The ACS Resident and Associate Society: Meeting the needs of today's young surgeons
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About the cover...
Surgical residents, young surgeons, and the newly renamed organization within the College that serves their specific needs, the Resident and Associate Society of the ACS (RAS-ACS), are the focus of this month’s special issue of the Bulletin. On page 3, ACS Executive Director Thomas R. Russell, MD, FACS, offers his view on the relevance of the RAS-ACS, and other articles point to the current and future activities of this group.

Cover photos courtesy of Drs. Rebecca Rose (far left on the cover), Melinna Kibbe (third from left), and Mallory Williams (second from right); photos of University of Iowa Hospitals residents and fellows courtesy of Ravi N. Samy, MD.
Dr. Buncke receives Jacobson Award

New ACS Affiliate membership category established

Contributions sought for 2005 Residents Trauma Papers Competition

2004 Japanese exchange traveler announced

Nominations sought for resident teaching award

ACS Traveling Fellowship to Germany available

College receives education research grant

NIH offers research fellowship in vascular surgery

ACS ultrasound courses go international

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ACS comments on anti-referral legislation

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From my perspective

As you may recall, the cover story and my column in the April issue of the Bulletin focused on the proclamation from Claude H. Organ, Jr., MD, FACS, ACS President, that his term would be “the year of the resident.” There are few messages we can send from the College that are more important than one that underscores the importance of young surgeons in training to the future of this organization and, indeed, our profession.

To reinforce that message, we have dedicated this special issue of the Bulletin to issues of importance to surgical residents and to the work and activities of the group that has been created for them within the structure of the College. That group, which has been known as the Candidate and Associate Society, was established several years ago to benefit surgeons of the future through involvement in activities of the College. At their meeting in June, the Regents of the College approved a motion to change the official name to the Resident and Associate Society of the American College of Surgeons (RAS-ACS) to better reflect a more visible stature for the group and to provide a solid mechanism through which they can raise their concerns and have them addressed. I believe that these actions send a resounding message that the College’s leadership is dedicated to meeting the needs of residents and young surgeons.

Purpose and functions

The RAS is dedicated to identifying the goals and needs of today’s residents and young surgeons in all surgical specialties. Our objective in further enhancing this society is to reach out to and affect 100 percent of the residents in training and the Associate Fellows who are just entering practice and who are striving to become vocal and influential members of the College.

One might ask why the College didn’t have an organization devoted specifically to residents and young surgeons in the past. That is a good question, and it is probably best answered by saying that such a group didn’t seem particularly necessary until recent years. However, no forum could be more relevant today. Clearly, residents have burning issues that must be addressed. Moreover, we all recognize that we must bring them into this organization and keep them in it if we care at all about the future of the American College of Surgeons.

Practicing surgeons look to the College to protect their political and financial interests and to provide them with opportunities for continuing education, professional development, lifelong learning, and fulfillment of the requirements for maintenance of certification. We now must acknowledge that as residents face more regulations, new requirements for achieving board certification, and increased debt and lower reimbursement, they need to be part of an organization that understands and responds to their distinct needs. I believe that the RAS provides a unique forum through which their issues can be effectively addressed.

Areas for development

One of the primary goals of the RAS is to open up opportunities for residents and Associate Fellows to serve on College committees and to have a say in the decision-making process, particularly with respect to educational and advocacy pro-

The RAS-ACS provides residents and Associate Fellows with a forum in which to meet and discuss their concerns and to have a real voice within the College.
grams. By providing these young surgeons with seats on more committees of the College, we will be taking a positive step toward helping them attain the leadership skills and insights necessary to become influential forces not only within this organization but within their hospitals and training institutions, and within their state and federal governments as well.

Additionally, because the art and science of surgery continue to be inculcated with a bottom-line, business-oriented mentality, we need to ensure that surgeons understand the complexities of coding, reimbursement, and so on. Training programs in the past offered little guidance in these skills because they didn’t need to; today, the 80-hour workweek regulations prevent current programs from having time to devote to these important topics. Thus, with the cooperation of the RAS, the College will be developing programs to introduce residents in a formal, didactic way to practice management, coding, debt management, fiscal responsibility, and retirement planning.

We will also be offering programs that will introduce residents to the six core competencies identified by the American Board of Medical Specialties—patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Surgeons now must prove their proficiency in these areas in order to attain and maintain board certification.

Questions about whether the time that residents spend in the hospital is used effectively and whether they are employees or students have been raised for decades. However, the work-hour restrictions have heightened the intensity and urgency of these debates. It is quite clear that residents’ hours in the hospital will need to be put to good use. Hence, the College, training programs, and other entities will need to create a competency-based curriculum that will begin in PGY-1 with an introduction to the fundamentals of surgery and proceed in teaching advanced operative techniques through the use of simulators and other new technology throughout the remaining residency years. We also must help residents to work as responsible leaders of teams of health care professionals who will be involved in patient care.

To bring this broad educational experience to residents and their training programs, the RAS and the College are working on new communication tools that will make better use of electronic methods of information dissemination, including the development of a Web portal for our members. This new technology will allow us to customize information that residents will need and to “push” it to them in an extremely timely and effective way.

Finally, we will continue to expand our job bank, which already is becoming more robust. This service allows young surgeons to seek employment in whatever field interests them, from academic surgery to rural practice, and allows their older colleagues to post available job opportunities.

**Spread the word**

Surgical residents are our future. Through the efforts of the RAS, the College is well positioned to assist young people as they blaze the trail for tomorrow’s patient care. The RAS is developing programs that are sure to ignite greater interest in this organization and in this profession. It provides residents and Associate Fellows with a forum in which to meet and discuss their concerns and to have a real voice within the College. To deny them this sort of presence and visibility would be a serious error.

Every program director in every surgical specialty needs to be aware of the commitment the American College of Surgeons has made to enhancing the educational and professional status of surgical residents in this country. It is only through this commitment that we can truly fulfill our goals.

Thomas R. Russell, MD, FACS

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*If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.*
ACS Career Opportunities
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The College, together with the American Medical Association and other coalition partners, continues to educate Congress about the need to avoid the negative Medicare physician payment updates that are projected to occur between 2006 and 2012. As part of this campaign, the College organized a coalition effort that resulted in 242 representatives and 73 senators signing a letter to Centers for Medicare & Medicaid Services (CMS) Administrator Mark McClellan, MD, PhD, requesting a more accurate calculation of the Medicare physician reimbursement formula. The letters, championed by Sens. Jon Kyl (R-AZ) and Blanche L. Lincoln (D-AR), and by Reps. Philip M. Crane (R-IL) and Sherrod Brown (D-OH), address such issues as added program expenditures resulting from CMS coverage decisions and the need to remove the costs of physician-administered drugs from the payment formula. To view copies of the letters, please go to http://www.facs.org/ahp/views/sgr.html.

Department of Health and Human Services (HHS) Secretary Tommy Thompson recently announced the availability of $498 million in state grants “to strengthen the ability of hospitals and other health care facilities to respond to bioterrorism attacks, infectious diseases, and natural disasters that may cause mass casualties.”

The fiscal year (FY) 2004 National Bioterrorism Hospital Program Continuation Guidance Document (http://www.hrsa.gov/grants/preview/guidancedot/hrsa04biot.htm) provides instructions on how to apply for those funds. One of the top priorities in the document is “Regional Surge Capacity for the Care of Adult and Pediatric Victims of Terrorism and Other Public Health Emergencies.” The requirements include a number of “critical” benchmarks, including trauma and burn care. Another critical benchmark identifies the need for surge capacity and calls for awardees to establish a system that “allows the triage, treatment, and initial stabilization of 500 adult and pediatric patients per 1 million population.”

Passed soon after the attacks of September 11, 2001, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188) includes language that allows these appropriated funds to be used “to develop and implement the trauma care and burn center care components of the State plans for the provision of emergency medical services.” Previously identified as an “optional” benchmark, trauma and burn care are now classified as Critical Benchmark #2-9 to “enhance statewide trauma and burn care capacity to be able to respond to a mass casualty incident.”

To date, HHS has invested more than $3.7 billion in aid to states with bioterrorism and disaster preparedness. For more information and a list of each state’s FY 2004 award, go to http://www.hhs.gov/news/press/2004pres/20040524.html.

In related news, a recent report by the National Foundation for Trauma Care indicates that the nation’s trauma centers received little of the roughly $1 billion in federal funding authorized for state bioterrorism preparedness in 2003. The report says only four states have given those funds directly to trauma centers and that most amounts were “meager.” It adds that the nation’s trauma centers are in finan-
cial crisis and that up to 20 percent, or 120 of the facilities, could close within three years “without corrective action.” The report can be found at http://www.traumacare.com/NFTC_CrisisReport_May04.pdf.

A. Brent Eastman, MD, FACS, a trauma surgeon from San Diego, CA, who is a former chair of the College's Committee on Trauma and a current member of the Board of Regents, and Mary Fallat, MD, FACS, a pediatric surgeon from Louisville, KY, have been appointed to the expanded Institute of Medicine (IOM) study on the “Future of Emergency Care in the U.S. Health System.” Dr. Eastman will serve on the full committee, and Dr. Fallat will be a member of the Pediatric Emergency Care Subcommittee. C. William Schwab, MD, FACS, from the University of Pennsylvania Medical Center, was appointed to the full committee earlier this year.

This study will: (1) examine the emergency care system in the U.S.; (2) explore its strengths, limitations, and future challenges; (3) describe a desired vision of the emergency care system; and (4) recommend strategies to help achieve that vision. The committee requested the College's insights and is expected to release its results within the next two years. For more information, visit http://www.iom.edu/project.asp?id=20313.

HHS Secretary Thompson announced he is forming an internal task force to speed the availability of new medical technologies, such as drugs, biological products, and medical devices. The task force will include representation from the Centers for Disease Control and Prevention, CMS, the Food and Drug Administration, and the National Institutes of Health.

The group is seeking public comments (due by August 23, 2004) on how to stimulate innovation in medical technologies. A notice explaining the comment period was published in the May 24 Federal Register and may be accessed by going to: http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/04-11612.htm.

Medical liability reform continues to be a major focus of the state legislatures. Advocates for reform were disappointed when Iowa Gov. Tom Vilsack (D) vetoed legislation to cap noneconomic damages at $250,000. The same was true for advocates in Missouri, where Governor Bob Holden (D) vetoed reform legislation that the General Assembly was unable to override. On a more positive note, Oklahoma Gov. Brad Henry (D) recently signed into law tort reform legislation that would place a $300,000 cap on noneconomic damages in medical liability cases.

A recent report issued by the Children’s Defense Fund estimates that 36 states will lose at least $100 million each in federal Medicaid funding in FY 2005 unless Congress acts to extend a temporary increase in the federal medical assistance percentage (FMAP), which is set to expire June 30. The CDF estimates the reduction in potential federal funding would range from $10 million in Wyoming to more than $1 billion in California and New York. The report can be found at http://www.childrensdefense.org/childhealth/medicaid_match_rate.pdf.
ork-hour restrictions, debates about whether residents are employees or students, debt repayment, and lower reimbursement are some of the nagging issues of concern to today’s surgical residents and young surgeons. Having recognized that young people entering surgery today are dealing with more difficult and urgent issues than ever before, the American College of Surgeons formed the Candidate and Associate Society of the ACS in 2000 to provide residents and young surgeons with a forum through which their concerns could be brought to the attention of College leaders.

During its June 2004 meeting, the Board of Regents approved a proposal to change the name of that organization to the Resident and Associate Society to better reflect a more visible status for the group. The following articles, as well as the column by ACS Executive Director Thomas R. Russell, MD, FACS, on page 3, are intended to underscore the importance of young surgeons in training to the future of the College and to the surgical profession as a whole.
RAS-ACS is shaping future College leaders:

An interview with Jeffrey S. Upperman, MD

by Diane S. Schneidman, Senior Editor

Author’s note: The Candidate and Associate Society of the American College of Surgeons (CAS-ACS) was formed within the College in 2000 to benefit the surgeons of the future through their involvement in ACS activities. The CAS’s mission has been to: (1) familiarize residents and young surgeons in all surgical specialties with the College, its programs, and its leadership; (2) provide an avenue for participation in College affairs; (3) enable members to develop and use leadership skills in organized surgery; and (4) provide opportunities for the opinions and concerns of residents and young surgeons to be heard by the College leadership. The society was renamed the Resident and Associate Society (RAS-ACS) during the June 2004 Board of Regents meeting.

Jeffrey S. Upperman, MD, chaired the society until he was called to service in Iraq in April of this year. Before he left the country, Dr. Upperman agreed to be interviewed for this article, which is intended to inform the College membership about the current and future direction of RAS-ACS. The interview took place by telephone on March 31, 2004.

What are your thoughts regarding the status of the RAS-ACS at the present time, and what direction do you think it should be moving in?

I think the Fellows, Associate Fellows, and Candidates who originally designed CAS wanted an advocacy organization and a home base within the College for surgical residents and young surgeons. They wanted CAS to provide the members of the Candidate Group and the Associate Fellows with a voice within the College and to serve as an educational training ground for developing young leaders. At this point, I think we’ve begun to codify how that vision would work.

As we move forward, we’re trying to develop a series of programs to support that initial intent, but we also want to take RAS to the next level and actually teach residents some useful skills and get them into the decision-making pipeline. That is to say, we’re attempting to develop an organization that will be recognized as providing young surgeons with the training and the background in College activities necessary for them to eventually serve as Regents or other College leaders. In other words, I view RAS as sort of a dynamic pipeline that provides growth opportunities for young people who are interested in getting involved with organized medicine.

What is your main goal as Chair of RAS-ACS?

My main objective as Chair has been to try to get as many residents and “Fellows in training” on as
many College committees as possible—not that they would sit with these committees necessarily to deliberate, but to learn. Again, if they are part of the leadership pipeline, they will come to understand how a multi-million dollar advocacy organization works, and I think they will be better prepared citizens when the time comes for them to join the ranks of the College’s leadership. I don’t see why they should have to wait to learn all these things until they attend their first Board of Governors or Board of Regents meeting. Why don’t we start preparing them now?

What groups other than the Board of Governors and Board of Regents would you like the residents to get involved with?

I think residents should be able to participate in meetings of all of the College’s standing committees, except for the Central Judicial Committee (CJC). The CJC fulfills one of the core functions of the College and handles very proprietary information that the residents don’t necessarily need to be exposed to. Again, they don’t have to vote. They would just attend committee meetings and be involved at some level, so they can gain the experience and an understanding of what’s going on within the organization.

What are some other initiatives you believe the RAS-ACS needs to carry out in the development of the leadership pipeline?

As an initial step, we’re looking at how we deliberate and how we can usher through new ideas proposed by a resident or a group of residents. So, we’re dealing with the nuts and bolts of governance.

We’re also looking at what we can do in terms of programming. We’re trying to come up with a menu of programs focused on leadership development, including a leadership training course for chief residents. In these times of diminishing work hours, new requirements for academic competence, more and sicker patients in the hospital, and so on, chiefs find themselves in a situation where it’s more challenging to learn and be active in the hospital environment. So, I think we need to develop our leadership in ways that are different from what was done in the past. Residents used to learn how to be chiefs by spending an inordinate number of hours making a lot of mistakes and figuring out how to avert those problems in the future. Now that there are rules against residents operating on their own and staying up for long hours, we need to develop programs that support chief residents in their efforts to figure out how to make it all work.

So, do you think that the College needs to emphasize this type of leadership training because, with the resident work-hour and other restrictions, the training programs just aren’t going to be capable of providing that sort of educational experience?

That is what I believe, and I think RAS offers a unique forum and set of opportunities that training programs aren’t necessarily going to be able to provide. I’m talking about preparing the type of leaders who, essentially, ACS Executive Director Thomas R. Russell, MD, FACS, is trying to develop—“a cast of clones,” if you will. Under his model and ours, you’re not leaving leadership to chance. Instead, you’re trying to build a cadre of residents and junior members who understand the language, who understand what plays on Capitol Hill, and who have a sense of what works in dealing with other medical and surgical organizations.

They also will be able to deliver the message to surgeons and residents that the College is working for them: “This is what we’re doing; these are the types of activities we offer. Stand with us shoulder to shoulder, and this is what we can deliver.” The traditional attitude of believing that we can stand alone is just not working. There’s been an erosion on a lot of fronts, and the issues that surgeons face are very complex. Unless some organized approaches are applied within our culture to develop young surgical leadership, there’s a possibility that they could go down the same wrong path when they become the leaders of this organization, or they might not know which path to take at all.

With whom in the College’s leadership have you discussed the RAS’s objectives, and what sort of response have you received?

I have spoken with Dr. Russell, Paul Collicott, MD, FACS, Director of Member Services, and others, but we’ve had no formal discussions about creating Candidate Group seats on College committees at this point.
Part of a strategic planning discussion that we plan to have during the Spring Meeting will include RAS’s educational agenda and strategies for accomplishing it. We also will discuss how we’re going to govern ourselves, how we’re going to restructure ourselves, and how we’re going to carry out the leadership development activities that we’ve been talking about. Hopefully, by putting these systems in place, RAS chairs—myself and those in the future—will be able to go in front of the Board of Regents and tell the leadership that “this request comes from your Resident and Associate Fellow leadership.” We can tell the Regents that these are the issues we think are important for the College to address, and these are the ways we think we can resolve them. We’re thinking about how we can enter into these discussions and about how we can really build this pipeline. (The strategic planning session that Dr. Upperman mentions took place on April 25, 2004, subsequent to this interview. For more information about the outcome of that meeting, see the related article on page 21.)

