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Physicians are “taking off the gloves” in their battle with managed care organizations (MCOs), and are filing class action lawsuits against several of the insurers. Two of the MCOs, Aetna and CIGNA, decided to settle the cases rather than continue litigating. This month’s cover story describes the Aetna settlement. The CIGNA agreement will be discussed in the August edition of the Bulletin. Cover photo: © Punchstock.
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From my perspective

All surgeons are affected by the workforce issue at some level, whether it’s a matter of trying to recruit a new partner or ensuring that the local hospital has an adequate number of emergency room physicians and trauma surgeons. And, of course, medical schools, training institutions, and the certifying boards need to determine the public’s need for surgeons and physicians of all specialties. So the physician supply issue really is a global one.

Today, concerns about the medical workforce are reemerging, as evidenced by a recent article in the New England Journal of Medicine that examined the ongoing debate over whether we have a surplus or a deficient supply of generalist and specialist physicians.* The workforce issue has been, and continues to be, an important one because it has implications for our entire health care delivery system.

Ongoing topic of debate

In the last few decades, several workforce studies were completed by national medical education panels, including those done by the Graduate Medical Education National Advisory Committee (GMENAC) and the Council on Graduate Medical Education (COGME). These surveys analyzed the number of medical school graduates and their impact on the total physician workforce. The GMENAC report, for example, took 10 years to develop and attempted to forecast the supply of and need for physicians in the years 1990 and 2000. The panel concluded that by the year 2000, the U.S. would have a surplus of 145,000 physicians if medical schools continued to produce the same number of graduates and if international medical school graduates continued to immigrate at the same rate as they did at the time the study was conducted.

Throughout the 1990s, COGME produced a series of reports that also indicated that the U.S. would have an excess number of physicians by the year 2000. COGME further predicted particularly dramatic growth in the number of specialists, and warned of a possible dearth of generalists, such as family practice physicians, internists, and pediatricians. Following these reports, a number of initiatives were debated—and sometimes instituted—at the national level to control the number of physicians, particularly specialists, entering the workforce.

For the last few years, concerns about physician supply have often been superseded by growing concerns about managed care, Medicare reimbursement, and other issues. However, Richard Cooper, MD, former dean of the Medical College of Wisconsin, and others recently reopened the debate. Dr. Cooper and his colleagues assert that there has been a strong correlation between the gross domestic product per capita, the growth of the population, and the number of physicians in the U.S. They claim that this correlation reflects underlying causal links between the nation’s prosperity, the number of people who are demanding medical services, and the consequent need for health care professionals.†


Further complicating the debate are questions about how many physicians are really needed and about the value of the medical services needed by the population at large. Some experts argue that a large number of physicians simply inflates health care spending and leads to the provision of more services, some of which may be unnecessary. Other analysts claim that a leaner workforce will contribute to a more efficient, less wasteful health care system. This is the train of thought that was applied in the creation of health maintenance organizations that followed the group or staff model.

**Factors to consider**

As we discuss and deliberate on this subject and the direction we need to take over next five to 10 years, we need to consider it in the context of other changes that are taking place within graduate education and the health care delivery system. For instance, the actual work that will be done will undoubtedly undergo considerable change during that period of time.

For example, we are developing many new treatment options to control infectious diseases that allow patients to receive most of their care on an outpatient basis. Hence, the resources and the number of physicians that are needed to provide services to patients with AIDS, for instance, are far fewer than they were 10 years ago. Similarly, the need for surgical intervention in the treatment of peptic ulcers has basically been eliminated because of new advances in drug therapies. So, we need to think about what types of physicians are going to be most necessary to treat patients with conditions that may be best managed on an outpatient basis.

We also need to be mindful of the fact that we are going to be operating on patients who are older and sicker than the people who were receiving surgical care in the past. Indeed, not long ago many of the patients on whom we operate today would have been denied surgical care because of their age or health status. We must consider the possibility that new pharmaceutical approaches could be developed to treat these patients, as well. If that happens, the need for surgical specialists will again decline.

Also affecting the surgical workforce issue is the fact that surgical procedures may be replaced by more disease-specific approaches, rather than specialty-directed options. Treatments that are targeted at curing disease processes require a blend of skills and knowledge from a spectrum of specialties, as opposed to the highly specific competencies that specialists traditionally have attained. Furthermore, lifestyle interests and advancements in technology make some specialties more attractive to young surgeons than others are.

Undoubtedly, new specialties will be born as we strive to meet the fluid and evolving needs of our patients and our health care system. One example of a new specialty that is starting to gain recognition is “emergent surgery.” The individuals in this specialty—known as “hospitalists”—would be responsible for the admission to the hospital of emergency room patients who are experiencing trauma or other acute surgical problems. It is also possible that we may see more surgeons receiving training that is tailored to the provision of care in rural settings or in “boutique” hospitals.

**Conclusion**

Worries about sheer numbers and supply and demand were the original sources of controversy about physician supply and the surgical workforce. As Blumenthal’s article points out, over the years, miscalculations by the groups that have studied the medical workforce, changes in patient needs, advances in technology, and so on, have made the problem ever more complicated and abstract.

The reality is that there will always be a need for surgeons. The key question regarding the issue of workforce, however, is not how many surgeons we will need. Rather, it is what impact the changing nature of the work that we do will have on the size of the surgical workforce we will need to provide care for individuals who require our services.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
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GS05: New Technology: What’s Proven, What’s Not
Moderator: Christopher K. Zarin, MD, FACS

GS06: Recognition, Management, and Prevention of Operating Room Catastrophes
Moderator: Christopher R. McHenry, MD, FACS

*GS08: Acquiring Skills to Perform New Procedures: Principles, Challenges, and Opportunities
FREE OF CHARGE
Moderator: Ajit K. Sachdeva, MD, FACS, FRCSC

GS13: Key Issues in Management of Rectal Cancer
Moderator: David A. Rothenberger, MD, FACS

GS16: Sentinel Lymph Node Biopsy for Breast Cancer
Moderator: Armando E. Giuliano, MD, FACS

GS18: Groin Pain Management
Moderator: Robert J. Fitzgibbons, Jr., MD, FACS

*GS21: Patient Safety in Clinical Surgery FREE OF CHARGE
Moderator: William C. Nugent, MD, FACS

