had any difficulty thinking. Certainly, the work tired me, but I slept in the hospital, which took care of all other necessities. In addition, compared with present day house staff, all the lab work (blood counts, urinalyses, and histories and physicals) had to be on the chart by 8:00 am for rounds. There was no dictation, and no lab techs to do the work.

I always remember the story of an Egyptian heart surgeon, a British resident, who came back to Egypt to repay something to his native land. He scheduled three heart patients for surgery, which he intended to be gratis. He began at 8:00 am. The first patient died. The next two did very well. He finished at 3:00 pm the next day. So much for fatigue. He could not have been very confused.

John S. Hooley, MD, FACS

I enjoyed reading Dr. Russell’s column in the September issue of the Bulletin. I agree wholeheartedly with the need to formulate an entirely new and practical curriculum, not only for surgeons but for all physicians starting in medical school.

It’s incredible to me that very few medical schools include nutri-
tion in their curriculum. They also fail to include courses about comprehensive medicine, which is the new paradigm in the treatment of many diseases. Lastly, if the future surgeons hope to survive, they should be taught about the business of medicine.

Unless the medical schools and the chiefs of the postgraduate programs get in touch with the real problems facing physicians, the caliber of the future physicians and surgeons will progressively deteriorate. This trend will only exacerbate the existing crises in health care.

Herve M. Byron, MD, FACS

I read Dr. Russell’s “From my perspective” column in the September 2003 Bulletin on the surgeon’s future. I must say that the problem he touches on is global. In Scandinavia, and in Europe in general, the problem is the same. Declining interest for surgery, the social background of the young has changed markedly and the loyalty to the profession is almost gone.

Half of the medical students today are female, with a quite different social attitude toward life, family responsibility, child bearing, and so forth. Surgeons in particular (similar to pilots) suffer from insufficient time for training in practice. Who knows if “simulators” will compensate for that? Rules and regulations restrict surgical training. There is no continuity in health care, doctors have become “shift workers,” and no one seems to care.

One of the young surgeons told me, “All these formalities and requirements for education, courses, maintenance of certification, CME, and so forth—it is very easy to attend the courses and obtain the CME points, and so forth, but how does one be a good surgeon?”

To be the devil’s advocate, I think that this trend will continue and get worse still with passage of time. What we need is a change of attitude within the profession! But how to do that?

Leif Hultén, MD, PhD, FACS

As a retired and senior Fellow of the College, I’d like to indicate my support for ideas presented in Dr. Russell’s “From my perspective” column in the September 2003 Bulletin.

May I recall to you the earlier process used by the College of requiring endorsement of candidates (as I remember, those whose training consisted largely of working and scrubbing with a preceptor) by a designee of the College who was assigned to scrub in with the candidate to personally testify to the candidate’s surgical skills. This process may need resurrection. Physical examination of Fellows may require help of our colleagues in other fields—psychiatry, neurology, ophthalmology, cardiology, and oncology, at least for starters. Also, when should such exams begin and how often should they be repeated?

Although I won’t see such changes in my lifetime, I’m thrilled that the leaders of my profession are thinking about it.

Robert G. Walkowiak, MD, FACS

I am writing in regard to two articles about rural surgery by Drs. Hunter, Deveney, and Vangelisti that appeared in the May 2003 Bulletin. I read these two brief articles with interest and with a feeling of sadness as I now look back on my own training. After 29 years in the practice of surgical oncology, I contemplate the sad point that we have reached in a once very proud profession of surgery and the even prouder profession of training surgeons.

Over the past 36 years since I began my internship in surgery, I have been informed repeatedly about the decisions that some distant body, such as the ACGME, has made in deciding that surgical residents do not need to know about orthopaedics, gynecology, urology, otolaryngology, and so forth. Now these articles document the foolishness of those decisions.

As the authors point out, apparently someone who spends five years learning how to do laparoscopic everything has trouble taking care of all those things that general surgery residents learned how to do in the 1960s.

Considering how young Drs. Hunter and Deveney appear from their photographs, it is certainly no surprise to me that they are unaware of the broad scope of surgery and of surgical training in the past. I applaud their efforts, even though I find it sad that they feel that a really broad base of surgical education should only be directed to a resident who might plan to practice in a small community where serious medical problems come along “every now and then.”

Peter D. de Ipolyi, MD, FACS
Residency programs are being recruited to participate in a train-the-trainer project for “End-of-Life/Palliative Care,” now a requirement for postgraduate training in general surgery. Coordinated by David E. Weissman, MD, director of palliative care, Medical College of Wisconsin, and a faculty of national leaders in palliative care education, the project has involved more than 30 surgery programs since 2001.

Residency programs will assess: (1) their current educational programs in end-of-life care; and (2) the discipline-specific knowledge and self-confidence of residents and faculty via a validated survey instrument. A team from each residency program will attend a two-day workshop learning how to incorporate end-of-life/palliative care into their existing curriculum and will attend a one-day follow-up conference in six to eight months. Each program will have the opportunity to publish an abstract detailing its progress in the *Journal of Palliative Medicine*.

Twenty-five additional residency programs are being recruited for the 2003-2004 academic year on a first-come, first-served basis.

For more information, contact Rose Hackbarth via e-mail at rhackbar@mcw.edu, or via phone at 414/805-4607.

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**National residency end-of-life care training project recruiting participants**

**Next month in JACS**

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

**Original Scientific Articles**
- Testicular Pain after Hernia Repair
- Preoperative MRI Evaluation of Breast Cancer
- Management of Laparoscopic Cholecystectomy Injuries
- Withholding CPR for Trauma

**What’s New in Surgery**
- Burns and Metabolism