I’ve also talked with Claude H. Organ, Jr., MD, FACS, ACS President, about all of these matters as well, and we were very pleased to see that the theme for his Presidential year is “the year of the resident.” That’s exactly the type of statement we were looking to have the leadership make. We thought there were so many changes going on, and we needed support. We needed someone to put our concerns out in front. And, in this case, we didn’t even have to ask. It was right there.

The RAS typically presents a session at the Clinical Congress. What will this year’s program be like?

Our symposium at the Congress traditionally has been one in which we address a controversial subject or set of subjects by putting together a panel of speakers who are knowledgeable in the area to address the issues, and a Candidate or Associate Fellow moderates the program. We try to flesh out an area that is posing some sort of conflict.

This year the symposium will focus on the concept of “residents as employees or students” (see related article, page 14). We believe this program is important at this time because there has been a movement afoot to go after residents when problems arise in a case. We think that in such instances some questions need to be answered: Were the residents doing what they were told to do? Should residents be sued or held liable when they just happened to be on call the night a patient received the wrong medication? Are they fair game for lawyers to go after? There has been precedent set in some states where residents have had to foot the bill, if you will, for liability claims.

And the session will take into consideration the evolution of the whole work-hours issue. We know the 80-hour workweek is here to stay. If part of the reason the work-hour restrictions were implemented was due to concern for employee health and safety, then why didn’t the hospitals step in earlier and say, “It’s a risk and a danger for residents to drive home with so little sleep?” Why didn’t they provide van pools? I was speaking with one resident who told me that the way his hospital is organized, there is no place where residents can sleep if they are tired after their shift. Well, a hospital can’t have it both ways. If the administrators are worried about safety, then they need to do some things to ensure the well-being of their “employees.”

What other programs does RAS plan to develop?

We’re looking at the possibility of offering a “leadership fellowship” to those residents who are interested in organized medicine. It would allow the recipient to take a year or two off from the lab to get a master’s degree in public health or to otherwise study advocacy. Maybe the recipient could spend that time training under the direction of Dr. Russell in the College’s Chicago headquarters or of Cynthia Brown, Director of the Division of Advocacy and Health Policy, in the Washington Office, to gain an understanding of the inner workings of this organization and of how it interacts with the government. A number of other organizations do it. Why not us? Again, this would be a way for the College to develop the next generation of surgical leaders.

The one thing that no other organization in American surgery that I know of has done is to really try to nurture this concept of developing surgical resident advocates, and this is why we think RAS is so important. For example, surgical residents essentially were not at the table when the various medical groups decided that we needed work-hours reform. That’s not to say that the work-
hours issue was mishandled. It’s just that our lifestyle and our training needs are a little different from those of some other specialties, and I think it would have been good to have had a voice when those discussions were taking place and those decisions were being made.

What is the most important thing you want Candidates and other surgical residents to get out of these programs?

I think one of the things that has hampered surgeons for a very long time is that we just don’t know how to behave in the policymaking forum. We’re used to coming into the operating room and taking the attitude that, “I’m the boss. It’s my way or the highway. I’m making the call here. I’m stopping the bleeding.” When you’re in an organizational setting or in an advocacy position, it’s about give and take. It’s politics. You’ve got to be willing to take a little bit of the pain. You’ve got to be willing to compromise, and obviously some people do it better than others. In any event, these are the qualities that make people successful in the political advocacy realm and in organized medicine. So, surgeons in training and young surgeons need to be exposed in an overt fashion to how they should handle themselves so that, when they come to “the hallowed halls” and are going to be Governors or Regents, they don’t think their role is going to be some facsimile of their experience in the OR, where they can tell the staff and the leadership how to do things. They need to understand the inner workings of the organization and the channels through which decisions are made.

Many of the programs and initiatives we’ve discussed center on residents. What efforts are under way to help surgeons who are just entering practice beyond what the College already has in place, such as the job bank?

We’re trying to do a lot more for young surgeons who are just entering practice, and that’s why, for example, our last newsletter included a piece on the restrictive covenants, or the noncompete clauses, that are a common part of contracts between physicians and their employers. These clauses restrict the right of physicians to practice medicine for specified periods of time or in specified areas upon termination of their contract with the employing entity. Often, young surgeons make the mistake of ignoring these clauses or of thinking that these provisions are illegal or unenforceable.

We’re also concentrating on some educational programs focused on practice management. To that end, we are working with Charles Mabry, MD, FACS, an ACS Regent who presents many of the College’s courses in this area. So, we’re trying to be a conduit for information on practice-related subjects and not recreate the wheel, given that some activities that are important to Associate Fellows already are carried out by the College. We’re just trying to get the word out, and let people know what the College offers.

What are some of the issues of the future that you think these young leaders need to start addressing now?

It’s probably sort of an overused concept, but time management, prioritization, and working with teams of people are going to be paramount to the success of the modern-day surgeon. They no longer are going to be managing a team of junior surgeons who are going to be looking to them as the sole source of answers. They’re going to be part of an integrated team of nurses, nurse practitioners, physician assistants, and other types of allied health care professionals. They’re probably going to have to work more closely with faculty because, in some cases, those individuals may be pulled into the front lines to provide some services. It’s just a different model than the last couple of generations had to work with.

I think, within the paradigm of professionalism, communication and interpersonal skills are going to have to be worked on in an organized way, in addition to being learned “on the fly.” Training programs are charged with providing residents with opportunities to attain those skills, but I think that the College can serve as a resource of programs big and small aimed at helping surgeons to become more proficient in these areas, so they can come to the “Mecca” and presumably learn all the great things and all the models that work. I think we have the exposure and the resources to pull in the appropriate experts who have made the transition and who can show them how it’s done.
Have there been special efforts during your term or during your predecessor's term to recruit new members into RAS?

We have made no special efforts to go out and specifically recruit. However, we are trying to work with program directors and Division of Member Services staff to keep the word out front, and we're really looking at this special issue of the Bulletin as a way to get our face out there. People are reading the Bulletin. I get e-mails from people all the time asking me, "Did you see this or that in the Bulletin?" So through this special edition, the Fellows will see what we're doing, and they can pass it on to their house staff and say, "Look, you need to be a part of this organization."

RAS has about 7,000 members right now. Is that number meeting the group's expectations?

We think it's reasonably on target. One of the things I know Dr. Collicott is interested in is the whole concept of getting the residents into the pipeline and keeping them in once they enter practice. One of the factors that may cause some surgeons to drain out of the pipeline and not keep moving forward is that they might wonder what the College can really do for them. These surgeons may also figure that if their patients aren't concerned about whether their surgeon is a Fellow, because they don't know what Fellowship means, there's no need to be part of this organization. So, I think our goals with regard to membership are in line with the greater goals of the ACS. We want people to become and stay part of the ACS and to support it. We need to show them that trying to stand alone really may not be in their best interests.

Are there any other programs that you think the College should consider implementing to help the residents?

There may be folks out there who have an undergraduate educational background or some other type of knowledge base that is outside of surgery, and we should provide them with opportunities to develop those interests within and to the benefit of the College. For example, say a young surgeon has an undergraduate degree in English. Is it possible that this person could have an opportunity to, say, do an internship at the Journal of the American College of Surgeons or something else along those lines, assuming there's enough work for them to do? Some programs that are being developed, such as the new Web portal and a new media relations program focusing on television, may also provide a variety of novel opportunities for those folks who have different outlooks. These experiences might allow a young surgeon to contribute beneficial skills to the organization, to learn, and, again, to be a leader.

In addition, we are thinking about distributing a membership survey to determine the Fellows' interests and to see just what our leadership looks like. We're thinking about maybe using that information to show medical students and residents what types of people really participate in this organization. I've talked to medical students, and many of them say, "I really want to go into surgery. I really want to do it, but, you know, I want a life." You hear that over, and over, and over. Now that the Bulletin has started running its series of articles on surgeons' lifestyles, I can say, "Look at this surgeon. She runs marathons. Or, look at this couple who make a two-surgeon family work." I can put the information right there in front of them and give them tangible examples of how modern-day surgeons are able to practice surgery and still pursue other interests.

Any final thoughts?

Basically, I would characterize this as a time for youth, a time for young leaders to step up to the plate and be a part of the College, to contribute to the RAS agenda, to be part of this new look, to be part of this vibrant leadership-developing haven for surgeons in training. That would be the message I would want to emphasize and to convey to young surgeons. Again, in talking with some of the young folks, I just get the sense that they don't know who represents them. They want to know what the College does for them. The reality is that the College is doing a lot for them, but some of that work is going on behind the scenes. We just want to make sure that they realize that RAS is a very vocal, vibrant, and viable resource for them within the College. What I've been telling people is that we have a "new look and feel" College, and they should be part of it.
Surgical residents: Are they students or employees?

by Emily R. Winslow, MD, St. Louis, MO; Abdalmajid Katranji, MD, Peoria, IL; and Gregory S. Cherr, MD, Buffalo, NY

Each year, the Candidate and Associate Society of the American College of Surgeons, now known as the Resident and Associate Society (RAS), sponsors a symposium at the Clinical Congress of the ACS. In 2004, designated “the year of the resident” by Claude H. Organ Jr., MD, FACS, President of the ACS, the symposium will address the fundamental question, What is a surgical resident? Is a resident a student, an employee, or both? How can the differences between the designations be resolved?

What’s the difference?

Most surgeons would agree that the most important purpose of residency training is to learn the art and science of surgery. In this respect, surgical residents are first and foremost students. However, residents learn by carrying out activities within health care institutions that view them as employees and provide them with benefits. Furthermore, multiple government agencies have ruled that residents are employees. In 1999, the National Labor Relations Board recognized residents as employees when it allowed them to unionize. With rare exception, the Internal Revenue Service (IRS) also considers residents employees.

Recent changes in resident work-hours regulations have focused attention on the fundamental role of postgraduate trainees in surgery. Although the education of surgical residents is emphasized via such mechanisms as teaching conferences, the American Board of Surgery...
(ABS) in-training examinations, and journal clubs, a significant portion of residents’ time is spent performing tasks that may be considered “services,” such as procuring X rays, dictating discharge summaries, and writing prescriptions. Furthermore, the educational value of certain tasks varies during the course of residency training. For example, placement of a central line is a valuable skill that a junior resident should learn. For chief residents, however, this procedure has less educational value and may take time away from other more useful pursuits. Although great emphasis is placed on resident teaching conferences, attending to critically ill patients must take priority over more formal types of housestaff education. Who hasn’t seen a surgical resident slip out of a grand rounds lecture to respond to the trauma code beeper?

Money issues

Resident salaries, pertinent to employment, are a topic that many surgeons find distasteful. Part of this reaction may stem from the fact that surgical residents in the past worked longer hours for far less money. Others may feel that a career in surgery is a calling rather than a business enterprise, and, therefore, discussions about resident reimbursement are inappropriate. Still others may note that after completing training, practicing surgeons receive adequate compensation for their work. Over the past 30 years, the cost of attending medical school in the U.S. has risen 250 percent at public schools and 400 percent at private schools.6 Medical school graduates from the class of 2003 entered postgraduate training with debt averaging $109,457.7 Unfortunately, when accounting for inflation, resident salaries have remained stagnant. Faced with these realities, medical students and residents (predominantly from non-surgical specialties) have attempted to increase salaries by unionizing and challenging the legality of the National Resident Matching Program or by reducing work hours; others have chosen specialties with shorter residencies or higher reimbursements than surgery.8

Despite an increasing emphasis in the role of residents as employees, we believe that most physicians would argue that the core concepts of residency training include study and investigation—the defining characteristics of a student.9

A number of issues strain the balance between the resident as a student or an employee, including the 80-hour workweek, resident income-tax payment, and housestaff benefits such as maternity/paternity leave and day care. As these issues are addressed and resolved, fundamental changes in the method of training surgical residents are likely to occur. These changes may affect the number, quality, and diversity of future surgeons and therefore the future of surgery in America. This article will review one of these issues (housestaff maternity leave) to illustrate the difficulty of formulating resident training policies that address both education and employment.

Housestaff maternity leave

In the debate over whether residents should be exempt from paying of the Federal Insurance Contributions Act (FICA) tax, one of the stipulations used to argue that residents are employees rather than students was that they are provided with benefits characteristic of employees. Specifically, the 2000 memorandum from the IRS cited sick leave and disability leave as part of the facts and circumstances test by which residents could be considered employees.4 Interestingly, this issue of medical leave for residents, specifically maternity leave, is one that has received much recent attention within the medical community as well.

In fact, until recently, many residency programs did not have defined policies for maternity leave.9 In 1996, the American Medical Women’s Association issued a position statement calling for all residency training programs to have a written policy concerning maternity and disability leave.10 In a review article examining pregnancy during residency, one of the major sources of stress for pregnant women was found to be inadequate time for maternity leave and fatigue after returning to work.11 In 2002, the Association of Women Surgeons (AWS) issued its own position statement on maternity leave for surgical residents. In brief, it supported the concept of combining four weeks of “medical leave” with two weeks of vacation, for a total of six weeks of paid maternity leave.12
Despite this statement by the AWS, there remains little or no consensus on the issue of maternity leave across surgical training programs. One of the difficulties has been that the employer of the resident may be either the hospital or the university with which it is affiliated. Both of these institutions have variable policies for their employees. For example, the graduate school of biomedical sciences at Washington University in St. Louis, MO, provides 45 days of maternity leave. In contrast, the hospital policy in general allows for the standard six weeks as specified by the Family and Medical Leave Act of 1993 (FMLA), with the specifics dictated by the employee’s management. This example illustrates the variable and potentially conflicting policies that women may face when pregnant.

For residency programs, the difficulty in defining maternity leave policies is that a third entity is involved, namely the specialty board. For general surgery programs, this means that no matter what hospital or university policy is chosen, ultimately the resident is held to the ABS requirements for eligibility. The rules for eligibility state that the ABS expects each year of training to include no less than 48 weeks of full-time surgical experience. In the case of maternity leave, the ABS does allow for one of the first three years and one of the last two years to be 46 weeks of full-time surgical experience. This allows for six weeks of maternity leave in the case of a well-timed, carefully planned (and uneventful) pregnancy. However, it does not allow for flexibility when pregnancies occur within a year in which vacation has already been taken or for any extension of leave if complications occur. Should the resident require additional maternity leave, she may be required to “make up” any weeks required beyond the six allowed by the ABS. For this reason, many residency programs state explicitly that such situations could result in the need to complete an additional year of residency training. Although this is certainly understandable from an educational perspective, it is logistically difficult for most residents to extend training or delay practice or fellowship plans.

In summary, although the resident’s status as employee or student can influence some specifics of family leave policy, it is ultimately the policies of the ABS that limit the impact of these distinctions. The one critical factor in the individual’s institutional policy is how extensions in training as mandated by the ABS will be managed and funded. Further questions include the effect of this policy on the recruitment and retention of female surgical residents.

Conclusion

For surgical residents, many issues exist that may adversely affect the balance between “employee” and “student.” By identifying and addressing these critical training issues, we will continue to attract the best and brightest into the profession of surgery. We hope that this article will encourage residents to come to the annual RAS symposium titled “Surgical Residents: Students or Employees—And Why It Matters,” which will take place during the 2004 Clinical Congress in New Orleans, LA.

References


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Regulations mandating an 80-hour workweek have made surgical residency less daunting than it was in the past. At the very least, residents don’t have to spend every moment away from the hospital brushing up on grand rounds cases, pouring over the latest journal articles, and trying to catch up on sleep. But the general surgery residency—often followed by subspecialty training and a fellowship—is still a long haul. And the work continues to be heavy, with 12-hour days Monday through Friday, on-call duty every third or fourth night, and only one full day off on weekends—for five to eight years.

Consequently, the surgical residency keeps surgeons in training two or more years after colleagues in internal and emergency medicine are out in practice, working 13 to 14 shifts a month and earning a living. Furthermore, the rigors of residency mean surgeons in training must put much of their personal lives on hold. Surgical residents and young surgeons, nevertheless, relish the experience, as this article indicates.

**Intangibles**

In explaining their satisfaction with their career choice, these physicians often point to the intangibles of the surgical experience, including the following:

- **Intimacy.** In contrast with primary care physicians or diagnostic and medical specialists who focus on prescribing medication, interpreting imaging studies, and effecting lifestyle changes in their patients, surgeons quite literally take patients’ bodies and lives directly in hand. As Emily Winslow, MD, a junior surgical resident at Washington University, St. Louis, MO, said, “There’s something about the way you feel when you are operating and taking care of surgical patients that’s far different from the way you feel doing anything else.”

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**Surgical lifestyles:**

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**Surgical training offers more joys than hardships**

by Karen Sandrick, Chicago, IL
• **Immediacy.** “There’s no hedging, no wavering, no second-guessing, or smoldering over decisions,” says Mallory Williams, MD, a third-year resident, at Wayne State University, Detroit, MI. There is also the immediate satisfaction that comes from physically attacking a clinical problem head on, says Rebecca Rose, MD, a first-year resident in general surgery at the University of Buffalo, NY.

• **Urgency.** Surgeons care for some of the most severely ill and injured patients and often at the most critical times—repairing torn blood vessels, redirecting blood flow to dying muscles, excising encroaching malignancies, replacing deteriorated joints, and reenergizing static limbs. A court reporter before she entered medicine, Dr. Rose feels she is now in a field where she can make a difference in a person’s life.

• **Proficiency.** There is the pride that accompanies mastery of a technical skill and the operating room environment, says Ryan Lewis, MD, chief general surgery resident at Keesler Medical Center, Keesler Air Force Base, Biloxi, MS.