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Moderator: Andrew L. Warshaw, MD, FACS

GS36: Unexpected Findings at Laparoscopic Cholecystectomy
Moderator: W. Scott Melvin, MD, FACS

*GS37: American College of Surgeons and the Core Competencies: Innovative Approaches for a New Era FREE OF CHARGE
Moderator: Ajit K. Sachdeva, MD, FACS, FRCSC

GS47: Operative Techniques for Bad Situations
Moderator: David V. Feliciano, MD, FACS

MD07: Postoperative Enterocutaneous Fistulas
Moderator: Herand Abcarian, MD, FACS

Clinical Congress 2002

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Dateline Washington

Congress prepares for 2006 Medicare cuts

The College and its coalition partners successfully blocked the estimated 4.5 percent Medicare payment cuts scheduled to take effect this year and next, persuading Congress to replace them with 1.5 percent payment increases for both 2004 and 2005. Unfortunately, problems with the underlying payment update formula remain, and physicians could again face annual cuts of approximately 5 percent from 2006 through 2012, according to the Medicare trustees. This news has led congressional supporters to hold hearings on the current Medicare sustainable growth rate formula that is used to determine reimbursement to physicians and other health care professionals.

On May 5, Michael Bilirakis (R-FL), Chairman of the Health and Environment Subcommittee of the House Committee on Energy and Commerce, held a hearing on this issue. Participants from the General Accounting Office, the Congressional Budget Office, and the Medicare Payment Advisory Commission were given an opportunity to testify about the nature of the payment problem and the cost of possible solutions.

Although Congress is unlikely to develop legislation that would fix the formula this year, hearings of this type set the stage for congressional action early in 2005. Senate Finance Committee Chairman Charles Grassley (R-IA) has also expressed interest in hosting similar hearings later this year. Fellows are encouraged to visit the Legislative Action Center to contact their legislators about the problems inherent in the Medicare fee schedule.

Higher Education Act due for reauthorization

The College is working with a broad coalition of physician organizations to extend the federal Economic Hardship Deferment to the full length of a medical residency as part of the reauthorization of the Higher Education Act. Current law permits resident physicians to defer repayment of their federal student loans for up to three years if they exceed a defined debt-to-income ratio. This three-year limit places a significant financial burden on surgical residents who must complete five to seven years of residency training.

In addition, the College supports increasing the annual limit on federally subsidized Stafford Loans from $8,500 to $12,000 per year. Although the cost of education has risen each year, Stafford Loan limits have remained the same since 1992. This modest increase approximately covers the cost of inflation since the limits were last raised. Surgeons can view College and coalition letters on these issues at: http://www.facs.org/ahp/views/gme.html.

“Cover the Uninsured Week” raises awareness

A coalition led by former Presidents Jimmy Carter and Gerald Ford, as well as the Robert Wood Johnson Foundation and leaders of business, labor, and consumer organizations, sponsored “Cover the Uninsured Week,” May 10-16. The event featured more than 1,500 public health programs in all 50 states for one of the largest mobilizations ever aimed at raising awareness about the estimated 44 million Americans who are without health insurance. As part of the effort, Sen. Bill Frist, MD, FACS (R-TN), and Sen. Jay Rockefeller (D-WV) released a report, “Characteristics of the Uninsured: A View from the States,” at...
On May 5, a press conference was held calling for a rededication of efforts to resolve the growing national problem of uninsured Americans (available at www.CoverTheUninsuredWeek.org).

In addition, Sen. Judd Gregg (R-NH) and a team of nine Republican senators released a proposal that would expand health care coverage to 22 to 30 million uninsured Americans, targeting low-income individuals, small business employees, immigrants, children, young adults, and preretirees. The congressional task force made specific recommendations to provide coverage to the uninsured through tax deductions, credit subsidies, and health savings accounts. They also proposed steps to improve health care delivery, such as providing tax deductions for specialists who care for uninsured patients. Finally, the task force offered several proposals to rein in the rising costs of health care, including medical liability reforms that would cap noneconomic damage awards.

The management of scope of practice issues in state legislatures continues to bedevil surgeons, and the College is working closely with the surgical specialty societies to preserve patient safety and high-quality surgical care. Most recently, Oklahoma optometrists conducted a successful last-minute legislative effort to amend a conference committee bill with a paragraph permitting them to perform eye surgery with scalpels. As signed into law by Oklahoma’s governor, H.B. 2321 authorizes the Board of Examiners in Optometry to decide optometric scope of practice including the types of procedures that optometrists may perform on the eye and face. These procedures include cataract surgery, plastic surgery, facial reconstruction, and eyeball removal.

This development comes on the heels of a Veterans Affairs (VA) hospital in Kansas permitting an Oklahoma-licensed optometrist to perform anterior segment and other surgical procedures. In response to concerns raised by the College, the American Academy of Ophthalmology, and the American Medical Association, VA officials temporarily suspended these privileges while they reexamine the situation.

The College has joined a coalition of physician groups to support the Veterans Eye Treatment Safety (VETS) Act, H.R. 3473. This bill would prohibit nonphysicians from performing eye surgery within the VA health care system. The College believes the VA decision sets a dangerous precedent. Expanding the scope of practice for nonphysicians to perform surgery is a serious threat to patient safety. Surgeons can tell their elected representatives to cosponsor H.R. 3473 to protect veterans and other surgical patients by sending a letter through the federal Legislative Action Center at http://capwiz.com/facs/mail/onedick_compose?alertid=4521361.

On April 10, President Bush signed into law the Pension Funding Equity Act, H.R. 3108. Included in this legislation is a provision confirming that the National Resident Match Program does not violate antitrust laws. The new law applies to both pending and future lawsuits. Based on the legislation, the defendants in the national lawsuit have asked a federal judge to dismiss the case; that decision was pending at press time.
What surgeons should know about...

The new Stark Phase II rules

by Jean A. Harris, Associate Director, Division of Advocacy and Health Policy

The Centers for Medicare & Medicaid Services (CMS) released a regulation on March 26 implementing additional provisions of the physician self-referral law and making some changes in the existing rules. The self-referral legislation is better known as the “Stark” law, in reference to its principal congressional sponsor, Rep. Fortney “Pete” Stark (D-CA). The new rule, known as the Stark Phase II regulation, becomes effective July 26. The purpose of this article is to notify surgeons about the scope of the changes, but it is not a substitute for legal advice.