• **Gratification.** As a direct result of their work, surgeons often see improvement in their patients’ quality of life or relief of debilitating symptoms, and they sometimes have the chance to totally eliminate the underlying locus of disease. “Seeing that you can help patients improve in their quality of life or in their debilitating type symptoms makes the job worth it,” says Dr. Lewis.

**Because they want to**

It’s dear from talking with these physicians that they have chosen surgery for the sheer joy of it. Dr. Winslow recalls the time she was reading a surgical journal on a return flight from a medical meeting and a fellow passenger asked, “Is that for work?” No, she thought. She was reading it because she wanted to.

Melinna Kibbe, MD, an assistant professor of surgery at Northwestern University Medical School, Chicago, IL, spends most evenings and weekends working to establish a laboratory that will be studying ways of inhibiting restenosis in bypass grafts through nitric oxide-based pharmacology. “If there is something you want to do outside your career, you find time to do it. For me, I’m very much interested in my research. That’s my choice,” Dr. Kibbe says. “Surgery is what we do and enjoy and spend our free time thinking and wondering and reading about,” Dr. Winslow adds.

**Overturning stereotypes**

The physicians have no regrets now that they are putting to rest some of the negative surgical stereotypes they confronted early in their training. These surgeons-in-training see that they’re not mere technicians who perform the same procedures day in and day out practically by rote. They are constantly amazed by the thrill of discovery: no matter how many times they operate, their route is never quite the same as they pass instruments along the course of a patient’s anatomy and not nearly as straightforward as the textbooks make it appear. The surgeons realize they are “cog-
The family room, baking bread from scratch every once in a while, and trying to play the piano for at least 15 minutes a day. Dr. Kibbe is designing and maintaining Web sites for family members and surgical colleagues.

**Effects on family**
When a physician is in the thick of the surgical residency experience, there is no doubt that the demands of training interfere with family time. "Looking back, I've missed a lot of dance recitals and classes and parent-teacher conferences, things my wife had to go to without me because of my surgical residency," says Dr. Lewis. Even now he gets calls from his five-year-old daughter asking when he will be coming home: "Are you going to make it to my gymnastics class?"

"In the medical field, you have to be in a hurry," Dr. Rose says, "so I always jump at any opportunity to work on a personal project or do something that's just for myself."

"I've been lucky to find the things I'm passionate about," Dr. Rose says. "I love being a surgeon and I love being a mother."

The pursuit of a surgical career often is uprooting. Dr. Rose has had to relocate her three children three times over the last few years. First, when her children were ages seven, 12, and 14, she moved from Los Angeles, CA, to Salt Lake City, UT, where she earned her undergraduate degree at Brigham Young University. She then took her family to Ann Arbor, when she went to medical school at the University of Michigan. After remarrying and acquiring two stepchildren, Dr. Rose moved to Buffalo, where she has been doing her internship and residency.

But the surgeons' families are supportive and understanding. When they first married, Dr. Winslow's husband was a teacher, who was home every afternoon at 3:00 pm and had to wait another five or six hours until she got home, only to hear a weak "hello" before she staggered straight off to bed. "He changed careers for a lot of reasons, but one of them was certainly because computer consulting fit in better with what I did."

Dr. Kibbe's significant other of 14 years followed her to Pittsburgh, where he practiced law while she completed a fellowship in vascular surgery.
Then he joined an environmental corporate law firm in Chicago, IL, when she took an academic position at Northwestern University Medical School.

Despite the limited amount of free time they have, the surgeons find ways to stay connected with their families. When Dr. Williams was a junior resident, his wife Patrice would bring his two children to the hospital if an on-call rotation was light. “Sometimes we would eat dinner, and sometimes those dinners were disrupted by urgent matters. But it was comforting for me and my family to have that interaction time, even if it was just five to 10 minutes,” he says. Bringing a little of his home life into the hospital also gave Dr. Williams the chance to watch as his daughters took their first stumbles and eventually learned to walk.

During her undergraduate days, Dr. Rose would go camping with her children, sandwiching in study time whenever she could. In the last nine months, she’s helped plan weddings for her two older children. She’s now awaiting the birth of her first grandchild.

Over time, the intensity of professional commitments abates. Because an Air Force base medical center functions like a large community hospital, Dr. Lewis can get home most evenings, even when he is on call, and help his four children, ages 10, seven, five, and two, with their homework or read them a bedtime story. “I don’t bring work home. So if I’m home by 7:00 or 8:00 at night, I can spend all my time with my wife and children,” he says.

The attraction

Each of the physicians has come to surgery in his or her own way. After graduating from Harvard Medical School, Dr. Winslow entered an internal medicine residency but reapplied in surgery halfway through the year because medicine didn’t provide her with as much day-to-day pleasure as she had hoped. “It was easier to get up in the morning to take care of surgery patients, and I was excited to come home at night and read more about it,” she says.

Dr. Kibbe decided to become a surgeon when she was 14 years old and had surgery to correct scoliosis. It wasn’t until her last two years of college at the University of Chicago (IL) that she chose vascular surgery. As a member of a basic science team trying to localize brain natriuretic peptide, she learned she could dissect the minute vasculature of the rat brain. A lecture in atherosclerosis and a video on carotid endarterectomy solidified her decision.

Dr. Rose became curious about medicine while taking depositions from physicians as a court reporter. “I went from saying things like, ‘I wish I could have gone into medicine,’ to asking questions about how I would do it,” she says. And the ability to use her hands led her into surgery.

Dr. Lewis has wanted to be a surgeon since he started in medical school. Even after he and his wife had three children when he was in medical school and another during his residency, he wasn’t drawn to specialties like radiology or emergency medicine that have more regular off hours but are more like shift work.

Dr. Williams was certain initially that he wanted to be a family medicine physician or an infectious disease specialist. He was so sure he didn’t want

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COLLEGE EMBRACES SURGICAL RESIDENTS

President dedicates term to "the year of the resident"

Annual Spring Meeting offers more resident programs

CAS-ACS now Resident and Associate Society

by Juan Carlos Paramo, MD, Miami, FL

The members of the Candidate and Associate Society of the ACS were very pleased and honored that ACS President Claude H. Organ, MD, FACS, declared his presidency to be "the year of the resident." To further enforce and promote his enthusiastic vision, the Regents recently approved a recommendation to rename and strengthen the CAS-ACS. The new name of the organization is the Resident and Associate Society (RAS), demonstrating that the College is responsive to the needs of surgical residents.

On April 25, 2004, at the Spring Meeting in Boston, the leadership of the RAS and the ACS had an unprecedented strategic planning session. A commitment for increased communication, involvement, and participation of residents in activities and committees of the College was made. With this in mind, we anticipate growing opportunities for residents to attend events of their particular interest.

For example, RAS wants to make the annual Spring Meeting "The Meeting of the Resident." This year, a one-day resident program was organized which included a series of lectures on resident-relevant issues. In addition, two general sessions, Spectacular Cases from Residents and Surgical Jeopardy, were held with excellent audience response and participation.

In the future, we anticipate an even higher number of events targeted to residents. Next year's Spring Meeting will include a session on Clinical Abstract Submissions from Residents, as well as the already well-established programs mentioned above. We are developing sessions that will allow residents to actively participate and, therefore, strengthen the program's interest and usefulness to residents.

All of these efforts are intended to remind the surgical residents that the College embraces them. We know residents are the future of surgery and of the College. Join the College; join RAS—"the society of the resident."

Dr. Paramo is a surgical oncologist at Mount Sinai Medical Center, Miami, FL, and Chair of the RAS Communications Committee.
The Technology Evaluation Center (TEC) was founded as a joint effort between the Kaiser Permanente Foundation and the Blue Cross and Blue Shield Association. The purpose of the medical advisory panel (MAP), which is a part of the TEC, is very simple: as new technology, treatments, and operations evolve, the MAP examines whether they are effective and, hence, should be recommended for use. This function will become even more important as biological agents, which cost as much as $40,000 per dose, or new technology, costing $20,000 to $50,000 per instrument, increasingly make their appearance. This year, in a significant departure from the past, the panel voted that in addition to considering efficacy it would examine cost-effectiveness.

The MAP has been active for more than 18 years, with many members serving six years or so. The panel, composed of 17 physicians and one ethicist, meets every four months.

At the heart of the MAP is a highly professional staff consisting of physicians, PharmDs, and PhDs who evaluate the question that is currently before the panel. The gold standard applied to determining the effectiveness of the therapy, technology, or procedure under consideration is properly done randomized clinical trials (RCTs). However, in the case of diagnostic tests, observational data from prospective studies (rather than RCTs) are the norm, and equally rigorous approaches are undertaken for their review.
Evaluation process

The individual reviewer starts each process by going to the Index Medicus and other sources and retrieving all papers (often more than 1,000) relevant to the subject under review. These are rapidly whittled down to prospective studies. Other studies, including case studies and retrospective studies, are included in the evidence considered, but the weight given to their conclusions is so low as to make their impact virtually negligible on our conclusions. The prospective trials are subjected to rigid criteria for the design, the statistical analysis, and whether they answer specific questions. One must remember that it is difficult to use an RCT as evidence when the problem in question differs considerably from the initial intent of the clinical trial.

At the end of this process, the question that is being studied is reviewed on the basis of five criteria. They are:

1. The technology must have approval from the appropriate governmental bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be obtainable outside of the investigational setting.

The staff reviews the data from RCTs and other prospective studies (particularly those involving diagnostic tests) and provides the MAP with a fairly long report on all of the studies that have been reviewed, their various characteristics, their strengths and weaknesses, and whether the treatment being considered meets the five criteria.

The panel then reviews not only the report, but also the original source material used during the review. Both are provided well in advance of the meeting so the panel may review them. The panelists then decide whether they agree with the conclusions of the reviewer or want to change it. It is not unusual for the MAP to disagree with the staff’s analysis and/or to send it back for revision.

Once the studies are completed, all analyses are placed on the TEC Web site, http://www.bcbs.com/tec/index.html. Initially, the products were available to Kaiser Permanente, the national Blue Cross and Blue Shield Association, and its affiliated plans. Now, individual health plans may use the panel’s findings or those of local groups to decide whether to cover a drug or device. Medicare also uses the TEC’s resources, either when considering already completed work on topics it is interested in or when commissioning original work.

My role

Some members of the surgical community seem to misunderstand my role on the panel. First and foremost, my role as a surgeon is to help the panel to understand issues from the surgical perspective and to correct misapprehensions concerning the surgical procedures we review. Other than that, I use the same criteria to judge the efficacy of certain procedures and medications as the other MAP members, following established criteria and tracking the data closely. My role, therefore, is not to seek approval for new surgical procedures, but to point out how they solve certain medical problems.

When I joined the panel, I was impressed by the quality of the reviews and asked Allen Korn, MD, chairman of the MAP, whether it would be possible to publish those of surgical interest in the Journal of the American College of Surgeons. He agreed, and several have been published and others are in the pipeline.

Examples

Perhaps the easiest way for me to explain my role is to take four recent examples of some of the topics of surgical interest that the panel has studied, some of which have been published.

1. Radiofrequency ablation of carcinoma of the liver and/or metastases of colon cancer.

The panel considered whether radiofrequency ablation (RFA) alone improved the health outcomes of patients with unresectable tumors as compared to percutaneous ethanol injection. The MAP concluded that RFA was suitable for small, unresectable, primary hepatic neoplasms but not for unresectable liver metastases. I recently asked Dr. Korn and the panel to reexamine radiofrequency ablation with longer follow-up and more careful evaluation in light of a number of recent developments. This request is especially important given the MAP’s suspicion that RFA is being used instead of resection in many patients who could...
safely undergo operative procedures.

I have asked for the reexamination for the following reasons:

- RFA may be less efficacious in killing tumors than once thought. In several series in which livers had previously undergone RFA before transplantation, the explant contained a substantial amount of tumor at the previous sites of what was thought to be completed RFA. Indeed, in up to 58 percent of cases, RFA failed to eradicate the intended lesion. In another 28 percent, other lesions went undetected because hepatocellular carcinoma appears to be multicentric, as Cha and his colleagues have noted, and thus a singular isolated attempt to eradicate it in closed fashion is ineffective. In addition to the published articles dealing with this subject, Beth Israel Deaconess Medical Center’s transplant experience shows that seven out of nine patients who underwent transplantation had persistent lesions in the explant that presumably had been eradicated by RFA.

- The mortality of this procedure, previously seen as innocuous, appeared to be as high as 10 percent and may be higher in patients with compromised hepatic function with hepatocellular carcinoma complicating cirrhosis as a result of hepatitis B and C. This appears to have been the result of inadequate follow-up in the radiological literature.

2. The use of chondrocytes to restore articular surfaces.

This is a promising form of therapy, and if chondrocytes could coat worn articular surfaces, it might help patients avoid joint replacements. Here, however, the studies were quite poor, and as many as three other therapeutic maneuvers may have been carried out simultaneously with chondrocyte injection. No RCTs had been done at that time, although one study is currently under way in Norway.


The panel was interested in whether there is any long-term benefit in the comorbidities (including hypertension, diabetes, and hypercholesterolemia) and in late mortality following bariatric surgery. With those criteria, the picture of bariatric surgery is far less promising than its advocates would have us believe.

The difficulty is that insufficient attention was paid to the panel’s third criterion—that the technology must improve the net health outcome. Yes, patients lose weight following bariatric surgery, but the initial period of weight loss following any restrictive procedure takes place over the first 12 to 18 months; thereafter, patients often gain it back, sometimes needing a second procedure, if they are not followed rigorously in a program with long-term nutritional counseling. Moreover, there was a bewildering variability in results following some of the operations. Third, the so-called RCTs are actually not what they appear to be in many instances, but a report of results in two different groups without proper design.

The MAP also attempted to evaluate different operative techniques. While open gastric bypass seemed to yield reasonable outcomes that were nearly identical or reproducible among different centers and countries, laparoscopic gastric bypass and the laparoscopic band procedure did not result in the same outcomes. The panel was attracted to the laparoscopic band procedure because it is easily performed, it is minimally invasive, it seems to have very low morbidity and mortality when done properly, and the size of the stomach could be adjusted over the years to make certain that the efficacy of the procedure would continue.

Outcomes among a number of series reported in the literature showed tremendous variation. The panel noted with great satisfaction Paul O’Brien’s data with his very careful follow-up and continual adjustment of the laparoscopic band with patients having up to 54 percent loss of excessive body mass. This, however, was far in excess of the average decrease of excess weight of 34 percent in most American series. Whether this relatively poor result was due to inadequate follow-up, the lack of continual adjustment, unavailability of nutritional counseling, or a myriad of other factors was unclear, but the panel was disappointed that Mr. O’Brien’s excellent results could not, up to now, be duplicated in the U.S.

As a result, the panel elected to approve open gastric bypass based on a Swedish study in which good results and improvements in net health outcome was the result. No American study met the criteria, and, likewise, laparoscopic gastric bypass’s results seemed to be extremely variable, perhaps
because of the difficulty of the procedure and lack of adequate follow-up programs.

This outcome ignited a firestorm within the bariatric community, which argued that the panel had not considered a number of specific papers. However, the evaluator did include those papers in the initial evaluation, but they did not meet the MAP’s criteria.

4. Lung-volume reduction surgery

The history of lung volume reduction surgery (LVRS) is replete with numerous false starts and, interestingly, probably would not be studied yet if the Medicare program had not insisted that the National Emphysema Treatment Trial (NETT) be conducted. NETT was a clinical trial in which patients were randomly assigned either to medical treatment or to LVRS. NETT participants assigned to the surgical arm of the study had to engage in pulmonary rehabilitation for a period of time prior to having the surgery. Medicare patients in the surgical arm of the trial received coverage for LVRS.

After the initial rage following the introduction of the procedure by Cooper and his colleagues,8 a number of other factors appeared to have entered the supposedly good results:

- Pulmonary rehabilitation had a substantially positive effect on lung function, causing some patients to improve to the point of not requiring the operation.
- There appeared to be a certain heterogeneity of the patient population in which some achieved excellent results and some achieved minimal results.
- Above all, there was a specter of a significant morbidity and mortality in patients who were referred for this procedure. These patients were those who were extremely limited in lung function as well as poor operative risks in general, resulting in significant mortality.9

I had long believed that the surgical community that performed the lung-reduction operation had not been rigorous about selecting patients for the procedure. The panel believed that patients with homogenous disease not limited to the upper lobes were not candidates for the operative procedure. Therefore, in that particular group, the operation was not efficacious, nor should it be judged as such. However, from a surgeon’s clinical perspective, one could argue that the patients with heterogenous, primarily upper lobe disease were good candidates for the operation and that the mortality was not excessive. The MAP seemed to have accepted this argument on a split vote. Thus, the procedure was adopted.

Conclusion

I have tried to outline the functions of this little-known and even less understood panel. I hope that my respect for those individuals who constitute the professional staff of the organization, Dr. Korn, and my fellow panelists is apparent in this report. They continue to surprise me with the points they make. I very much enjoy participating in the MAP and believe that perhaps I am doing some good by bringing the surgical voice to its deliberations.

I would reiterate that my principal role in this venture has been to interpret surgical procedures, including their limitations and outcomes, and what we wish to accomplish in a given patient.

I would hope that the American College of Surgeons Oncology Group and other ACS clinical trials programs will help surgeons really understand how to conduct rigorous randomized prospective trials. I think RCTs will make life a lot easier for us and our patients. One of the difficulties surgeons have is that we are so certain that what we do is correct that we have not bothered to justify our actions through the cold light of randomized prospective trials; these are the tests that others are using to evaluate the efficacy and, soon, the cost-effectiveness of our work.