What were the purposes of the Stark law?

The self-referral law is intended to protect the public from referral patterns for certain services in which the physician or a member of the physician’s family has a financial interest. The scope of the law is very broad, defining what are acceptable physician compensation arrangements and other financial arrangements between physicians and certain other health providers.

Congress passed the Stark law after a number of studies showed that physicians who had an ownership interest in entities to which they referred ordered some services in excess. The original law, passed in 1989, was limited to clinical laboratory services, but the expanded bill now in effect was passed in 1993. The amended bill extended coverage of the Stark rule to nine additional services and extended portions of the restrictions on referral to the Medicaid program.

This law is closely linked to the federal Anti-Kickback Statute, which prohibits offering or taking a kickback to induce a referral. The two laws cover much of the same turf, but the federal Anti-Kickback Statute requires “wrongful intent” for violation of its law and a violation is a criminal matter. On the other hand, the Stark law does not require wrongful intent and a violation is considered a civil matter rather than a criminal one.

Why is the government issuing these new regulations?

The first of the regulations implementing the expanded 1993 statute were not issued in final form until 2001. It took slightly more than three additional years for CMS to develop the Stark II regulation, which refines existing exceptions, adds new ones, and sets the reporting requirements and sanctions. In the new regulation, CMS has continued the practice started in Stark Phase I of interpreting the prohibitions on referral narrowly and the exceptions, where a referral is permitted, broadly.

The regulation continues to have a very broad definition of the physician’s immediate family and no exceptions are provided. (See Table 1, page 9, for a list of immediate family members.) For example, the regulation does not create an exception for a relative on the list who does not live in the same household as the physician. The law says no referral may be made for any of 10 designated health services (DHS) unless an exception exists in the regulation. (See Table 2, page 9, for a listing of DHS.) Needless to say, exceptions are at the heart of Stark Phase II, as they were with Stark Phase I. There are three categories of exceptions: those related to the prohibition on referrals, those related to ownership or investment, and those related to compensation arrangements. (See Table 3, page 10, for a complete listing of the exceptions.)
What are some of the new exceptions offered in Stark Phase II?

A new exception was created for physicians to participate in communitywide health information systems. Health information systems must be available to everyone in their communities who wants to use them, and they must allow electronic records to be exchanged among providers and practitioners in those communities.

Some observers have noted that “community” is undefined, so controversy may ensue regarding how wide a community must be. Not only does this provision apply to electronic medical records, but it also may include complementary drug information systems, general health information, medical alerts, and related information for patients. The physician may use both hardware and software under this exception.

To better meet the needs of rural residents, an additional exception has been created for intrafamily rural referrals. This exception has been created for cases where no other entity furnishes the DHS within 25 miles of the patient’s home. If the patient is getting in-home care, the exception applies if no DHS entity is available “in a timely manner in light of the patient’s condition.” There are also newly created exceptions for physician retention payments from hospitals, from federally qualified health centers, and from practices in health professional shortage areas (HPSA).

What other changes are made in the Stark Phase II regulations?

A grace period of up to 90 days has been established for arrangements that have fallen out of compliance for reasons beyond the control of the DHS entity. This will be particularly useful in situations such as loss of rural or HPSA designations or delays in obtaining signed copies of renewal agreements.

### Table 1.

**Definition of immediate family member**

- Physician’s husband or wife
- Birth or adoptive parent, child, or sibling
- Stepparent, stepchild, stepbrother, or stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law
- Grandparent or grandchild
- Spouse of a grandparent or grandchild

### Table 2.

**Designated health services (DHS)**

- Clinical laboratory services
- Physical and occupational therapy and speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Note: The CPT codes included in each category of services appears on the ACS web site at: [http://www.facs.org/ahp/cptcodes.pdf](http://www.facs.org/ahp/cptcodes.pdf).

The Stark law says financial arrangements between a physician (or a family member) and an entity may be direct or indirect and includes both ownership and investment interests as well as compensation arrangements. Direct financial relationships occur when there is no person or entity imposed between the entity furnishing DHS and the physician (or family member); indirect financial relationships occur when at least one person or entity separates the physician or a family member from the entity furnishing DHS. The Stark II
### Table 3.

**Exceptions to the Stark Phase II regulation**

<table>
<thead>
<tr>
<th>Prohibition on referrals does not apply to:</th>
</tr>
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<tbody>
<tr>
<td>• Services that are provided by or under the supervision of the physician or by or under the supervision of another physician in the same group</td>
</tr>
<tr>
<td>• In-office ancillary services, including canes, crutches, walkers and folding manual wheelchairs, blood glucose monitors, and infusion pumps (including external ambulatory infusion pumps)</td>
</tr>
<tr>
<td>• Services furnished by a prepaid health plan, including a Medicaid HMO</td>
</tr>
<tr>
<td>• Services performed by an academic medical center</td>
</tr>
<tr>
<td>• Implants furnished by an ambulatory surgical center during surgery, including, but not limited to, cochlear implants, intraocular lenses, other implanted prosthetics and prosthetic devices, and implanted durable medical equipment</td>
</tr>
<tr>
<td>• Dialysis-related drugs furnished in or by an end-stage renal disease facility</td>
</tr>
<tr>
<td>• Preventive screening tests, immunizations, and vaccines</td>
</tr>
<tr>
<td>• Eyeglasses and contact lenses following cataract surgery</td>
</tr>
<tr>
<td>• Intrafamily rural referrals</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Ownership or investment interests that do not constitute a financial relationship:</th>
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</thead>
<tbody>
<tr>
<td>• Publicly traded securities</td>
</tr>
<tr>
<td>• Mutual funds</td>
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<tr>
<td>• Physician ownership or investment in rural providers and hospitals</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Compensation arrangements that do not constitute a financial relationship under certain circumstances:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Payments for the rental of equipment or office space</td>
</tr>
<tr>
<td>• Bona fide employment relationships</td>
</tr>
<tr>
<td>• Personal services arrangements</td>
</tr>
<tr>
<td>• Physician incentive plans</td>
</tr>
<tr>
<td>• Isolated transactions (such as one-time sale of property)</td>
</tr>
<tr>
<td>• Remuneration provided by a hospital to a physician as long as it is divorced from furnishing DHS</td>
</tr>
<tr>
<td>• DHS furnished by a group practice but billed by a hospital</td>
</tr>
<tr>
<td>• Payments by a physician to an entity furnishing DHS for items priced at fair market value</td>
</tr>
<tr>
<td>• Charitable donation by a physician to an entity furnishing DHS</td>
</tr>
<tr>
<td>• Nonmonetary compensation up to $300 per year (to be adjusted by CPI-U each year)</td>
</tr>
<tr>
<td>• Fair market value compensation by the entity furnishing DHS to the physician</td>
</tr>
<tr>
<td>• Medical staff incidental benefits from a hospital (such as free parking)</td>
</tr>
<tr>
<td>• Risk-sharing arrangements between health plan and physician (such as withholds, bonuses)</td>
</tr>
<tr>
<td>• Compliance training for a physician conducted in the local community by an entity furnishing DHS</td>
</tr>
<tr>
<td>• Indirect compensation arrangements between the receiving physician and the paying entity that furnishes DHS</td>
</tr>
<tr>
<td>• Referral services (such as a physician referral service operated by a hospital)</td>
</tr>
<tr>
<td>• Obstetrical malpractice insurance subsidies</td>
</tr>
<tr>
<td>• Professional courtesy offered by an entity furnishing DHS</td>
</tr>
<tr>
<td>• Communitywide health information systems</td>
</tr>
</tbody>
</table>