Dr. Fischer is professor of surgery, Harvard Medical School, and chairman of surgery, Beth Israel Deaconess Medical Center, Boston, MA. He has served on the MAP of Blue Cross and Blue Shield Association’s TEC for four years. Dr. Fischer is also a member of the College’s Board of Regents.

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90th Annual

Clinical Congress

October 10-14, 2004 • New Orleans, LA

Preliminary Program
Dear Colleagues:

On behalf of the entire College, I would like to extend our warmest invitation to you to join us October 10-14 in New Orleans, LA, for the 90th Annual Clinical Congress of the American College of Surgeons.

The program for this year has been developed in the College’s 90-year tradition of providing excellence in educational offerings across a broad range of topics, from the core foundations of surgical practice to leading-edge innovation. The Program Committee has exerted an outstanding effort in designing an extensive array of sessions to meet the needs of general surgeons, surgeons in the specialties, and surgeons in training. An extraordinary group of clinicians, academicians, surgeon scientists, and experts in relevant fields has been assembled to create an exceptional learning opportunity.

Virtually every area of contemporary surgical practice will be addressed, including such critical topics as the acute abdomen, early breast cancer, gastrointestinal hemorrhage, soft tissue sarcoma, and perioperative pain. Innovative and leading-edge topics also will be discussed, including gene silencing, robotics, assessment of surgical innovation, findings of recent clinical research, and the role of surgeons in mass casualty events. In addition, sessions will be offered on competency-related issues, such as practice-based learning and improvement, patient safety and teamwork, evidence-based surgery, management of the nonoperative aspects of the operating room, ethics and professionalism, morbidity and mortality conferences, and optimizing the learning environment for surgical training.

Choose from a myriad of postgraduate courses, including skills-oriented courses on such topics as ultrasound, stereotactic breast biopsy, bariatric surgery, computers, and personal digital assistants. Didactic postgraduate courses provide the opportunity for in-depth exposure to numerous clinical topics as well as issues in reimbursement and coding, review courses, and SESAP 12. Specialty sessions, multidisciplinary sessions, video-based educational sessions, and presentations of research being done by young investigators provide additional breadth and variety. Scientific and technical exhibits also will be offered.

During the past 90 years, the Clinical Congress has been a premier educational event for surgeons from across the continent. This year, the tradition continues in its finest form. Don’t miss it!

With best wishes,

Edward M. Copeland III, MD, FACS
Chair, Board of Regents
The College has a 90-year tradition of providing excellence in educational offerings across a broad range of topics. This year's Clinical Congress continues this longstanding tradition and features exceptional clinician presenters and an extensive array of activities. Surgeons can advance their skills and knowledge based on their learning needs, whether in areas of contemporary surgical practice, leading-edge research, advances in technology, professional competence, or clinical applications of new developments in the basic sciences. Attend the 90th Clinical Congress and continue your own tradition of seeking excellence in education and surgical patient care.

GOAL AND OBJECTIVE

The Clinical Congress is designed to provide individuals with a wide range of learning opportunities, activities, and experiences that will match their educational and professional development needs. By the conclusion of the Clinical Congress, participants should gain and be able to apply the knowledge necessary to improve their current level of competence in practice, research, and patient care.

NAMED LECTURES

Opening Ceremony and American Urological Association Lecture: Crossing the Quality Chasm in Health Care
Harvey V. Fineberg, MD, PhD, Washington, DC

John H. Gibbon, Jr., Lecture: Can a Genius Be a Surgeon, or, Can a Surgeon Be a Genius?
Robert L. Replogle, MD, FACS, Chicago, IL

Charles G. Drake History of Surgery Lecture: Assassinations
Donald D. Trunkey, MD, FACS, Portland, OR

Scudder Oration on Trauma: Changes and Management Strategies for Injuries to the Liver and Spleen
J. David Richardson, MD, FACS, Louisville, KY

Ethics and Philosophy Lecture: Good, Better, Best—What to Tell Patients About Surgical Outcomes
Bernard Lo, MD, San Francisco, CA

Commission on Cancer Oncology Lecture: Reflections on the Causes of Cancer Disparities
Harold P. Freeman, MD, FACS, New York, NY

I. S. Ravdin Lecture in the Basic Sciences: The Mystique of Organ Transplantation
Thomas E. Starzl, MD, PhD, FACS, Pittsburgh, PA

Distinguished Lecture of the International Society of Surgery
John Wong, MB, BS, FACS(Hon), Hong Kong, China

Martin Memorial Lecture
President George W. Bush (invited, acceptance pending), Washington, DC

CONVOCATION AND ANNUAL MEETING OF FELLOWS

The Convocation Ceremony will take place from 6:00 to 8:00 pm, Sunday, October 10, at the Hilton New Orleans Riverside. The Annual Meeting of Fellows will take place from 7:30 to 8:30 am, Thursday, October 14, at the Morial Convention Center.

GENERAL SESSION HIGHLIGHTS

• The Acute Abdomen
• Barrett’s Esophagus/Nissen Fundoplication and Its Role in the Prevention of Cancer
• Breast Surgery: Has the Knife Lost Its Edge?
• Multidisciplinary Cancer Management: Interactive Tumor Board Discussion of GIST, G-E Junction Carcinoma, DCIS, and Melanoma
• What Has the College Done for Me Lately? How ACS Leverages Power in Washington, DC
• A National Surgical Quality Improvement Program for All Surgeons: An ACS Initiative Whose Time Has Come
• Liability-Proofing Your Surgical Practice
• Economic Morbidity and Mortality Conferences
• Improving Reimbursement for the Care of the Trauma Patient: Coding Tools and Practice Management Techniques
• Specialty Coverage in Trauma Centers: Can Trauma Centers Survive?
• Gene Silencing: A New Frontier for Surgical Scientists and Its Clinical Implications

• Terrorism, Disasters, and Mass Casualty Events: The Challenge for Surgeons

• Safety in the Operating Room: Lessons Learned from Aviation and Other Systems

• Practice-Based Learning and Improvement: What Every Surgeon Needs to Know

• Management of Early Breast Cancer

• Laparoscopic Inguinal Herniorrhaphy vs. Tension-Free: Implications of Veterans Affairs Cooperative Trials

• Chronic Pancreatitis

• Surgical Management of Metastatic Liver Disease

MULTIDISCIPLINARY PROGRAMS

• Complications of Surgery: Getting Out of Trouble in the Operating Room

• Abdominal and Pelvic Radiation: Late Management

• Working Together in the Future: Interdisciplinary Surgical Teams

• Management of Geriatric Patients

SPECIALTY SESSIONS

• New Diagnostic Techniques in Colon and Rectal Surgery

• Ventral Hernia/Abdominal Wall Reconstruction

• What’s New in Venous Surgery

• Controversies in Therapy and Management of Symptomatic and Asymptomatic Carotid Occlusive Disease

• Laryngopharyngeal Reflux: Complications and Medical/Surgical Treatment

• Lung Volume Reduction Surgery: Update and Current State of Affairs

• Appendicitis in Children: Issues and Controversies in Diagnosis and Management

• Benign Prostatic Hyperplasia

• Update on Ovarian Cancer Management

ADDITIONAL ACTIVITIES

• Approximately 20 video-based education sessions

• More than 225 leading-edge research papers presented at Surgical Forum and Paper Sessions

• More than 140 peer-reviewed scientific exhibits

• Approximately 300 technical exhibits

• Special program for residents

• Special program for medical students
The Clinical Congress offers a wide variety of postgraduate courses from which to choose. This year, select from 22 skills-oriented (designated by SC) and 19 didactic (designated by PG) courses. Descriptions of each course follow.

**SC 1**

**Breast Imaging for the General Surgeon**

**Chair:** Edward J. Donahue, MD, FACS, Phoenix, AZ  
4 hours  
Sunday, October 10, 8:00 am–12:30 pm  
Fee: $250

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 pathophysiologic findings presented to the image seen.

**SC 2**

**Surgical Education: Principles and Practice**

**Chairs:**  
Mary E. Maniscalco-Theberge, MD, FACS, Washington, DC  
Col. Michael R. Marohn, DO, FACS, Baltimore, MD  
6 hours  
Sunday, October 10, 8:30 am–12:30 pm and 2:00–5:00 pm  
Fee: $300

The objective of this course is to enhance the teaching skills of surgeons active in student and/or resident education. The principles of adult learning, needs assessment, questioning and feedback skills, and performance evaluation will be reviewed. In addition, participants will develop a thorough understanding of how these principles may be applied, both in and out of the operating room.

**SC 3**

**Vascular Ultrasound**

**Chair:** David C. Han, MD, FACS, Hershey, PA  
5 hours  
Sunday, October 10, 12:00 noon–5:30 pm  
Fee: $800

(Due to limited seating and workshop capacity, early registration is encouraged.)

Prerequisite: Registrants must have completed a course in basic ultrasound in order to register for this course. Three options are available to meet the prerequisite: (1) completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons; (2) completion of the new CD-ROM course, Ultrasound for Surgeons: The Basic Course, which is available for purchase online (www.facs.org) in the ACS Publications and Services Catalog or by contacting the ACS Customer Service Department at 312/202-5474; or (3) completion of a comparable course elsewhere. Please include the following with your registration form: (1) continuing medical education (CME) certificate; (2) certificate of completion; and (3) registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to
obtain the proper documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to provide the practicing surgeon and surgical resident with core education and training in the indications, techniques, advantages, and limitations of ultrasound examinations in the diagnosis and treatment of patients with vascular diseases. Emphasis is given to those procedures that require some surgeon participation in image acquisition, such as intraoperative ultrasound. The surgeon should be able to obtain optimal images to improve therapy and direct treatment in the operative setting.

### SC 4

**Advanced Stereotactic Breast Biopsy**  
**Chair:** Richard E. Fine, MD, FACS, Marietta, GA  
4 hours  
Sunday, October 10, 1:00–5:30 pm  
Fee: $300

This course has been designed to provide surgeons who are already using stereotactic breast biopsy with the requisite number of CME hours required for the stereotactic recredentialing process. Topics will be discussed didactically and in interactive case presentation format. This four-hour course will stress practical solutions to targeting dilemmas, in-depth mammographic lesion analysis, mammographic/pathologic correlation, and image-guided intervention—the rationale for stereotactic vs. ultrasound-guided biopsy.

### SC 5

**Ultrasound Instructors Course**  
**Chairs:**  
Reid B. Adams, MD, FACS, Marietta, GA  
Col. Michael R. Marohn, DO, FACS, Baltimore, MD  
4 hours  
Monday, October 11, 8:00 am–12:00 noon  
Fee: $100

Prerequisite: Approval by the National Ultrasound Faculty Vice-Chair for Education; application required. E-mail Kathy Johnson at kjohnson@facs.org for additional information.

The course is designed to provide the experienced surgeon sonographer with the skills necessary to teach ultrasound to surgical residents at the local level and to practicing surgeons at the national level.

### SC 6

**Stereotactic Breast Biopsy**  
**Chair:** Arthur G. Lerner, MD, FACS, White Plains, NY  
8 hours  
Monday, October 11, 8:00 am–12:00 noon and 1:00–5:15 pm  
Fee: $800

(Due to limited seating and workshop capacity, early registration is encouraged.)

The objective of this course is to introduce the surgeon 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 analysis of stereotactic vs. other alternatives, will be presented. It is highly recommended that the skills-oriented postgraduate course Breast Imaging for the General Surgeon be taken prior to this course.

### SC 7

**Head and Neck Ultrasound**  
**Chair:** Robert A. Sofferman, MD, FACS, Burlington, VT  
7 hours  
Monday, October 11, 8:30 am–12:00 noon and 1:00–5:00 pm  
Fee: $800

(Due to limited seating and workshop capacity, early registration is encouraged.)

Prerequisite: Registrants must have completed a course in basic ultrasound in order to register for this course. Three options are available to meet the prerequisite: (1) completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons; (2) completion of the new CD-ROM course, Ultrasound for Surgeons: The Basic Course, which is available for purchase online (www.facs.org) in the ACS Publications and Services Catalog or by contacting the ACS Customer Service Department at 312/202-5474; or (3) completion of a comparable course elsewhere. Please include the following with your registration form: (1) CME certificate; (2) certificate of completion; and (3) registration confirmation/verification. If
you do not have one of these documents, please contact the organization that sponsored the course to obtain the proper documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to provide the practicing surgeon with knowledge and practical skills in the application of diagnostic and interventional head and neck ultrasound. The program will consist of lectures and hands-on skill stations, using a variety of ultrasound equipment. Live model and phantom moulages will be used to develop skills in head and neck ultrasound imaging and ultrasound-guided head and neck biopsy.

### SC 8

**Ultrasound in the Acute Setting**

**Chair:** Mark G. McKenney, MD, FACS, Miami Beach, FL  
7 hours  
Monday, October 11, 8:00 am–12:00 noon and 1:00–5:00 pm  
Fee: $850  
(Due to limited seating and workshop capacity, early registration is encouraged.)

**Prerequisite:** Registrants must have completed a course in basic ultrasound in order to register for this course. Three options are available to meet the prerequisite: (1) completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons; (2) completion of the new CD-ROM course, Ultrasound for Surgeons: The Basic Course, which is available for purchase online (www.facs.org) in the ACS Publications and Services Catalog or by contacting the ACS Customer Service Department at 312/202-5474; or (3) completion of a comparable course elsewhere. Please include the following with your registration form: (1) CME certificate; (2) certificate of completion; and (3) registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain the proper documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

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.

### SC 9

**Bedside Procedures Workshop**

**Chair:** George C. Velmahos, MD, FACS, Los Angeles, CA  
7.5 hours  
Monday, October 11, 8:00–11:30 am and 1:00–5:30 pm  
Fee: $850

The objective of this workshop is to teach surgeons how to perform three bedside procedures: percutaneous dilational tracheostomy, percutaneous endoscopic gastrostomy, and percutaneous vena caval filter placement. Bedside procedures have proven 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, while 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.

### SC 10

**Computers in Surgery: Creating a Scientific Presentation**

**Chair:** David A. Krusch, MD, FACS, Rochester, NY  
3.5 hours  
Workshops (choice of one):  
(10a) Monday, October 11, 9:45 am–1:15 pm  
(10b) Monday, October 11, 2:00–5:30 pm  
Fee: $375

The objective of this course is to provide the advanced computer user with instruction in creating a successful scientific presentation using PowerPoint™, electronically manipulating still and moving images for presentation, improving presentation skills, and publishing the presentation on the Web. The course will focus primarily on advanced PowerPoint techniques and is designed to enhance the ability of the surgeon in the presentation and publication of scientific material in electronic format. As a prerequisite, participants
should understand basic computer concepts and be familiar with PowerPoint. This three-and-one-half-hour course will be presented entirely in a workshop format and without a lecture component.

**SC 11**

**Foundations in CPT and ICD-9-CM Coding**

**Chair:** Albert Bothe, Jr., MD, FACS, Chicago, IL

6 hours

Monday, October 11, 9:45 am-12:45 pm and 2:00-5:30 pm

Fee: $350

This basic course will focus on introducing the participant to Current Procedural Terminology (CPT), ICD-9-CM, and evaluation and management (E&M) coding principles. The participant will use office and hospital notes to determine the appropriate components of the three required elements. At the conclusion of the course, participants will understand the differences between coding and reimbursement principles and how to navigate the diagnosis sections of ICD-9-CM and the American Medical Association's CPT manual. They will be able to describe the key components for choosing CPT E&M codes and use diagnosis and CPT coding principles to ensure clean claim submission. Participants are required to bring their copy of *Current Procedural Terminology (CPT) Coding*, 2004 edition.

**SC 12**

**Computers in Surgery: Basic Course**

**Chair:** David A. Krusch, MD, FACS, Rochester, NY

6.5 hours

Lecture: Monday, October 11, 9:45 am-12:45 pm; Workshop: Tuesday, October 12, 8:30 am-12:00 noon

Fee: $425

The objective of this course is to teach basic personal computer techniques to the beginning user. A lecture session, as well as a hands-on workshop, will provide the practicing surgeon with a practical working knowledge of current concepts. The course content will include an introduction to basic PC hardware and concepts, types and methods of Internet connectivity, remote access to clinical data, medical knowledge-based searching techniques, and medical resources available on the Internet. Upon successful completion of the course, participants should be able to choose appropriate personal computers and use the Internet to enhance professional productivity. Participants are required to attend both the lecture and the workshop.

**SC 13**

**Breast Ultrasound**

**Chairs:**

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

Mark A. Gittleman, MD, FACS, Allentown, PA

7.5 hours

Tuesday, October 12, 8:00 am-12:00 noon and 1:00-5:00 pm

Fee: $1,000

(Due to limited seating and workshop capacity, early registration is encouraged.)

Prerequisite: Registrants must have completed a course in basic ultrasound in order to register for this course. Three options are available to meet the prerequisite: (1) completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons; (2) completion of the new CD-ROM course, Ultrasound for Surgeons: The Basic Course, which is available for purchase online (www.facs.org) in the ACS Publications and Services Catalog or by contacting the ACS Customer Service Department at 312/202-5474; or (3) completion of a comparable course elsewhere. Please include the following documents with your registration form: (1) CME certificate; (2) certificate of completion; and (3) registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain the proper documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

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.