Note: Remember the word “physician” means physician and family members shown in Table 1.
regulation makes exceptions for physician investment in publicly traded securities and mutual funds and physician ownership of rural hospitals and other facilities.

The fundamental themes of the compensation rules remain the same: most physician compensation must be of fair market value and compensation cannot be related to the value or volume of referrals. The revised regulation clarifies that physician employees may be paid personal productivity bonuses, but not bonuses based on ancillary referrals. The regulations also deem certain hourly compensation arrangements to be at fair market value. Certain fluctuating compensation arrangements are permitted if the compensation methodology is set in advance. Finally, group practice and employed physicians may be paid under risk-sharing arrangements.

The exception for services provided to members of a prepaid health plan had Medicaid health maintenance organizations added to it.

The Office of the Inspector General (OIG) of the Department of Health and Human Services is responsible for protecting the integrity of the Medicare program and, therefore, shares responsibility for enforcement of the Stark law with CMS. In the event information is needed regarding the financial relationships an entity furnishing DHS has with a physician, either CMS or the OIG may request the information. The request is made to the entity, not the physician, and sanctions for violating the law are applied to both. The regulations call for nonpayment for any Medicare claims for DHS and the imposition of civil monetary penalties on physicians and entities that furnish DHS.

Is this the end of the Stark regulations, or will more follow?

A Phase III is to come. CMS has announced that the Stark III regulation will contain most of the Medicaid restrictions on referrals. CMS also will have to respond to comments made on parts of the Stark II regulation.

Where can I learn more about the Stark law and its related regulations?

Material on the Stark law, including the Stark II regulation, is available at http://www.cms.hhs.gov/physicians, in the “Physician Highlights” box at the top of the page. CMS will accept comments on certain parts of the Stark II regulation until June 24. The College, of course, will be preparing comments.

The Stark Phase I regulation has had a major impact on the way physicians structure their business arrangements. Now that the Stark Phase II regulation has been published, many physicians will want to, or, more importantly, have to, change the way their practice is structured or their financial affairs. The regulation is welcome because it will generally permit more flexibility in relationships between physicians and other entities and provide many more “bright line” rules than the existing regulation. Any physician who may be affected by the regulation should seek the advice of an attorney, preferably one who specializes in health affairs.
The Gloves Are Off:

The Aetna and CIGNA settlements: Part I

by Irene Dworakowski,
Regulatory and Coding Associate,
Division of Advocacy and Health Policy
During the 1990s, a number of lawsuits were filed across the country on behalf of physicians against managed care organizations—including Humana, Aetna, CIGNA Healthcare, Coventry, HealthNet, PacifiCare, United, WellPoint and Anthem. These lawsuits alleged that the health plans conducted improper contracting and payment practices including bundling of services, downcoding and recoding of services reported, failure to recognize modifiers, breach of state prompt payment laws, and misrepresentation of the criteria they used to approve or deny various treatments and coverage.

In October 2000, the lawsuits were consolidated and transferred to the U.S. Federal Court in Florida as a class action lawsuit. Over 950,000 physicians, physician groups, and physician organizations submitting claims with any of the defendant managed care organizations since August 1990 became members of the class action.

Two of the defendants, Aetna and CIGNA, have agreed to settlements rather than to continue in the litigation. The other managed care companies that are defendants in the lawsuits have not agreed to settle at this time, and the case against those organizations continues toward trial, currently scheduled for March 2005.

The Aetna settlement was approved in November 2003. Although the settlement is final, Aetna filed an appeal of the U.S. Federal Court’s decision to grant class action status to the case. The appeal is currently pending in the U.S. Court of Appeals for the Eleventh Circuit in Atlanta, GA. The final CIGNA settlement was announced in April 2004.

Physicians who are members of the class action must abide by the provisions of the settlements. Both settlement agreements allowed physicians to opt out of the class that brought these legal actions. Opting out of the settlements would allow physicians to bring suit against Aetna or CIGNA in the future. Aetna and CIGNA are permitted to deny access to the prospective relief established by the settlements to those who opt out of the class action, except where required by contract or law. For surgeons who are included as members of the Aetna class action, the deadline for opting out of the settlement has passed. The time frame for requesting exclusion from the class action against CIGNA will be contained in the second notice of the settlement, which class action members should have received in May 2004.

This first of two articles will examine the specifics of the Aetna settlement. The second article, in the August Bulletin, will focus on the CIGNA settlement.

Retrospective relief

Aetna provided $100 million to compensate class members for improperly paid or denied claims without any requirement that they submit documentation. The deadline for submitting a proof of claim to obtain a share of this money has passed. Due to Aetna’s appeal regarding class action status, surgeons who applied to Aetna for compensation will have to wait for compensation until the appeal is decided. Any monies due physicians who did not file a proof of claim form will be donated to the Physicians’ Foundation for Health Systems Excellence, Inc. This not-for-profit foundation, mandated by the settlement and initially funded at $20 million, was established to create initiatives such as expansion of health care information available to patients and providers, broadening consumer access to cost-effective health insurance benefits, and enhancing quality patient care.