**SC 14**

**Abdominal Ultrasound: Transabdominal/Intraoperative/Laparoscopic**

**Chairs:**

Maurice E. Arregui, MD, FACS, Indianapolis, IN

Junji Machi, MD, PhD, FACS, Honolulu, HI

12 hours
Prerequisite: Registrants must have completed a course in basic ultrasound in order to register for this course. Three options are available to meet the prerequisite: (1) completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons; (2) completion of the new CD-ROM course, Ultrasound for Surgeons: The Basic Course, which is available for purchase online (www.facs.org) in the ACS Publications and Services Catalog or by contacting the ACS Customer Service Department at 312/202-5474; or (3) completion of a comparable course elsewhere. Please include the following documents with your registration form: (1) CME certificate; (2) certificate of completion; and (3) registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain the proper documentation. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to provide the practicing surgeon and surgical resident with advanced education and training in abdominal ultrasound, including transabdominal, intraoperative, and laparoscopic ultrasound, as they are used in the diagnosis and treatment of abdominal diseases. This one-and-one-half-day course will consist of lectures and individual hands-on sessions. Human models, live animals, excised livers, and phantom moulages will be used to develop skills in abdominal ultrasound imaging and ultrasound-guided procedures. Endoscopic ultrasound and anorectal ultrasound will also be discussed.

**SC 15**

**Mastering Surgical and Office-Based Coding**

**Chair:** John T. Preskitt, MD, FACS, Dallas, TX

6 hours

Tuesday, October 12; 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: $350

This course will build on and apply the coding principles discussed in the foundations course (SC11) to surgical scenarios. These concepts will be expanded to include Medicare reimbursement rules and guidelines for surgical coding. Participants will apply the skills learned to coding hands-on surgical case scenarios, including vascular access, coding for breast surgery and reconstruction, gastrointestinal endoscopy, colon surgery, vascular cases, gallbladder, lesions, and wound repairs. At the conclusion of the course, participants will understand the AMA’s definition of the surgical package, Medicare’s definition of the global surgical package, and when to apply modifiers to surgical procedures and office encounters. They will also be able to identify the items on explanation of benefits forms that physicians should review, and to analyze physician profiles and identify profiles that may pose risk to the physician or practice. Participants are required to bring their copy of Current Procedural Terminology (CPT) Coding, 2004 edition.

**SC 16**

**Bariatric Surgery Primer**

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

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

16 hours

Tuesday, October 12; 8:00 am–4:40 pm and 6:30–8:45 pm;

Wednesday, October 13, 8:00 am–5:30 pm

Fee: $850

This intense, two-day course will feature didactic presentations, panels, and live, interactive, closed-circuit televised 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 possible postoperative complications and their appropriate management and prevention strategies. In addition, principles underlying a multidisciplinary approach to bariatric surgery and the consequences of post-bariatric weight loss will be discussed. Live, interactive, closed-circuit
televised 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 relating to bariatric surgery and the ethical perspectives on elective surgery for metabolic disease. A special evening presentation by an international expert and dinner are included in the course.

SC 17

Laparoscopic and Hand-Assisted Laparoscopic Colon Resection

Chair: Deborah A. Nagle, MD, FACS, Philadelphia, PA

Lecture only, 5 hours; Entire course, 12 hours

Lecture: Monday, October 11, 9:45 am–12:00 noon and 1:00–4:30 pm
Lab: Tuesday, October 12, 8:00 am–12:00 noon and 1:00–5:00 pm

Fee for lecture portion: $375
Fee for entire course: $1,200

(Due to limited seating and workshop capacity, early registration is encouraged.)

Prerequisite for the entire course: Approval by the course chair; application required. To participate in the entire course, including the cadaveric portion, surgeons must complete an application and should have performed at least 100 laparoscopic operations, such as cholecystectomy, fundoplication, hernia, or appendectomy. E-mail Kathy Johnson at kjohnson@facs.org for additional information and an application.

The objective of this course is to increase participants’ knowledge and skill in laparoscopic colon surgery and to support and practice the acquisition of more advanced laparoscopic skills, such as hand-assisted laparoscopic colon resection.

The course participant will: (1) review anatomy of the intestine as it relates to laparoscopic resection; (2) learn hand-access laparoscopic techniques and understand how to use HAL as a bridge to more advanced laparoscopic skills; (3) learn laparoscopic techniques for bowel mobilization and devascularization; (4) learn laparoscopic techniques for extracorporeal and intracorporeal anastomoses; and (5) recognize and review surgical oncology principles as they apply to laparoscopic intestinal resection. Surgeons may register for the didactic portion of the course if they are interested in entry-level laparoscopic skills.

SC 18

The Basics of Handheld PDA Devices for Surgeons

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

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

6.5 hours
Lecture: Tuesday, October 12, 1:30–5:00 pm
Workshop (Choice of one):
(18a) Wednesday, October 13, 8:30 am–12:00 noon
(18b) Wednesday, October 13, 1:30–5:00 pm
Fee: $425

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

SC 19

Mammogram Interpretation and Clinical Application for General Surgeons

Chair: Darius S. Francescatti, MD, FACS, Chicago, IL

5 hours
Tuesday, October 12, 8:00 am–1:30 pm
Fee: $325

This one-day course will emphasize the acquisition of fundamental skills in viewing and analyzing the normal mammogram. Similarly, in a stepwise fashion, the characteristics of the abnormal mammogram will be delineated and categorized into abnormal patterns of calcifications, nodular densities, asymmetry, and architectural distortion. Pathologic image correlation of presented material will be stressed. The clinical correlation of the mammographic image and the selection of biopsy techniques will be included. Breast sonography, a vital component in the analysis of image-detected breast cancer, will be incorporated into clinical scenarios to more closely parallel and reflect the decision process faced by general surgeons in practice today. The important aspects of formulating clinical treatment plans based on mammographic and sonographic findings will be facilitated and reinforced by interactive case presentations between course participants and a panel of surgical experts in the field of breast surgery.
Lymphatic Mapping and the Significance of Sentinel Node Biopsy

CHAIR: Armando E. Giuliano, MD, FACS, Santa Monica, CA
7 hours
Wednesday, October 13, 8:00 am–12:00 noon and 1:00–5:00 pm
Fee: $400

The objective of this course is to teach basic intellectual and practical aspects of sentinel lymph node dissection. Participants will learn about the use of sentinel node biopsy for melanoma and breast cancer. They will learn different techniques to perform the procedure and will understand the use of radioisotopes and lymphoscintigraphy. In addition, the histopathologic evaluation of sentinel nodes and the controversies surrounding special techniques will be discussed.

Endocrine Surgery

CHAIR: Quan-Yang Duh, MD, FACS, San Francisco, CA
6 hours
Monday, October 11, 9:45 am–12:45 pm and 2:00–5:30 pm
Fee: $300

The objective of this course is to provide a thorough summary and review of recent developments in the diagnosis and management of patients who need surgical therapy for thyroid, parathyroid, adrenal, and endocrine pancreas disorders.

Advanced Breast Ultrasound

CHAIR: Richard E. Fine, MD, FACS, Marietta, GA
7 hours
Wednesday, October 13, 8:00 am–5:30 pm
Fee: $800

Prerequisite: Approval by course chair; application required. E-mail Kathy Johnson at kjohnson@facs.org for additional information.

The didactic portion of this new course is designed to provide the physician currently using breast sonography in clinical practice with an advanced understanding of ultrasound to more effectively use this imaging modality. The practice incorporation of ultrasound guidance with innovative new devices for the diagnosis and treatment of breast cancer in both the office setting and the operating room will be stressed. Image to pathologic correlation and new pathologic diagnostic indications will be presented. The use of three-dimensional breast ultrasound in the evaluation of breast tumors will be discussed. At the conclusion of this part of the course, faculty, as a panel, will address questions relating to the topics discussed. Faculty will be available throughout the course to answer questions individually.

The workshop session will focus on providing an in-depth understanding of ways to improve the ultrasound image quality based on the machine settings and tools. Practical understanding of the use of ultrasound with both established and new technology will be emphasized. Workstations will also highlight the use of three-dimensional sonography, cryoablation, cryo-assisted tissue sampling, vacuum-assisted devices for treatment and diagnosis of breast lesions, and ultrasound-assisted placement of radiation catheter implants for localized brachytherapy following lumpectomy.

SESAP 12 in Clinical Decision Making

CHAIR: John A. Weigelt, MD, FACS, Milwaukee, WI
9 hours
Monday, October 11, 8:30 am–12:00 noon and 1:30–5:00 pm;
Tuesday, October 12, 8:30 am–12:00 noon
Fee: $475

Three sessions are planned in which a case-based approach will be used to illustrate the value of the Surgical Education and Self-Assessment Program (SESAP) information for making clinical decisions. Panel moderators will present complicated cases to a panel of experts for review and discussion, concentrating on topics covered in SESAP 12. After each case discussion, the moderator will summarize the case and reference the pertinent questions in SESAP 12.

Diseases of the Liver, Biliary Tract, and Pancreas

CHAIR: Keith D. Lillemoe, MD, FACS, Indianapolis, IN
6 hours
Monday, October 11, 9:45 am–12:45 pm;
Tuesday, October 12, 8:30 am–12:00 noon
Fee: $400
This course will focus on the diagnosis and management of benign and malignant lesions of the pancreas. The objective of this course is to update participants on the etiology, pathophysiology, diagnosis, and treatment, both surgical and nonsurgical, of patients with diseases of the pancreas. A number of innovative approaches, especially in diagnostics and therapeutics, as well as the evolution of surgical operations in this complicated area, will be presented. A multidisciplinary systems approach, including medicine, surgery, radiology, and other subspecialties, will be presented.

PG 25

Vascular Surgery: Controversies in Vascular and Endovascular Surgery
CHAIR: Joseph L. Mills, MD, FACS, Tucson, AZ
6 hours
Monday, October 11, 1:30–5:00 pm; Tuesday, October 12, 1:30–5:00 pm
Fee: $350

Vascular surgery is undergoing a major paradigm shift from major open operative procedures to minimally invasive endovascular interventions. The objective of this course is to provide a detailed current update and prognosis for the future with respect to major interventions for cerebral, aortic, visceral, and lower extremity arterial diseases as well as for venous thromboembolic disease. It has been estimated that 50 to 90 percent of standard open operations performed in the 1980s and 1990s have already been or will soon be replaced by endovascular approaches. Which endovascular techniques are here to stay, which open operations are destined for extinction, and how does a vascular surgeon gain and maintain competence in this rapidly evolving field? Cutting-edge techniques for carotid intervention with cerebral embolic protection; advances in aortic endografts, including thoracic and branched grafts, management of complex lower extremity occlusive disease with cutting balloons, subintimal angioplasty, and small-caliber stents; and lytic therapy with retrievable IVC filters for deep vein thrombosis will be among the topics covered.

PG 26

Gastrointestinal Disease
CHAIR: Desmond H. Birkett, MD, FACS, Burlington, MA
6 hours

Monday, October 11, 1:30–5:00 pm; Tuesday, October 12, 1:30–5:00 pm
Fee: $400

This course will focus on the diagnosis and management of benign and malignant lesions of the upper gastrointestinal tract, including the esophagus, stomach, and duodenum. The objective of this course is to enable the participant to learn and be aware of current treatments of surgical gastrointestinal disease, as well as the medical therapies that pertain to them. In addition, emphasis will be placed on the diagnosis, especially the highly technical aspect, of the etiology and investigation of upper gastrointestinal disease as they apply to patients who may be candidates for surgery.

PG 27

Thoracic Surgery
CHAIR: Richard I. Whyte, MD, FACS, Stanford, CA
6 hours
Monday, October 11, 1:30–5:00 pm; Tuesday, October 12, 1:30–5:00 pm
Fee: $400

The purpose of this course is to provide an update on current issues facing the field of thoracic surgery. Topics to be covered include clinical controversies, emerging procedures, current educational challenges facing the field, and translational medicine as applied to thoracic surgery.

PG 28

Controversial Issues in Trauma
CHAIR: Thomas M. Scalea, MD, FACS, Baltimore, MD
6 hours
Tuesday, October 12, 8:30 am–12:00 noon and 1:30–5:00 pm
Fee: $400

Current controversies and difficult challenges in resuscitation and management of the injured patient will be discussed in a series of sessions. The topics are divided into operative and nonoperative. Nonoperative topics include: (1) hypothermia; (2) FAST vs. computed tomography [CT] for blunt abdominal trauma; (3) observation vs. angiography for blunt splenic injury; (4) different types of angiography for blunt carotid injury; (5) factor VIIa; and (6) targeted resuscitation strategies. Operative topics include: (1) combined bony and vascular injuries; (2) venous injuries; (3) ED thorac-
otomy; (4) surgery for liver injuries; (5) colostomy for colonic injuries; and (6) damage control.

PG 29

Colon and Rectal Surgery: Benign Colorectal Disease
CHAIR: Jan Rakinic, MD, FACS, Springfield, IL
6 hours
Tuesday, October 12, 8:30 am–12:00 noon and 1:30–5:00 pm
Fee: $300

After completing this course, participants should have a working understanding of the: (1) evaluation of constipation and treatment options; (2) incidence, diagnosis, and therapy of emerging colorectal diseases; and (3) evaluation and management of specific urgent colorectal problems seen in consultation.

PG 30

Cardiac Surgery
CHAIR: Keith A. Horvath, MD, FACS, Chicago, IL
6 hours
Tuesday, October 12, 8:30 am–12:00 noon;
Wednesday, October 13, 1:30–5:00 pm
Fee: $350

The objective of this course is to provide practicing cardiac surgeons and residents in training with current information on timely topics in myocardial revascularization, surgery of the mitral and aortic valves, and surgery for congenital heart disease.

PG 31

Optimal Outcomes to Maintain a Competitive Edge
CHAIR: Robin S. McLeod, MD, FACS, Toronto, ON
6 hours
Tuesday, October 12, 8:30 am–12:00 noon;
Wednesday, October 13, 8:30 am–12:00 noon
Fee: $275

In recent years there has been an increased emphasis on the need to assess outcome in the practice of surgery. Not only do surgeons need to know the evidence supporting the use of certain procedures and treatments, but they also need to know the outcomes achieved by themselves and their hospitals. Certain skills are necessary in order to evaluate the literature and assess one's own results. The objectives of this course are to: (1) provide surgeons with the skills necessary to practice evidence-based medicine; (2) demonstrate how to measure outcome and how to use these data to improve outcome; and (3) indicate the tools that are available to assist surgeons to practice evidence-based medicine and to assess their own outcome.

PG 32

Breast Disease
CHAIR: Sally M. Knox, MD, FACS, Dallas, TX
6 hours
Tuesday, October 12, 1:30–5:00 pm;
Wednesday, October 13, 1:30–5:00 pm
Fee: $350

Surgical diagnosis and management of breast diseases have been the focus of research efforts and new technology during the past decade. As knowledge has increased regarding tumor biology and genetics, new technology has emerged for diagnosis, ablation, and surgical management. The participant will, after attending the course, be familiar with the various combinations and permutations in the treatment of malignant and premalignant breast disease, including a review of the latest randomized trials and emerging treatments and technologies for managing breast cancer.

PG 33

Career Development
CHAIR: M. Margaret Kemeny, MD, FACS, Jamaica, NY
6 hours
Tuesday, October 12, 1:30–5:00 pm;
Wednesday, October 13, 8:30 am–12:00 noon
Fee: $125

The objective of this course is to support the career advancement of young faculty members, with special emphasis on women faculty. At the end of the course, participants will be able to: (1) develop a plan for their career advancement; (2) manage their time more effectively; and (3) enhance their negotiating skills to obtain the resources needed for their academic activities.

PG 34

Vexing Problems in Minimally Invasive Surgery: Evidence, Experience, and Innovation
CHAIR: John G. Hunter, MD, FACS, Portland, OR
The common problems facing laparoscopic surgeons have largely been solved, but certain clinical, social, and political issues facing laparoscopic surgery continue to be vexing. This course seeks to develop several case studies that represent a spectrum of such problems. Course faculty will lead the discussion with an evidence-based analysis of the problem, a discussion of personal experience dealing with similar cases, and some innovative solutions. Course registrants are encouraged to submit cases that they would like to discuss. Illustrative cases must be sent electronically in their entirety (with X rays in digital format) to the course chair (hunterj@ohsu.edu) by September 15, 2004, to be considered for presentation.

PG 35

Pediatric Recertification Exam Preparation: Oncology and Critical Care

Chair:
- Michael P. LaQuaglia, MD, FACS, New York, NY
- Samuel D. Smith, MD, FACS, Little Rock, AR

6 hours
Tuesday, October 12, 8:30 am–12:00 noon and 1:30–5:00 pm
Fee: $400

This interactive course is designed to help prepare pediatric surgeons for the recertification examination in pediatric surgery. The faculty will primarily review topics in oncology and neonatal and pediatric critical care relevant for pediatric surgeons. The course will also provide a useful update for other surgeons who care for children.

PG 36

Urology Review for Recertification Candidates

Chair:
- Richard D. Williams, MD, FACS, Iowa City, IA
- Jerome P. Richie, MD, FACS, Boston, MA

6 hours
Tuesday, October 12, 8:30 am–12:00 noon and 1:30–5:00 pm
Fee: $275

This course will help participants prepare for the recertification examination in urology. Faculty will review five domains of urology: pediatric urology; oncology and urinary diversion; obstruction, calculus disease, and trauma; impotence, infertility, and infection; and incontinence and voiding dysfunction.

PG 37

Contemporary Treatment of the Pressure Sore Patient

Chair:
- Linda G. Phillips, MD, FACS, Galveston, TX

6 hours
Wednesday, October 13, 8:30 am–12:00 noon and 1:30–5:00 pm
Fee: $275

Prevention and treatment of pressure sores continues to be a difficult chronic health burden. This course will review the measures for prevention of the pressure sore and the evaluation and treatment of the entire scope of the problems that patients with pressure sores have. Clinical interventions, including topical biologicals, dressings, and surgical intervention, will be discussed. Evaluation of concomitant medical problems, such as malnutrition, neurogenic bladder, spasticity, osteomyelitis, and other medical problems, will be discussed. Guidelines for selecting the optimal surgical intervention for specific pressure sores will be offered. Participants are invited to present difficult cases.

PG 38

Technical Aspects of Exposure and Operative Management of Major Injuries

Chair:
- Demetrios Demetriades, MD, FACS, Los Angeles, CA

6 hours
Wednesday, October 13, 8:30 am–12:00 noon and 1:30–5:00 pm
Fee: $400

This session will provide practical guidelines regarding exposure and technical approaches to the repair of serious injuries of various body areas (neck, chest, abdomen, vessels).

PG 39

Surgical Infection and Antibiotics

Chair:
- Donald E. Fry, MD, FACS, Albuquerque, NM

6 hours
Wednesday, October 13, 1:30–5:00 pm;  
Thursday, October 14, 8:30 am–12:00 noon  
Fee: $275

The proliferation of antibiotics, as well as their various specificities, has made infectious disease a surgical subspecialty over the past 20 to 30 years. This course will focus on the contemporary use of antibiotics in surgery. Emphasis will be placed on the proper use of antibiotics in prophylaxis, and on new and evolving uses of antibiotics in the management of surgical patients.

Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons

CHAIRS:  
Charles D. Mabry, MD, FACS, Pine Bluff, AR  
Frank G. Opelka, MD, FACS, Boston, MA  
7 hours  
Monday, October 11, 8:00 am–12:00 noon and 1:00–5:00 pm  
Fee: $450

This educational seminar is designed for surgeons interested in improving the management and efficiency of their surgical practices. The course will include lectures as well as skills laboratories, in which participants will work with the instructors to solve real-life practice management problems.

Health Care Leadership: An Adaptation of Aviation Team Training to Surgery

CHAIRS:  
Jack Barker, PhD, Miami, FL  
Donald W. Moorman, MD, FACS, Boston, MA  
6 hours  
Wednesday, October 13, 8:30 am–12:00 noon and 1:30–5:00 pm  
Fee: $400

Approximately 25 years ago, mechanically sound aircraft were crashing because of crew errors. To reduce these errors, crew resource management (CRM) training, which emphasizes leadership and teamwork skills, was initiated. This course will introduce surgeons and other team members, such as anesthesiologists and nurses, to the techniques that will help them to reduce errors. Topics will include team functioning and leadership models, communication techniques, error science, mental models, preoperative and postoperative briefings, competence, and a just culture of account-
SCIENTIFIC PROGRAM REGISTRATION

Register Online & Save Time—www.facs.org

American College of Surgeons
90th Annual Clinical Congress
New Orleans, LA
October 10–14, 2004
Register online at
www.facs.org
or
Mail to:
American College of Surgeons
Attn: Registration Services
PO Box 92340
Chicago, IL 60675-2340
or
Fax to:
800/682-0252 or
312/202-5003

SPECIALTY

- SUR - General Surgery
- THO - Cardiothoracic Surgery
- CRS - Colon & Rectal Surgery
- OBG - Gynecology & Obstetrics
- NEU - Neurological Surgery
- OPT - Ophthalmic Surgery
- ORT - Orthopaedic Surgery
- ORL - Otolaryngology
- PED - Pediatric Surgery
- PLA - Plastic & Maxillofacial Surgery
- URO - Urology
- VAS - Vascular Surgery
- Other: ___________________

The deadline for advance registration is August 27 for U.S. registrants and August 6 for international registrants.

Cancellation deadline: August 27 for U.S. registrants and August 6 for international registrants. Refunds will not be issued after these dates.

Do not include hotel deposit with this form. It will delay your reservation.

Check here if ADA (Americans with Disabilities Act) accommodation is desired. An ACS staff person will contact you.

Daytime Phone: ______________________

Category

1. Fellow of the American College of Surgeons No fee No fee
2. Initiate No fee No fee
3. Associate Fellow No fee No fee
4. Resident Member No fee No fee
5. Medical Student—Member No fee No fee
6. Surgical Resident—with verification letter* $215 $240
7. Guest Physician (U.S.)* $590 $640
8. Guest Physician (international)* $590 $640
9. Medical Student—Nonmember* $20 $20
10. Hospital Administrator (non-M D ) $250 $300
11. Hospital Purchasing Agent $250 $300
12. Medical Association Personnel $250 $300
13. Nurse $250 $300
14. Surgical Assistant $250 $300
15. Surgical Technician $250 $300
16. PhD $590 $640
17. Social Program $50 $75
18. Commercial Press $440 $490

Registration Subtotal $ _______ $_______

Check here if ADA (Americans with Disabilities Act) accommodation is desired. An ACS staff person will contact you.

Daytime Phone: ______________________
Cancellation Policy: Registration and postgraduate course fees will be refunded if a written request is received at the College and postmarked no later than August 6 for international registrants or August 27 for U.S. registrants. A $50.00 handling fee will be retained.

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

Formal, written confirmation will be mailed to all registrants.

Please ensure legibility prior to mailing or faxing.

Payment must accompany registration. Purchase orders are not accepted.

<table>
<thead>
<tr>
<th>POSTGRADUATE COURSES</th>
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<tr>
<td>101 SC 1 Breast Imaging for the General Surgeon $250</td>
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<td>102 SC 2 Surgical Education: Principles and Practice $300</td>
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<td>103 SC 3 Vascular Ultrasound* $800</td>
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<td>104 SC 4 Advanced Stereotactic Breast Biopsy $300</td>
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<td>105 SC 5 Ultrasound Instructors Course* $100</td>
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<td>106 SC 6 Stereotactic Breast Biopsy $800</td>
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<td>107 SC 7 Head and Neck Ultrasound* $800</td>
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<td>108 SC 8 Ultrasound in the Acute Setting* $850</td>
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<td>109 SC 9 Bedside Procedures Workshop $850</td>
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<td>110 SC 10a Computers in Surgery: Creating a Scientific Presentation $375</td>
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<td>111 SC 10b Computers in Surgery: Creating a Scientific Presentation $375</td>
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<td>112 SC 11 Foundations of CPT and ICD-9-CM Coding $350</td>
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<td>113 SC 12 Computers in Surgery: Basic Course $425</td>
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<td>114 SC 13 Breast Ultrasound* $1,000</td>
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<td>116 SC 15 Mastering Surgical and Office-Based Coding $350</td>
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<td>117 SC 16 Bariatric Surgery Primer $850</td>
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<td>118 SC 17 Laparoscopic and Hand-Assisted Laparoscopic Colon Resection</td>
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<td>119 SC 18a Basics of Handheld PDA Devices for Surgeons $425</td>
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<td>121 SC 19 Mammogram Interpretation and Clinical Application for General Surgeons $325</td>
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<td>123 SC 20 Lymphatic Mapping and the Significance of Sentinel Node Biopsy $400</td>
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<td>204 PG 25 Vascular Surgery $350</td>
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<td>206 PG 27 Thoracic Surgery $400</td>
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<td>207 PG 28 Controversial Issues in Trauma $400</td>
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<td>208 PG 29 Colon and Rectal Surgery: Benign Colorectal Disease $300</td>
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<td>209 PG 30 Cardiac Surgery $350</td>
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<td>210 PG 31 Optimal Outcomes to Maintain a Competitive Edge $275</td>
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<td>212 PG 33 Career Development $125</td>
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<td>213 PG 34 Vesicoprostatic Surgery: A New Approach to Malignancy $400</td>
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<td>214 PG 35 Pediatric Recertification Examination Preparation $350</td>
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<td>215 PG 36 Urology Review for Recertification $350</td>
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<td>216 PG 37 Contemporary Treatment of the Pressure Sore Patient $275</td>
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<td>217 PG 38 Technical Aspects of Exposure and Operative Management of Major Injuries $400</td>
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<tr>
<td>219 PG 40 Charting a Sound Course for Surgical Practices $450</td>
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*Requires prerequisite for registration.

Fees payable in U.S. funds to: American College of Surgeons

- Check (enclosed)
- MasterCard
- VISA
- American Express

Card Number ____________________________ Exp. __/___
Card Issued to ____________________________
Signature ____________________________

Registration Subtotal $ __________
PG Course Fee Subtotal $ __________
Total Amount $ __________
Registration is open to all physicians and individuals in the health care professions. Registration includes a name badge, program, and entrance to the exhibits and all sessions other than postgraduate courses. Registered attendees may purchase postgraduate course tickets based on availability. Advance registration is strongly encouraged. Please use one of the following registration options:

- **Internet**—Register online at [www.facs.org](http://www.facs.org). Visa, MasterCard, or American Express payment of all applicable fees must be paid at the time of your online registration.

- **By mail**—Complete and mail the registration form to: American College of Surgeons, Attn: Registration Services, PO Box 92340, Chicago, IL 60675-2340. Payment can be made by check (payable to ACS) or credit card.

- **By fax**—Complete the form and fax to: 800/682-0252 or 312/202-5003. Credit card payments only.

*Payment of applicable fees must accompany the registration form.* Space in postgraduate courses cannot be reserved without payment. All fees are payable in U.S. dollars. Purchase orders are not accepted. If registration is submitted by fax or online, the original form from this program is not required.

Registration confirmation will be mailed to all advance registrants upon processing. Individuals who register online will only receive e-mail confirmation. Prior to the meeting, advance registrants will receive their official name badge, attendance verification card, and postgraduate course ticket(s), if applicable. Course syllabi will be distributed on-site in New Orleans. If advance registration is not possible, bring the completed registration form with proper credentials to on-site registration at the Morial Convention Center. There is no on-site registration fee for Fellows, Initiates, Associate Fellows, Resident and Associate Society members, Medical Student members, and Affiliate members. Postgraduate course tickets may be purchased on-site in New Orleans, subject to availability.

**INITIATES**

Initiates of the ACS will automatically be registered for the Clinical Congress and only need to return the registration form if postgraduate course or social program event tickets are desired. Family members of Initiates do not need to register to attend the Convocation Ceremony only.

**FAMILY/GUESTS**

Accompanying spouses/guests and young adults (16 years or older) may register under the Social Program category, which includes a badge, admittance to the exhibit area, shuttle buses, and all sessions other than postgraduate courses. Social Program registration is not intended for physicians. Spouses and guests who are physicians must register under the appropriate physician category in order to receive CME credit or display physician credentials. The Social Program registration fee is nonrefundable.

**POSTGRADUATE COURSES AND FEES**

Only registered meeting attendees may purchase postgraduate course tickets. Seating capacities are limited, and ticket requests will be filled on a first-come, first-processed basis. All courses require a ticket for admission. Tickets may only be exchanged before the beginning of a course and may only be exchanged for another course. A complete listing of postgraduate courses begins on page 30.
REGISTRATION LOCATION AND HOURS

Registration locations and hours are listed below:

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*Registration unavailable.

REGISTRATION FEES AND CREDENTIALS

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<td>240</td>
</tr>
<tr>
<td>Medical student, nonmember*</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>PhD*</td>
<td>590</td>
<td>640</td>
</tr>
<tr>
<td>Allied health care personnel*</td>
<td>250</td>
<td>300</td>
</tr>
<tr>
<td>Commercial press</td>
<td>440</td>
<td>490</td>
</tr>
<tr>
<td>Social program</td>
<td>50</td>
<td>75</td>
</tr>
</tbody>
</table>

*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 the completed registration form to expedite processing. Residents should obtain a letter from their program director; students should contact their department chairs. Nonmember physicians, allied health personnel, and medical students who pay the applicable registration fees will have their membership application fees waived if they apply for membership by December 31, 2004.

CANCELLATION

Refunds will be issued if written requests are postmarked no later than August 6 for international registrants and August 27 for U.S. registrants. A $50 handling fee will be retained for all refunds. Cancellations and registrations postmarked after the deadline will be ineligible for refunds.

CME CREDIT

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

The American College of Surgeons designates this educational activity for a maximum of 42 Category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

The Clinical Congress Program Book will contain an attendance verification card for recording CME credit. The program book will be available in the registration area.

CONVOCATION & ANNUAL MEETING

The Convocation Ceremony will take place from 6:00 to 8:00 pm, Sunday, October 10, at the Hilton New Orleans Riverside.

The Annual Meeting of Fellows will take place at a new time, from 7:30 to 8:30 am, Thursday, October 14, at the Morial Convention Center.

DEADLINE FOR REGISTRATION

The registration deadline for international registrants is August 6. The deadline for U.S. registrants is August 27. Registrations received and postmarked after the deadlines will be billed according to the pricing structure published on the registration form.

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. You may request a letter from the College welcoming you to the meeting if you feel one will be helpful; contact the International Liaison Section via email at postmaster@facs.org or by fax at 312/202-5001.

VOLUME 89, NUMBER 7, BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
**RAS SYMPOSIUM**

The Resident and Associate Society (RAS) will present Surgical Residents: Student or Employee—And Why It Matters from 1:00 to 4:00 pm, Sunday, October 10. The symposium will address the following important and timely questions: Are surgical residents students with a primary goal of education? Are surgical residents employees with the associated benefits, such as overtime pay and access to child care or pension plans? How do these issues affect surgical training, resident reimbursement, and hospital finances? An open-microphone discussion will include audience participation. For more information, contact the Division of Member Services, Resident and Associate Society staff liaison, Ms. Peg Haar, at phaar@facs.org. Reminder: Please indicate on the registration form that you plan to attend.

**ACS CAREER OPPORTUNITIES**

Visit with HealtheCareers Network representatives to learn how to compose and subsequently post your resume on the ACS Career Opportunities Job Bank at no cost. Additionally, participants will learn how to search for potential job opportunities in their specialty. This unique, interactive online recruitment tool will greatly enhance any job search because it is an integrated network of dozens of the most prestigious health care associations. Posted resumes will be visible to thousands of health care employers nationwide.

You can flag your online Career Opportunities profile indicating plans to attend the 90th Clinical Congress in New Orleans and complete a simple text box with local contact information. The database also helps users match up with employers who have indicated that they will be attending the conference and reply online to their jobs.

**MEDICAL STUDENT PROGRAM**

The College invites medical students to attend the Clinical Congress and to participate in a program that the Division of Education has designed specifically for those individuals who may be interested in pursuing surgery as a career. Sessions with leading surgeon faculty members and residents will include such topics as deciding if surgery is the best career choice, taking the appropriate steps in each year of medical school to be competitive for surgery residency programs, identifying the qualities that program directors want in applicants, asking for letters of recommendation, interviewing successfully, choosing residency programs, preparing to optimize the resident experience, and beginning to consider various surgical specialties and settings in which to practice. Be sure to take advantage of this unique opportunity to interact with other students, residents, program directors, faculty, and surgeons practicing in academe and the community. Early registration is encouraged, as space is limited. Students must be enrolled in an Liaison Committee on Medical Education-accredited medical school to participate. For additional information, please contact Ms. Rosemary Morrison at 312/202-5018 or rmorrison@facs.org. To register, please use the registration form on pages 41-42 or register online at www.facs.org.

**RESIDENTS PROGRAM**

Surgery residents at all PGY levels are invited to participate in a special program that the Division of Education designed to assist with planning for posttraining careers and making the transition from training to practice. Several sessions are planned, focusing on such topics as: financial planning (managing debt and building for the future); pursuing career opportunities as academic or community surgeons; practice management; contracts and negotiation; time management; leadership development; conflict resolution; stress management; and balancing personal and professional commitments. Join residents from other programs and interact with experts who can share techniques for managing the residency experience more effectively and being better prepared for life after residency. For additional information, please contact Ms. Cherylnn Sherman at 312/202-5424 or at csherman@facs.org. Residents must be enrolled in a program accredited by the American Council on Graduate Medical Education to participate. To register, please use the registration form on pages 41-42 or register online at www.facs.org.

**RURAL SURGEONS MEETING**

The Advisory Council for General Surgery Subcommittee on Rural Surgery will hold an open forum during the Clinical Congress. The forum is scheduled for 4:00-5:30 pm, Tuesday, October 12, at the Hilton New Orleans Riverside. The subcommittee was formed after the initial forum in 2003. Its mission statement is, “To improve the patient’s access to quality surgical care in the rural setting by identifying and addressing the needs of surgeons in this unique environment.” The subcommittee hopes to continue to learn more about the particular interests and challenges of rural Fellows in a roundtable discussion about what the College can do for and with our Fellows serving this specialized population.
SENIOR SURGEONS MEETING

The College is sponsoring an open forum during the Clinical Congress for retired surgeons and their spouses to explore the various options available to them in the estate and financial planning arenas. The forum is scheduled for 1:30-3:00 pm, Tuesday, October 12, at the Hilton New Orleans Riverside. This session is sponsored by the Division of Member Services as part of a continuing effort to assist members who are nearing retirement age or those who are currently retired and in need of new ideas and innovative resources to enhance their ability to manage their money now and in the future.

AFFILIATE GROUP FUNCTIONS

Groups planning a social function or business meeting in conjunction with the Clinical Congress will need to make arrangements through the ACS. For more information and to request a function space request form, please contact ACS Convention and Meetings at 312/202-5293.

SHUTTLE BUS SERVICE

Complimentary shuttle bus service will be provided for all registrants at regular intervals between the Morial Convention Center and most designated ACS Clinical Congress hotels. Schedules and routes will be available at the Convention Center and participating hotels.

CLINICAL CONGRESS NEWS

The official Congress newspaper, Clinical Congress News, will be distributed at the Morial Convention Center and at major hotels each morning during the Clinical Congress.