Prospective relief

A number of measures established by the settlements will change Aetna administrative requirements and procedures. These measures will affect the day-to-day interactions between physicians and Aetna. In many cases, the settlement enjoins Aetna to reflect the payment policies established by the Centers for Medicare and Medicaid Services (CMS).

The measures that will impact surgeons’ practices are:

- Fee schedules. Aetna’s physician fee schedules will be available on the Internet by December 31, 2004. Fee schedules can be changed only once per year. Until that time, participating physicians can send Aetna one written request to obtain fee schedule amounts for up to 50 CPT codes as specified in that correspondence.
• Payment rules. Aetna was required to post all of its payment rules on its provider Web site by May 6, 2004. All coding edits used by Aetna must comply with the guidelines contained in the American Medical Association’s (AMA) Current Procedural Terminology (CPT).* In cases where CMS has established a national policy for a procedure, Aetna will adopt that policy. Any additional code edits used by Aetna will also be disclosed on the Web site. Aetna has agreed to identify any computer claims processing software used to review claims for payment by product name and version. (The primary software used is McKesson Corporation’s ClaimCheck™.) They also agreed that all of their automated code edits and claims payment rules will be consistent across all their products. Any changes in payment rules will be communicated to providers no later than 90 days before the change becomes effective.

• Web-based adjudication tool. In September 2003, Aetna invited its participating providers to start using Clear Claim Connection™, a code-auditing disclosure tool developed by McKesson Information Solutions. The tool allows physicians to ascertain how billing codes submitted for payment will be handled by Aetna’s claims-processing system. Aetna participating providers must register for access to Clear Claim Connection™ and other tools designed to assist participating physicians to clearly communicate with Aetna on a secure Web site located at https://www.aetna.com/provider.

• Prompt payment. Aetna is required to pay clean claims submitted electronically within 15 days and clean paper claims within 30 days. Aetna’s definition of a clean claim is one that contains the information that Aetna requires and is submitted consistent with Aetna’s established processing procedures.

• Global periods. Aetna will establish no global periods for surgical procedures that are longer than those established by CMS.

• CPT codes. Add-on codes reported with the proper primary procedure codes will be not subject to multiple procedure rules and will be separately reimbursed by Aetna. Multiple procedure rules will not be applied to modifier –51 (multiple procedures) exempt codes and procedures identified by those codes will be reimbursed separately. Additionally, the company will annually update its code editing software to recognize any changes in the list of modifier –51 exempt codes.

• Modifiers. Aetna will recognize the appropriate use of CPT modifiers appended to procedure codes and reimburse accordingly. The settlement specifically identifies the recognition of modifier –25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) and modifier –59 (distinct procedural service).

• No automatic downcoding of services. The code level of evaluation and management (E/M) codes and code series that differentiate the intensity of a service (simple, intermediate, complex) will not be automatically downcoded. Aetna reserves the right to reduce the level of service if the information contained in the patient’s medical record does not support the code level reported or if the company’s fraud and abuse detection programs identify that the code level reported is inappropriate.

• Supervision and interpretation services. When a surgical procedure and radiological su-

A number of measures established by the settlements will change Aetna administrative requirements and procedures. These measures will affect the day-to-day interactions between physicians and Aetna.

*All specific references to CPT terminology and phraseology are: © 2003 American Medical Association. All rights reserved.
pervision and interpretation are performed by the same physician, such as an ultrasound-guided liver biopsy, CPT codes for both procedures will be separately recognized and eligible for payment.

• Change in medical necessity definition. Patients who are covered by Aetna policies will be entitled to receive medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice. Physicians and patients are no longer required to choose the least costly procedure, although they may do so if the procedure will produce the therapeutic or diagnostic results desired.

• Gag clauses. Gag clauses are prohibited. Physicians will be free to discuss all the various treatment options with their patients, whether or not the options are reimbursed under the patient’s plan.

• Nonparticipating physicians. Language contained on explanation of benefits forms will be revised to remove any inference that the disallowed amount is unreasonable and will notify patients of the amount that nonparticipating physicians may bill them. The settlement agreement continues to allow nonparticipating physicians to balance bill patients. Aetna will not require nonparticipating physicians to use electronic transactions or otherwise become Health Insurance Portability and Accountability Act-compliant.

• Faster credentialing. Aetna has agreed to complete credentialing for its provider panels within 90 days of receiving a completed application for a new participating physician group member.

• Stop-loss insurance may be purchased elsewhere. Aetna will not restrict physicians from purchasing stop-loss coverage from other insurers.

• As ordered by the settlement agreement, Aetna has established a nine-member physician advisory board whose goal is to give physicians the opportunity to provide guidance to Aetna on health care issues of national scope. Aetna and the medical societies and physicians who were plaintiffs to the lawsuit chose the members of the board. Robert W. Oblath, MD, FACS, represents the College on the Aetna board. The board conducted its first meeting in April 2004. Discussion topics to be addressed by the board will be based on items identified by Aetna and discussion topics submitted by physicians at http://www.aetna.com/provider/physician_advisory_board.htm.

A discussion of the specific components of the CIGNA agreement and the enforcement process for independent review of appeals will continue in Part II of this article, which will be published in the August issue.