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.

HELP AND INFORMATION CENTER

The Help and Information Center will be located at the Morial Convention Center and will be available during registration hours. Assistance with general information, travel, housing, local information, and a messaging center will be available.

FRIENDS OF BILL W

Friends of Bill W will meet Sunday, October 10, through Wednesday, October 13, from 7:00 to 8:30 pm at the Hilton New Orleans Riverside.

SOCIAL PROGRAM

A Social Program is offered. Participants must pay a nonrefundable fee, which entitles them to attend scientific sessions, view the technical exhibits, purchase event tickets, and use the shuttle service. Registered Social Program spouses and guests will also receive a travel tote bag. Because tour capacities are limited, advance registration is strongly encouraged. For more information, please visit the Web site at www.facs.org.

Important note: All tours will depart from and return to the Hilton New Orleans Riverside. Please arrive at least 15 minutes prior to the scheduled tour time. We strongly recommend comfortable walking shoes for all tours. Unless otherwise indicated, all lunches referred to are included in the price of the tour. Children under 12 years of age are not permitted on Social Program tours.

Registration forms must be received by August 6, 2004 (all international attendees including Canada), or August 27, 2004 (U.S. attendees) in order to receive a badge and tickets prior to the meeting. Registrations received after the deadline will be held for pickup at the on-site registration desk in New Orleans.

TRANSPORTATION

Fly United or Delta and save on airfare to New Orleans. Special meeting saver airfares are available on United or Delta airlines.

Choose from the following savings options:
• Receive 5 percent off lowest applicable domestic published fares.
• Receive 10 percent off the published unrestricted coach fares.

Obtain an additional 5 percent discount on the above fares if tickets are purchased at least 60 days in advance. New: Due to a code share agreement, United discounts may apply to select U.S. Air flights. Please contact United Airlines to inquire about code share arrangements.
Area/zone fares based on geographic location are also available with no Saturday night stay required.

These special discounts are available by calling either the official airline directly or through the ACS Web site.* Be sure you or your travel agent mention(s) the meeting name to which you will be traveling and the ACS file number in order to obtain these special fares.

**United Airlines**  
1-800/521-4041  
7:00 am–10:00 pm (ET)

**Delta Air Lines**  
1-800/241-6760  
8:00 am–11:00 pm (ET)

ACS File 501 CR  
ACS File 201428A

Save time and book your travel online through the ACS Web site. Go to the Clinical Congress page at www.facs.org for further details.

*(Area/zone fares not available through online ticket purchase; please call numbers shown above.)*

**Car rental**

Avis, the official car rental company for the 2004 Clinical Congress, offers convenient locations throughout the New Orleans area. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates and discounts, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

AWD number: B169699

Avis reservations: 1-800/331-1600

Web site: www.avis.com

**GENERAL HOUSING INFORMATION**

**Applying for hotel accommodations**

The following housing procedures apply to all general registrants of the Clinical Congress. If you are a Regent, Officer, Past Officer, Advisory Council Chair, Governor, Recipient of the Distinguished Service Award, or Standing Committee Chair and are applying for the Hilton New Orleans Riverside, please use the special housing application sent to you.

**Housing procedures**

ACS has appointed ITS to coordinate housing for the 90th Annual Clinical Congress. Reservation requests will be processed on a first-come, first-served basis and must be received by **September 10, 2004**. Requests received after this deadline, or after the room blocks are filled, are subject to rate and space availability. Housing requests can be made using one of the following options:

**Phone**—Call the ACS/ITS Housing Bureau at 800/650-6928 or 847/282-2529 between 8:00 am and 5:00 pm CT, Monday through Friday. Credit card deposit only.

**Fax**—Complete the hotel reservation form and fax to 800/521-6017 or 847/940-2386. Credit card deposit only.

**Mail**—Complete the hotel reservation form and mail with check or credit card deposit to: ACS/ITS Housing Bureau, 108 Wilmot Road, Suite 400, PO Box 825, Deerfield, IL 60015.

**Online**—Go to www.facs.org and visit the “Travel Information” page in the Clinical Congress section. Complete the hotel reservation form via the housing link. Credit card deposit only.

Reservations received after the housing deadline of September 10, 2004, or after the room blocks are filled, are subject to space and rate availability.

Please do not send your request directly to the hotel or to the ACS office; doing so will only delay the processing of your request. The ACS/ITS Housing Bureau will send you a reservation confirmation. Please verify your confirmation for accuracy. This is the only confirmation you will receive. If you do not receive a confirmation via e-mail, fax (within 72 hours), or mail (within 14 days) after sending a request, please contact ITS at the numbers indicated above.

**Deposit policies**

All reservations must be accompanied by a deposit check of $175 per room paid by check (payable to “ACS 2004” in U.S. funds drawn on a U.S. bank) or credit card (American Express, VISA, MasterCard, or Discover). The deposit will guarantee your room for late arrival for the day of arrival only. Credit cards will be charged at the time the reservation is made.

**Changes and cancellations**

Do not call or write the ACS office to change or cancel your reservation. Changes to and/or cancellation of your reservation should be made with the ACS/ITS Housing Bureau until September 21, 2004. Beginning September 27, 2004, you must contact the hotel directly to make any changes. Please ask for a confirmation number when canceling or changing your reservation.

Deposits are refundable only if cancellations are made at least 72 hours in advance of the arrival date. Reservations canceled after September 10, 2004, are subject to a $23.50 processing fee. Allow 90 days for processing of your refund.

**New Orleans hotels**

For information about hotel locations and rates, please refer to the program planner sent via mail earlier this month or visit the Web site at www.facs.org.
In compliance...

...with the fair pay overtime initiative

by the Division of Advocacy and Health Policy

In April 2004, the U.S. Department of Labor issued new overtime “fair pay” rules under Section 13(a)(1) of the Fair Labor Standards Act (FLSA). The regulations take effect August 23, 2004. These rules update the federal regulations for the first time in 50 years and will require many surgeons’ offices to review their employees’ customary duties to determine whether they qualify for nonexempt or exempt status. This article focuses on information contained in the rules that would be of most interest to small surgical practices.

Applicability

The FLSA rules apply to employers that generate $500,000 in annual gross sales. Even if a practice does not meet that test, it probably meets one of the other criteria, such as conducting interstate commerce via telephone. The FLSA generally requires covered employers to pay employees at least the federal minimum wage for all hours worked and overtime premium pay of time-and-one-half the regular rate of pay for all hours worked exceeding 40 in a single workweek. The federal rules require overtime to be paid to anyone earning less than $455 per week or $23,660 per year and apply to all employees who earn up to $100,000 per year. Practicing physicians, residents, and interns, who are defined as professional employees under the FLSA, are exempt from the overtime rules. The rules also do not apply to workers covered by labor contracts. If a state’s overtime law has provisions that differ from the federal FLSA, a practice must comply with the standard most protective to employees.

The FLSA provides exemption categories from overtime pay for employees who are employed as bona fide administrative and learned professional employees. To qualify for these exemptions, employees generally must be paid a salary (a predetermined amount each pay period) or a fee (an agreed sum for a single job, regardless of the time required for completion) of not less than $455 per week. The table on page 49 illustrates the jobs that are generally classified as exempt and nonexempt.

Exemptions

To qualify for the administrative employee exemption, the employee’s primary duty must be the performance of office or non-manual work directly related to the management or general business operations of the employer or the employer’s customer, and must include the exercise of discretion and independent judgment with respect to matters significant to the practice. This category may apply to the office manager of a practice.

To qualify for the learned professional employee exemption, the employee’s primary duty must be the performance of work requiring advanced knowledge in a field of science acquired by a prolonged course of specialized intellectual instruction. Registered nurses paid on a salary or fee basis are in this category. Physician’s assistants are also considered learned professional employees, provided that they have successfully completed four academic years of preprofessional and professional study, including graduation from a pro-

Around the corner

- ACS-sponsored basic and advanced coding courses and practice management course for surgeons, July 22-24 in Atlanta, GA. Visit the ACS coding and practice management course Web page at http://www.facs.org/dept/ahp/workshops to register.
- Economedix teleconferences scheduled as follows: Creating An Effective OSHA Compliance Program (July 21 and 24), Practice Valuations... What Is Your Practice Worth? (Aug 4 and 7), and Physician Compensation Formulas of Successful Practices (Aug 18 and 21). For more information and to register, go to http://yourmedpractice.com/ACS-Teleconference.
gram accredited by the Accreditation Review Commission on Education for the Physician Assistant and are certified by the National Commission on Certification of Physician Assistants. Registered or certified medical technologists who have successfully completed three academic years of preprofessional study in an accredited college or university plus a fourth year of professional course work in a school of medical technology approved by the Council on Medical Education of the American Medical Association would generally meet the requirements of this category as well.Licensed practical nurses and health care employees who have limited discretion and little supervisory or administrative duties within a practice do not qualify as exempt learned professionals, and are entitled to overtime pay. Registered nurses who are paid by the hour also are entitled to overtime pay.

There is a specific exemption for computer employees, but it applies only to computer systems analysts, computer programmers, software engineers, or other similarly skilled workers in the computer field. In most cases, such individuals would not be employed in surgeons’ offices.

The instructions for proper and improper deductions from nonexempt and exempt employees’ compensation contained in the FLSA have not changed. To ensure compliance with the FLSA, surgical practices should have a clearly communicated policy that lists improper deductions and a complaint mechanism for employees to use if they believe an improper deduction has been made.

Any nonexempt employee covered by the FLSA who believes that he or she has not been paid the required federal minimum wage (currently $5.15 per hour) or overtime (one-and-one-half times the regular rate of pay for hours worked in excess of 40 in a work week) may file a complaint with the Wage and Hour Division of the U.S. Department of Labor.

The Department of Labor has established a dedicated Web site to provide in-depth information about the fair pay rule at http://www.dol.gov/esa/regs/compliance/whd/fairpay/main.htm. At the Web site, you can download the final rule, fact sheets summarizing the major provisions of the rule, and video seminars that provide detailed information about the rule. In addition, the Web site offers employers and employees the ability to submit questions directly to the Department of Labor Wage and Hour Division and to sign up for any updates of the rule.

This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site. If you would like to see specific topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or e-mail HealthPolicy@facs.org.
Harry J. Buncke, MD, FACS, a plastic surgeon from San Francisco, CA, became the tenth recipient of the Jacobson Innovation Award of the American College of Surgeons during a ceremony June 11, 2004, at the College’s headquarters in Chicago, IL.

Initiated in 1994, the award honors living surgeons or surgical teams who have been innovative in the development of a new technique in any field of surgery. The award is made possible through a donation from Julius H. Jacobson II, MD, FACS, a general vascular surgeon known for his pioneering work in the development of microsurgery. Dr. Jacobson is director emeritus and the Distinguished Service Professor of Surgery at the Mount Sinai School of Medicine of the City University of New York.

Dr. Buncke received the award in honor of his unprecedented work in the field of microsurgery and replantation. Often called “the father of microsurgery,” Dr. Buncke was the first surgeon to perform many microsurgical procedures, including the first great toe-to-thumb transplant in the U.S., the first successful scalp replant in the U.S., the first four-finger replant in the U.S., and the first successful tongue replant in the world. He is currently the director of the division of microsurgical replantation at the Ralph K. Davies Medical Center, San Francisco, CA.

Dr. Buncke received a BS degree from Lehigh University, Bethlehem, PA, and earned an MD degree from the New York Medical College, in 1951. After medical school, Dr. Buncke’s surgical training took him to the Metropolitan Hospital and the Flower and Fifth Avenue Hospital under the Cornell Medical School (1954-1955). He performed a residency in plastic surgery at the Bronx Veterans Administration Hospital (1956), and he was named a Marks Fellow in Plastic and Maxillofacial Surgery at the Queen Victoria Hospital, Sussex, England (1956). He later served as senior registrar in the plastic surgical and burn unit of the Glasgow Royal Infirmary, Glasgow, Scotland (1957).

Since 1975, Dr. Buncke has been the director of the division of microsurgical replantation at the Ralph K. Davies Medical Center, San Francisco, CA. In addition, he has been on the plastic surgery staff at Mills Memorial Hospital, San Mateo, since 1959. He has also served as clinical professor of surgery at the University of California, San Francisco, and as associate clinical professor of surgery at Stanford (CA) University.
Dr. Buncke’s work in the field of microsurgery and re-plantation is extraordinary, and as the first surgeon to execute many microsurgical procedures, he performed the first toe-to-hand transplant in a rhesus monkey (1966), the first microvascular transplant in the world (1969), the first great toe-to-thumb transplant in the U.S. (1972), the first successful scalp replant in the U.S. (1976), the first four-finger replant in the U.S. (1976), the first latissimus seratus transplant (1979), and the first successful tongue replant in the world (1997).

Throughout his distinguished career, Dr. Buncke has remained active in clinical practice and is a member of many prominent surgical societies. He has held leadership roles as the president of the American Society for Surgery of the Hand (1980) and chairman of the International Society of Reconstructive Microsurgery (1977). Besides holding memberships in all of the major U.S. surgical organizations, Dr. Buncke is a member of the French Society of Plastic and Reconstructive Surgeons, the Italian Society of Microsurgery, the Spanish Society of Microsurgery, and the Japanese Society for Hand Surgery.

Dr. Buncke has also been committed to disseminating knowledge about his work throughout the world. He has been visiting professor and has delivered distinguished lectureships at more than 50 institutions, is the author of 15 movies and television tapes, four books, and more than 400 publications. For his work in microsurgery, Dr. Buncke’s efforts have been honored with the Buncke Microsurgical Wing at the Hôpital du Tondu, Bordeaux, France, and the Markowitz Award from the Academy of Surgical Research; and he has been named Professor Honoris Causae from the French Ministry of Education.

The Jacobson Innovation Award is administered by the Honors Committee of the American College of Surgeons. Original thought combined with the first presentation of work that has led to a milestone in the advancement of surgical care is the main criterion for choosing a recipient of the Jacobson Innovation Award.

Jacobson Innovation Award recipients

1994, Professor Francois Dubois, Paris, France: Laparoscopic cholecystectomy.
1995, Thomas Starzl, MD, FACS, Pittsburgh, PA: Liver transplantation.
1996, Joel D. Cooper, MD, FACS, St. Louis, MO: Lung transplantation and lung volume resection surgery.
1998, Juan Carlos Parodi, MD, Buenos Aires, Argentina: Treatment of arterial aneurysms, occlusive disease, and vascular injuries by using endovascular stented graphs.
1999, John F. Burke, MD, FACS, Boston, MA: Development and implementation of a number of innovative techniques in burn care, including the co-development of an artificial skin (Integra™).
2000, Paul L. Tessier, MD, FACS (Hon), Boulogne, France: Development of a new surgical specialty (craniofacial surgery).
2003, Robert H. Bartlett, MD, FACS, Ann Arbor, MI: Pioneer in the development and establishment of the first extracorporeal membrane oxygenation (ECMO) program.

2004, Professor Francois Dubois, Paris, France: Laparoscopic cholecystectomy.
1995, Thomas Starzl, MD, FACS, Pittsburgh, PA: Liver transplantation.
1996, Joel D. Cooper, MD, FACS, St. Louis, MO: Lung transplantation and lung volume resection surgery.
1998, Juan Carlos Parodi, MD, Buenos Aires, Argentina: Treatment of arterial aneurysms, occlusive disease, and vascular injuries by using endovascular stented graphs.
1999, John F. Burke, MD, FACS, Boston, MA: Development and implementation of a number of innovative techniques in burn care, including the co-development of an artificial skin (Integra™).
2000, Paul L. Tessier, MD, FACS (Hon), Boulogne, France: Development of a new surgical specialty (craniofacial surgery).
2003, Robert H. Bartlett, MD, FACS, Ann Arbor, MI: Pioneer in the development and establishment of the first extracorporeal membrane oxygenation (ECMO) program.
New ACS Affiliate membership category established

A new category of membership in the American College of Surgeons has been created for physicians and nonphysicians in the health care field. The new Affiliate category, which is open to physicians (anesthesiologists, emergency medicine physicians, critical care physicians, and radiologists); PhDs, EdDs, and surgical scientists; allied health professionals (nurse practitioners, nurse anesthetists, physician assistants, and registered nurses); office/business managers; and technicians (certified surgical technologists and certified surgical technologist/certified first assistants), was officially approved by the Board of Regents at their February 2004 meeting.

Benefits offered include online access to the Journal of the American College of Surgeons; free registration at the annual Clinical Congress; discounts on selected Lippincott Williams & Wilkins textbooks; health, life, auto, disability, and loan payment insurance policies; an MBNA credit card; discounts on PDAs and computer software; use of the ACS travel agency; access to the “Members Only” side of the ACS Web site; and an official membership card.

Applications must be submitted with a reference letter from a Fellow of the American College of Surgeons along with the application fee, a copy of the applicant’s current license, and/or a copy of the applicant’s current certification.

Details on the application process, application fee, and dues information, as well as an application form, are available at http://www.facs.org/member_services/documents.html, or by contacting ikulyk@facs.org.

Contributions sought for 2005 Residents Trauma Papers Competition

Papers are now being accepted by the ACS Committee on Trauma for the 2005 Residents Trauma Papers Competition, which will be held during the Committee on Trauma’s annual meeting March 3-5, 2005, in Washington, DC.

The papers competition is open to surgical residents and trauma fellows in the U.S., Canada, and Latin America. The papers should describe original research in the area of trauma care and/or prevention categorized in either basic laboratory research or clinical investigation. Papers should be sent to the appropriate ACS state/provincial chair. If the chair is unknown, you may contact the ACS Trauma Office for that information at 312/202-5380.