Acknowledgment

The information contained in this article is based on documents provided by the AMA in March 2004 and supplemented by information contained on the Aetna provider Web site; the CIGNA Healthcare physician settlement Web site; the HMO settlements Web site, maintained by Milberg Weiss Bershad & Schulman LLP; and the HMO Crisis Web site, maintained by the law offices of Archie Lamb. Milberg Weiss Bershad & Schulman LLP and the law offices of Archie Lamb represented physicians in the Aetna and CIGNA Healthcare litigation.
Can Cedars-Sinai’s “M+M Matrix” save surgical education?

by Leo A. Gordon, MD, FACS, Los Angeles, CA
Surgical journals are receiving an avalanche of editorials from frenzied educators who are wringing their hands over the current state of American surgical education. The authors claim that today’s trainees receive an “extremely poor” educational experience.1 Similarly, some surgical educators crisscross the country on the grand rounds circuit, decrying the lack of a well-defined surgical curriculum. Recruitment is down, with some residency spots remaining empty. Symposia, think-tanks, focus groups, and break-out sessions to discuss and examine the issue are springing up across the surgical landscape.2,3 “Mentor mania” has developed in an attempt to define the qualities of the elusive surgical role model for the new millennium.4

Against this backdrop, the Accreditation Council on Graduate Medical Education has imposed work-hour restrictions, just as the variety and complexity of surgical diseases have increased, and the technology designed to combat them has expanded. Furthermore, a Dr. Phil-like focus on the lifestyle, self-esteem, and personal psychological fulfillment of the surgeon-to-be has taken center stage. A process that has long emphasized commitment, dedication, and continuous patient care now must offer opportunities for young professionals to share their feelings, to enjoy “quality time” with friends and family, and to develop their interpersonal skills. A sensitive and caring core curriculum has evolved, competing with standard and time-honored surgical teaching techniques. The burden on surgical educators has increased as these approaches vie for time, money, and attention.

When these trends are coupled with the Institute of Medicine (IOM) report on medical errors and a growing medical liability crisis, it is clear that rapidly implemented innovative change in surgical education is necessary. Some educators claim that the needed changes should be “Flexnerian” in character,5 while others say we must discover the “Halsted reformer of today.”6

In the evolution of the American surgical education system, the brightest flashes of innovation often follow the darkest hours of educational despair. So it was with Flexner. So it was with Halsted. So it will be with an entirely new approach to the traditional M&M conference developed at the Cedars-Sinai Medical Center in Los Angeles, CA. This approach is called the “M+M Matrix.”

The M+M Matrix

The M+M Matrix is a concept that redefines and reconfigures the traditional surgical morbidity and mortality conference. This seminal surgical conference is the logical place to begin such Flexnerian and Halstedian change.

The M+M Matrix is a mechanism for reconfiguring the traditional surgical morbidity and mortality (M&M) conference, which, as currently conducted in many training programs, has failed in its educational mission. The great lessons voiced at most M&M conferences are dismissed at the exit door. It is as if a culture developed that failed to invent a written language and is restricted to the oral transmission of complication-reducing surgical principles. The reasons for the failure of the traditional M&M conference include the lack of continuity, the lack of educational accountability, and its lack of logic. It is an educational Roach Motel©: Great surgical ideas check in, but they don’t check out.

The M+M Matrix implemented at Cedars-Sinai addresses these weaknesses through a process that involves a discussion of each surgical complication. That discussion is outlined and codified into a matrix—a framework on which residents and staff can build an approach to managing that complication as their education and careers progress. The moderator of the forum serves as the chief and driving force behind this changing educational approach. The moderator’s task is to supervise a one-week educational effort aimed at conference preparation. This individual formulates the weekly matrix outlines and works with the residents to arrive at unifying surgical principles.

The Matrix uses the inherent dynamic of a well-moderated, well-coordinated, and well-attended M&M conference. Using a weekly, monthly, and yearly cycle of e-mail, written examinations, and referenced discussions, the Matrix program codifies and sustains the great lessons of the traditional M&M conference while
purging it of the unfortunate legacy of shame and blame. It does so by changing the focus from rooting out problems to decreasing surgical complications and encouraging participants to recognize them earlier and to treat them more effectively.7

Using their well-documented views on medical education, it is likely that both Flexner and Halsted would focus on the surgical morbidity and mortality conference as the place to begin change in surgical education.

**Reasons to implement**

There are 10 reasons to bring about educational change through the surgical M&M conference. They are as follows:

1. The M&M conference is the only time of the week during which staff and residents assemble for a formal interactive session. The communal give-and-take of the surgical morbidity and mortality conference generates a passion for surgical education. The lively debates, the intellectual challenges, and the differing ways of managing surgical problems generate an educational spirit that can unify a surgical department.

2. The M&M conference puts the departmental clinical knowledge on display. This knowledge can debunk the “promulgation of surgical folklore.”5 Errors in surgical thought are analyzed and debated. Only through such open debate can the principles of proper surgical practice be voiced and inculcated.

Much is made of the transmission of faulty surgical knowledge from an overburdened staff or an inexperienced cadre of residents. This conference sets the record straight and memorializes current surgical practice.

3. The M&M conference develops organization and presentation skills. The first goal of any training program is to produce knowledgeable surgeons. The second goal is to ensure that these young surgeons can articulate that knowledge to colleagues and to patients.

The Matrix develops preparation, presentation, and organizational skills. The resident prepares to answer pointed questions and to defend his surgical actions. These essential skills are needed throughout any surgical career.

4. The M&M conference is a forum for ongoing educational change. Once it is clear to a department of surgery that the M&M conference is an educational hub, it becomes a forum for change. New educational techniques are introduced. New ideas are tested, refined, and ultimately implemented through the department’s educational program.

5. The M&M conference addresses the pressing issue of error and complication reduction in surgery. There is a growing national interest in errors and complications in medicine. The Matrix sensitizes residents to errors and complications early in their careers in an educationally meaningful manner.

Such sensitized surgeons will commit fewer errors. When complications arise, those surgeons will detect them sooner and will treat them more effectively.

Other specialties are beginning to recognize the value of the surgical M&M conference; hence, they are looking to surgery to provide an effective template for educational change.8 Surgery has the opportunity to take the national lead in this critical area.

6. The M&M conference is the ideal vehicle for implementing a “small team” approach to patient care.5 Hand-offs, sign-outs, and porous cross-coverage schemes are inimical to the seamless patient care required by the surgical patient. Having small teams work together in preparation of the M&M conference enhances a similar approach to clinical care. Each member of the clinical team has a role in conference preparation, and the most cohesive groups tend to develop presentations that stimulate audience interest and participation.

7. The M&M conference is an existing mechanism, currently free of the need for high-level funding. Because the M&M conference is part of the surgical training heritage, implementing educational change via the Matrix concept is relatively inexpensive. In today’s cost-conscious surgical environment, reconfiguring an existing mechanism rather than building a new one is economically appealing.

8. The well-moderated, well-attended, and well-planned M&M conference serves as a medical student recruitment tool. There is inherent medical student appeal generated by a well-at-
tended and well-coordinated Matrix conference. Once this conference becomes an educational engine, rather than a burdensome shame-and-blame witch trial, it will attract the best students to the surgical programs that use it.