The papers competition is funded by the Eastern and Western States Committees on Trauma, Region VII Committees on Trauma, Wyeth Pharmaceuticals, and the American College of Surgeons.

Deadline for submission of papers to the region chief is November 15, 2004. Further information can be obtained on the ACS Web Site at http://www.facs.org/trauma/trauma_papers.html, or via e-mail at cmorris@facs.org.
Earlier this year, North American Fellow George K. Gittes, MD, FACS, traveled to the annual meeting of the Japan Surgical Society and the ACS Japan Chapter. The Japan Surgical Society and Japan Chapter have announced their exchange traveler to the ACS Clinical Congress, Takahiro Sato, MD, PhD.

Dr. Sato is a specialist in gastrointestinal surgery and surgical oncology with an academic appointment at Kanazawa University. Dr. Sato will attend the Clinical Congress, make a presentation, and tour several surgical institutions in North America, with guidance from the College’s International Relations Committee.

The ACS Resident Award for Exemplary Teaching recognizes excellence in teaching by a resident and highlights the importance of teaching in the daily lives of residents. Nominations for the 2004 award are currently being sought from surgery and specialty training programs.

The recipient will be selected by an independent review panel of the Subcommittee on Resident Education based on evidence of teaching excellence. The award carries with it a $1,000 stipend and an invitation to attend the Clinical Congress as a guest of the College.

For additional information, please contact Patrice Blair, Associate Director, ACS Division of Education, at csherman@facs.org or 312/202-5220. All nominations must be received by July 16, 2004.

Thomas R. Russell, MD, FACS, ACS Executive Director (left), presented the 2003 Resident Award for Exemplary Teaching to Anthony W. Kim, MD, MS, a resident at Rush Presbyterian-St. Luke’s Medical Center and Cook County Hospital Integrated Training Program, Chicago, IL.

Also pictured are Myriam J. Curet, MD, FACS (second from right), Chair of the Resident Award Program, and Ajit K. Sachdeva, MD, FACS, FRCSC (right), Director, Division of Education.
ACS Traveling Fellowship to Germany available

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

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

Basic requirements
The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:
- Has a major interest and accomplishment in clinical and basic science related to surgery.
- Holds a current full-time academic appointment in Canada or the U.S.
- Is under 45 years of age on the date the application is filed.
- Is enthusiastic and personable and possesses good communication skills.

Activities
The Fellow is required to spend a minimum of two weeks in Germany:
- To attend and participate in the annual meeting of the German Surgical Society, which will be held in Munich, Germany, April 5-8, 2005.
- To attend the German ACS Chapter meeting during that congress.
- To visit at least two medical centers (other than the annual meeting city) in Germany before or after the annual meeting of the German Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons.

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

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

Financial support
The College will provide the sum of $6,000 U.S. to the successful applicant, who will also be exempted from registration fees for the annual meeting of the German Surgical Society.

He or she must meet all travel and living expenses. Senior German Surgical Society and ACS German Chapter representatives will consult with the Fellow about the centers to be visited in Germany, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his own travel arrangements in North America, because doing so will allow him to take advantage of reduced fares and travel packages for travel in Germany.

The ACS International Relations Committee will select the Fellow after review and evaluation of the applications. A personal interview may be requested prior to the final selection. Applications for this traveling fellowship may be obtained on the College's Web site at http://www.facs.org/memberservices/research.html, or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

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

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

For further information, contact Kate Early, International Liaison Division, American College of Surgeons, at 312/202-5281. You may also send requests via fax (312/202-5023) and via e-mail: kearly@facs.org.
The Division of Education of the American College of Surgeons is making 13 sessions from Clinical Congress 2003 available online at: www.acs-resource.org

*Try the online CME program:
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MD07) Postoperative Entero-cutaneous Fistulas
   Moderator: Herand Abcarian, MD, FACS

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*GS10) Patient Safety FREE OF CHARGE
   Moderator: Frank C. Spencer, MD, FACS

For more information, contact Dawn Pagels at dpagels@facs.org.
College receives education research grant

Medical Education Technologies, Inc. (METI), has agreed to provide the American College of Surgeons Division of Education with a grant for $75,000, over a period of three years, to support education research projects involving the development of innovative curricula that include the use of simulations and simulators. Grantees will be selected by an independent, peer-review committee appointed by the College’s Division of Education, and the request for proposals will be sent out in September 2004.

On Tuesday, May 25, 2004, Mr. Louis Oberndorf, president and chief executive officer of METI, presented a check for $25,000 as the first installment of the pledged grant to ACS Executive Director Thomas R. Russell, MD, FACS. Pictured at the ceremony (left to right) are Fred W. Holzrichter, CFRE, Manager of the Development Office; Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the Division of Education; Dr. Russell; Mr. Oberndorf; and Patrice G. Blair, MPH, Associate Director of the Division of Education.

NIH offers research fellowship in vascular surgery

The National Institutes of Health (NIH) has announced the availability of NIH-funded fellowship research for general surgery residents who have an interest in vascular surgery. The residents will spend two years in an established research laboratory in the Harvard-Longwood Medical Area in Boston, MA. Applicants should be U.S. citizens who are resident physicians and have completed either two or three years of clinical post-doctoral experience (surgical residency) or five years of clinical training (that is, are board eligible).

Frank W. LoGerfo, MD, FACS, professor and chief, Beth Israel Deaconess Medical Center, Boston, MA, is the program director for this project. For additional information, visit www.longwoodvascularsurgery.com or contact cottino@bidmc.harvard.edu.
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ACS ultrasound courses go international

Four surgeons from the ACS ultrasound faculty traveled to Germany in April to conduct both the Ultrasound for Acute Care Course and the Breast Ultrasound Course for military surgeons stationed in Europe. This was the first time that these courses have been exported outside of the U.S.

The courses were held at the Landstuhl Regional Medical Center on April 29 and 30, and were attended by 15 surgeons, including members of the U.S. Army, Air Force, and Navy currently stationed in Germany, Spain, and England. Deployed surgeons have found the portable ultrasound units to be extremely valuable, especially in the far forward military hospitals and in other areas where imaging technology is limited.

The courses were supported by Hospital Commander Col. Ronda Corum, who presented Landstuhl Command Coins of Excellence to the visiting faculty. Financial and material support for the courses were provided by Sonosite Inc., and Ethicon Endo-Surgery Inc.

ACS Ultrasound Faculty members included David C. Wherry, MD, FACS, Uniformed Services University of the Health Sciences, MD; Margaret Knudson, MD, FACS, University of California San Francisco; Shawna Willey, MD, FACS, director, Betty Lou Ourisman Breast Health Center at Georgetown University Hospital; and Jon Perlstein MD, FACS, David Grant Medical Center, Travis Air Force Base, CA.

Course participants and faculty, left to right: Front row: Ronald Place, Jeffrey Lawson, and Richard Mayers. Second row: Tyler Putnam, Dr. Wherry, Vijay Bindingnavele, Barbara Bradley, Dr. Knudson, Dr. Willey, Robert Piotrowski, Maria Pla, and Alan Sbar. Back row: John Verghese, Slobodan Jazarevic, Victor Lebedovych, Dr. Perlstein, and Boris Zavadovsky.
to be a surgeon that he decided to get the surgical clerkship out of the way first. But then he was struck by the speed with which he could change a patient’s situation. He also was more comfortable with the surgical personality—the matter-of-fact efficiency: "This person needs this and this and this, so we’ll do this, and it’ll be done,” he says.

Commitment
Each physician is on his or her own track for the future. Dr. Williams plans on an academic career in general surgery with an emphasis on trauma and critical care. Dr. Lewis will be a general surgeon in military practice for the next four years and then enter private surgical practice. Dr. Kibbe will be pursuing her research on nitric oxide. Dr. Winslow is debating whether she will concentrate on minimally invasive surgery or colon and rectal surgery, and Dr. Rose is deciding on a subspecialty fellowship.

The residents all agree that surgical training is demanding. The hours are long—but they were longer before—and the skills are difficult to hone. But they all say that the surgical residency isn’t nearly as bad as people had said it would be, mostly because of the challenge and the excitement, and, yes, the fun of operating. As Dr. Winslow puts it, “Even if you work a lot, you enjoy what you’re doing and keep on learning.”

References
NTDB™ data points

“Small package, big problem”

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

Trauma kills more children than all other diseases combined, and the numbers are staggering. Annually, there are close to 20,000 deaths, approximately 10 million emergency department visits, and over a quarter of a million hospitalizations. An estimated 50,000 children acquire permanent disabilities, most of which are the result of head injury. In addition to the cost in lost lives, the estimated direct annual cost of pediatric trauma approaches $14 billion. The indirect costs, which include lifelong disability and emotional and financial effects on families, are beyond calculation.

With pediatric trauma representing such a tremendous public health issue, it is surprising to find that prior to this report there was not a single accumulation or aggregation of pediatric trauma data that contained anywhere close to the number of cases in the National Trauma Data Bank™ Pediatric Annual Report for 2003. Out of the 731,824 records contained in the NTDB, 131,950 cases represent pediatric records that are 19 years of age or younger. The age distribution of pediatric patients peaks from ages 15 to 19, representing predominantly males injured in motor vehicle crashes and by violence (gunshots, shotguns, stabs, and fights). By the time a child reaches this age group, injured males outnumber females three to one. Depicted on this page is the cover of this new report, which highlights the pediatric subset of patients that are represented by the line in the darker shade of gray surrounded by the rectangle.

Summer is in full swing and children are out of school. Many take to the streets, sidewalks, and trails, peddling their bicycles. According to the national Centers for Disease Control and Prevention (CDC), children are responsible for 59 percent of the more than 500,000 people who are treated in emergency departments annually as a result of bicycle-related injuries.

It is up to all of us to take some simple steps to decrease the injury potential from bicycle-related trauma. The first and foremost is to reinforce the use of properly fitted bicycle helmets with everyone we know or come in contact with. As publicly emphasized by the CDC, bicycle helmets reduce the risk of serious head injury by as much as 85 percent and the risk of brain injury by as much as 88 percent. Another useful approach is to target children’s groups with bicycle safety and helmet use presentations. There is a useful Bicycle Helmet Campaign template with links that was put together by the Committee on Trauma’s Subcommittee on Injury Prevention and which can be found on the College’s Web site at http://www.facs.org/trauma/bicycle.html. It is part of our responsibility as health care providers to pitch in and do our share toward prevention, especially when the cost of not doing it is so high.

Throughout the year we will be highlighting these data through brief monthly reports in the Bulletin. For a complete copy of the NTDB Pediatric Annual Report 2003, visit us online at our new Web address, http://www.ntdb.org. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.
Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at their February 7, 2004 meeting:

- A general surgeon from Wichita, KS, was censured following disciplinary action by the Kansas State Board of Healing Arts for willfully and repeatedly violating the Pharmacy Act of the State of Kansas. He had been charged with violation of the ACS Bylaws, Article VII, Sections 1(b) and (f).

- An otolaryngologist from Cincinnati, OH, was placed on probation with the College until such time as he has a full and unrestricted license to practice medicine; until he has full and unrestricted surgical privileges in an accredited hospital; and until his practice pattern has been reviewed and approved by the Central Judiciary Committee (CJC). This action followed a charge that he had violated Article VII, Sections 1(a) and (f) of the ACS Bylaws. This surgeon was cited by the Ohio Medical Board after two misdemeanor convictions for disorderly conduct and public indecency.

- A vascular surgeon from Los Angeles, CA, was placed on probation for two years and is required to regularly supply the College with updates regarding his practice status and treatment progress. He had previously been charged with violation of ACS Bylaws, Article VII, Sections 1(a) and (f). This surgeon was cited by the California Medical Board for unprofessional conduct following a conviction of corporal injury to a spouse. The conviction was later reduced to misdemeanor status and the surgeon is required to receive regular treatment to address anger management and alcohol abuse issues.

- An orthopaedic surgeon from Carmichael, CA, was placed on probation until such time as he has a full and unrestricted license to practice medicine; until he has full and unrestricted surgical privileges in an accredited hospital; and until his practice pattern has been reviewed and approved by the CJC. He was charged with violation of Article VII, Sections 1(b) and (f) of the ACS Bylaws. This surgeon was found guilty of gross and repeated negligence in the care of six patients by the California Medical Board. His license in that state has been placed on probation for five years with terms and conditions.

- Kenneth Ray Ramach, a general surgeon from Denver, CO, was expelled from the College following the permanent surrender of his license to practice medicine in the State of Colorado in January 2002. This surrender was part of a settlement to avoid formal disciplinary proceedings. Dr. Ramach had been charged with violation of ACS Bylaws Article VII, Section 1(b).

- In October 2003, the Board of Regents expelled Ireneo T. Cadsawan of Westlake, Ohio. This action followed a September 24, 2002, plea of guilty by Dr. Cadsawan to one count of Medicaid fraud, a felony, in the Court of Common Pleas, Criminal Division of Franklin County, Ohio.

- In October 2003, the Board of Regents expelled H. Richard Winn of New York, New York. Dr. Winn pleaded guilty on July 16, 2002, to one felony count of obstructing justice as part of a plea agreement following a lengthy federal criminal investigation involving allegations of Medicare and Medicaid overbilling.
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.

Retirement

I read “Retirement: An opportunity to revisit ‘The road not taken,’” by Thomas Cogbill, MD, FACS (March Bulletin) with great interest, as the author and I are essentially contemporaries. Dr. Cogbill outlines many of the reasons why more and more surgeons are contemplating retirement as they enter their fifties, and he gives sage advice on the best ways to plan for that retirement. It is encouraging to hear that he has decided that he is not yet ready to retire. However, I believe there is a serious problem in surgery today when a surgeon such as Dr. Cogbill, at the peak of his career, should so seriously consider it. The loss of experienced surgeons due to early retirement is probably as great a threat to surgery today as the difficulty of encouraging young, bright medical graduates to enter surgical residencies.

I disagree that health issues are an important instigating factor. While the risk of debilitating illness grows after age 50 (as no doubt evidenced by our medical insurance premiums), a minority of surgeons of that age who retire do so for health reasons. Certainly eye problems are not to be blamed; cataracts are rarely an issue until the late sixties, and while we are all inconvenienced by presbyopia, corrective lens take care of the problem (and also solve the eye protection issue more aesthetically than goggles).

I would argue that surgeons in their fifties are entering their most productive years. They have not yet reached an age when physical disabilities limit their ability, yet have had over 20 years of experience that no amount of training can replace. Of course, as Dr Cogbill points out, they must keep up their skills, learn new ones, and be willing to change as medicine and surgery change. Those surgeons who do so have an experience base that is irreplaceable.

It is therefore unfortunate that more and more surgeons in their fifties are retiring due to what I would call “quality of life” or more exactly “quality of practice” issues. I think it is ironic that so much is now being written and so much effort put into addressing quality of life issues for surgeons in training. Those of us who went through that training over 20 years ago (and, like myself, valued and enjoyed those years of training) now are being asked to work harder, give up more free time, and do more paperwork. There are no benefits for this harder work, neither financial nor in the realm of greater recognition or thanks.

What are our options? Unfortunately, the many pressures on medical practice today, not to mention malpractice and reimbursement issues, make slowing down or part-time practice impossible. Therefore, particularly for those surgeons who have the resources, retirement becomes a good, if not the only, alternative.

Three years ago I found, by chance, my own solution—working in Great Britain. This opportunity affords me a good quality of life, and I can still operate, teach, and undertake research. However, there are few similar options open to most surgeons of my age.

There has been much done to change surgical training to improve the quality of life of the trainees so that more will join the profession. However, I believe it may be just as important to address the “quality of life” issues of those surgeons in the last third of their careers. If we do not do this, we will lose many surgeons who have a significant amount to offer their patients and profession. Finally, all those new surgeons who have been brought on will become very disillusioned when they see what awaits them in their fifties.

Robert A. Reichert, MD, FACS

The article regarding retirement by Dr. Thomas H. Cogbill that appeared in the March Bulletin is an excellent piece. I felt as if Dr. Cogbill had me personally in mind when he wrote the article. You see, I am to retire this year from the College of Medicine, University of Ibadan, Nigeria, where I have been working since 1975 after completing my residency and fellowship programs in surgery in the U.S. It is nice to know that our younger colleagues still have the interests of the older generation in mind.

Thanks for the advice and for being so concerned.

Oluwole Gbolagunte Ajao, MD, FACS

“Year of the resident”

I applaud ACS President Claude H. Organ, Jr., MD, FACS, for proclaiming this the year of the resident (April Bulletin). As we are well aware, society has demanded that competency be periodically assessed. The American Board of Surgery has announced that “maintenance of certification” will require additional work during the 10-year period.

I suggest that the College pick up this ball and run with it. Use the credentialing mechanism for fellowship to assess competency. I would rather see local practicing surgeons involved than academic types sitting in Philadelphia, Chicago, or wherever. The College’s involvement should stimulate young surgeons and trainees to seek and maintain fellowship.

H. Michael Lewis, MD, FACS
ACS comments on anti-referral regulation

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

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

To read the College’s comments online, visit http://www.facs.org/ahp/views/selfreferral.html. For more information, contact ccolgan@facs.org.

Next month in JACS

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

Original Scientific Articles
• Delayed Hemorrhage after Pancreaticoduodenectomy
• Management of Failed Biliary Repairs
• Pancreatic Fistula after Pancreaticoduodenectomy
• Is Emergency Department Thoracotomy Futile Care?

What’s New in Surgery
• General Thoracic Surgery
• Pediatric Surgery