9. The surgical M&M conference generates a year-long curriculum for the entire department. The Matrix program generates a curriculum from the cases discussed. The distribution and memorialization of that curriculum provides a department of surgery with an ongoing error and complication-oriented course of study. The Matrix creates a unifying cross-specialty study plan for the entire department.

10. The increasing educational value realized by redesigning this conference will counteract the deleterious educational effects of mandated work-hour restrictions. With the advent of work-hour restrictions, every conference is being scrutinized for its educational value. As many conferences are deleted, the value of the surgical M&M conference will increase. This increased value can be augmented through the Matrix concept. Conversion of the surgical M&M conference into a Matrix conference reflects a dominant theme of both Flexner and Halsted—patient safety through education. Both of these educators would agree that the Matrix answers another more recent report on American health care, the IOM’s report, To Err Is Human: Building a Safer Health System.

Response to IOM recommendations

To Err Is Human made five recommendations for the effective analysis of medical errors. The following is a list of those suggestions, with explanations of how the Matrix responds to them.

1. Report events to create a “story” of what occurred. The presentations offered in the Matrix program involve stories about the team members’ experiences in managing surgical complications. Refined organization and presentation skills enhance the impact of the story.

2. Report events in a manner that seeks the meaning of the story. The M+M Matrix uses the unique dynamic of the surgical morbidity and mortality conference to explain an event and to analyze the factors leading to it. It also demonstrates the educational meaning of the complication.

3. Develop recommendations for improvement. A Matrix conference not only analyzes the complication and suggests methods of improving medical care, but it goes one step further: it imprints those recommendations on the mind of the evolving physician. The Matrix memorializes those surgical lessons, constantly reviews them, and regularly administers examinations based on the surgical principles involved.

4. Implement the lessons learned. A primary task of the surgical educator is to assure the public that the lessons imparted to the surgical resident are retained and reinforced. The M+M Matrix defines and facilitates that process through staff supervision and ongoing evaluation of Matrix-educated residents.

5. Track the changes and gauge their effect. Testing physicians and tracking cases measures the effect of the M+M Matrix on a division of surgery. Written tests evaluate the surgeons’ knowledge. Computer analysis of medical records, operative logs, peer review recommendations, and complication lists track the effectiveness of the program in the area of complication reduction. Increasingly sophisticated computer tracking of patients, surgeons, and outcomes will finally allow us to do for our patients what FedEx® does for a fruit basket.

Conclusions

The Matrix concept is the mechanism by which all conference discussions are linked. It is the means by which seemingly unrelated complications are unified by examining their origins, anatomy, and pathophysiology. Only through such an integrated plan can a collective surgical memory become valuable. Surgical intuition, often discounted in today’s hyper-analytical world, suggests that the Matrix will decrease the incidence of surgical complications through a complication-oriented introduction to the discipline of surgery.

Point by point, the template for adopting the IOM’s recommendations is the surgical M&M conference transformed by the M+M Matrix.

The time has come for surgical educators to reevaluate the M&M conference. It is the logi-
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In the last several years, many surgeons have questioned our level of professionalism and for a number of reasons. Issues that force surgeons to consider whether we behave in a professional manner range from the public’s perception of adverse trends in health care delivery, and our often aggressive publicity approaches that seem to indicate our concern only with self-interest, to concerns that have arisen about a possible increase in medical student mistreatment. Information about this last unexpected but disturbing trend came from annual graduation questionnaires that have been distributed nationally for the last decade.

In response to all these concerns, leaders of many national organizations dealing with health care education and delivery have concluded that some physicians may exhibit behaviors that challenge our longstanding principles of professionalism. Organizations addressing this subject include the American Medical Association (AMA), the American Association of Medical Colleges, the Accreditation Council on Graduate Medical Education (ACGME), the American Board of Internal Medicine, and our own American College of Surgeons. These groups have made a commitment to enhancing professional
behavior and personal interactions between pa-
tients and physicians and medical educators and
students. This topic should be of great importance
to all of us, regardless of whether we are clinical
surgeons or surgical teachers.

Before addressing our possible shortcomings, we
need to define “professionalism.” This rather
vague term means many things to many people,
but generally it implies a commitment to and train-
ning and competence in a specific area of endeavor.
The professional athlete, police officer, or soldier
would be expected to have all of these attributes,
yet would not necessarily be expected to possess
certain other qualities that we demand of mem-
ers of the “learned professions.” Traditionally,
law, religion, and medicine have fit into this cat-
egory, and the essence of professionalism in all of
these fields is best encapsulated in the word “eth-
ics.”

Unfortunately, this term also is so broad that it
prevents an accurate assessment of medical pro-
fessionalism for the purpose of the question posed
by the title of this piece. How do we define medi-
cal professionalism (or even the lack thereof), and
what can we do to promote it in our own environ-
ments?

**Previous efforts**

Responding to a need for a strong statement on
the principles and ethics of professionalism, the
AMA Council on Ethical and Judicial Affairs ar-
ived at the following seven principles of profes-
sionalism in 1980:

1. A physician shall be dedicated to providing
competent medical service with compassion and
respect for human dignity.
2. A physician shall be honest with patients and
colleagues and strive to expose those physicians
deficient in character or competence or who en-
gage in fraud or deception.
3. A physician shall respect the law and also rec-
ognize a responsibility to seek changes in those
requirements which are contrary to the best in-
terests of the patient.
4. A physician shall respect the rights of pa-
tients, or colleagues, and of other health profes-
sionals and shall safeguard patient confidences
within the constraints of the law.
5. A physician shall continue to study, apply and
advance scientific knowledge, make relevant in-
formation available to patients, colleagues, and the
public, obtain consultation, and use the talents of
other health professionals when indicated.
6. A physician shall, in the provision of appro-
priate patient care, except in emergencies, be free
to choose whom to serve, with whom to associate,
and the environment in which to provide medical
services.
7. A physician shall recognize a responsibility
to participate in activities contributing to an im-
proved community.

Although it outlined important principles of
medical professionalism, the AMA Council re-
port seemed to deal with a broader set of prin-
ciples than was appropriate for our educational
institution.

In more recent years, the AMA Council on
Medical Education has responded to concerns
about evidence of student mistreatment revealed
in the medical school graduation questionnaires.
The council developed policies and recommen-
dations in this area that relate specifically to the
medical educator-student relationship. Their
general statement regarding a code of behavior
is as follows: “The teacher-learner relationship
should be based on mutual trust, respect, and
responsibility. This relationship should be car-
ried out in a professional manner and in a learn-
ing environment that places strong focus on edu-
cation, high-quality patient care, and ethical
conduct.”

**Institution forms committee**

At our institution, the Medical College of Vir-
ginia, Virginia Commonwealth University, the
dean, H.H. Newsome, MD, was pleased to see
the external interest in professionalism and was
concerned about potential internal problems. To
address these issues relating to professionalism,
I was given the charge of chairing a committee
to both study this topic and to “fix” any prob-
lems. At first, I interpreted this new responsi-
bility as an honor, implying that I possessed both
good judgment and leadership ability. Later, it
became apparent that the dean chose a surgeon
to chair this project for other reasons. Specifi-
cally, the data from the graduation question-
naires indicated that student reports of abuse,
with some exceptions, often highlighted the un-
professional behavior of certain surgical house
staff or faculty surgeons. Although this circumstance should certainly lead surgeons to take this subject seriously, it did dampen the “honor” of my appointment.

The committee appointed to both study and make recommendations regarding professionalism in our medical school community included faculty (both clinical and nonclinical), clinical house staff, and students and, although the deliberations were thoughtful, discussions were often chaotic due to the vagueness of some of the concepts being considered. Nonetheless, we did reach a consensus on a number of aspects of medical professionalism and made some specific recommendations that are now being implemented at our institution. A brief summary of our work may interest other surgeons, because the principles may be applicable in other institutions that are dealing with questions of professionalism.

**Defining professionalism**

Although ethics are the underpinnings of medical professionalism, we decided that a working definition that included examples of various desired behaviors would be required for us to be effective in this project. The major components of medical professionalism that were identified by a group from the Kansas University Medical Center (KUMC), and based on principles espoused by a number of organizations, summarize the desired behavior as well as any.3

The positive characteristics listed are: altruism, accountability, excellence, respect for others, a personal commitment to lifelong learning, duty, honor, and integrity. Challenges to these principles of professionalism are abuse of power, discrimination, bias, breach of confidentiality, arrogance, greed, misrepresentation, lack of conscience, and conflict of interest. Some descriptors of unprofessional behavior were: unmet professional responsibility, lack of effort toward health improvement and adaptability, poor interaction with patients and families, and inappropriate relationships with other health care professionals.

These concepts gave us a “working definition” of medical professionalism that we could use as a basis for the rest of our project—that of “fixing the problem.”

**Evaluating professional behavior**

The efforts to arrive at a definition of professionalism led us to believe that we needed some specific standards of behavior that could be used to evaluate all of the professionals in our environment, including faculty, house staff, and students. If our ultimate goal was to promote professionalism in our community, we felt an ongoing prospective assessment of these behaviors by and of everyone was a necessity.

After considerable discussion of specific standards for each of the groups in our environment, we concluded that the standards were really universal. The list of standards that we determined could be applied to all these groups was as follows:

- Recognize their positions as role models for other members of the health care team.
- Carry out academic, clinical, and research responsibilities in a conscientious manner, make every effort to exceed expectations, and make a commitment to lifelong learning.
- Treat patients, faculty, house staff, and students with humanism and sensitivity to the value of cultural, social, age, gender, disability, economic diversity, and sexual orientation without discrimination, bias, or harassment.
- Maintain patient confidentiality.
- Be respectful of the privacy of all members of the medical campus community and avoid promoting gossip and rumor.
- Interact with all other members of the health care team in a helpful and supportive fashion, without arrogance and with respect for and recognition of the roles played by each individual.
- Provide help or seek assistance for any member of the health care team who is recognized as impaired in his or her ability to perform professional obligations.
- Be mindful of the limits of one’s knowledge and abilities, and seek help from others whenever appropriate.
- Abide by accepted ethical standards in the scholarship, research, and standards of patient care.

The ACGME has already developed more detailed standards and a thorough evaluation process for house officers only. Our more limited list is consistent with that produced for postgraduate trainees.
Effect on the institution

The committee’s discussions and resultant initiatives have affected our institution in a number of ways. Professional behavior at the Medical College of Virginia has been highlighted by some of the activities described below, has become more visible in all of our personal interactions, and should enhance professionalism throughout our environment. Our efforts to implement a program on professionalism in response to the deliberations are still relatively preliminary. However, the enthusiasm generated among those individuals involved in the project convinces me that our endeavors will interest colleagues who may choose to follow a similar course at their own institutions. The initial efforts have included:

1. Widespread dissemination of the “Standards of Professional Behavior” listed previously. Initially dissemination of the standards was accomplished via e-mail and memoranda sent out from our dean’s office establishing this list of standards as a credo for our institution. The importance of this message was emphasized by requesting a signed statement from everyone confirming their receipt, their reading, and their acceptance of these principles. At Virginia Commonwealth University, the dean’s office is an appropriate source for such proclamations, but other environments may have different lines of authority.

Another means of communicating our commitment to the Standards of Professional Behavior is our institutional Web page, which allows us to promote the principles internally and with the public. We plan to use this vehicle to highlight individual standards at intervals in an innovative way to keep us all continually focused on appropriate professional behavior in our workplace. Already our university hospital and affiliated Veterans Affairs hospital have expressed interest in distributing some of these concepts to other institutions and organizations.

2. Evaluation process. Early on, we concluded that the achievement of optimal professional behaviors by all of us required some form of objective evaluation of performance. Although not totally original, we developed our own processes for evaluating the professionalism of faculty, house staff, and students, an assessment similar to those used to determine academic and clinical performance. These specific evaluation mechanisms are currently being tested over a one- to two-year period to determine both their feasibility and reliability. Already, some people believe the evaluation process we have developed is more complex than desired, but we anticipate ultimately developing an acceptable evaluation process for professionalism that effectively supplements our current process for determining competence in other areas. In the long run, we hope this process will have a broad and positive effect on student grading, recommendation letters, and faculty promotions. Also, the inclusion of professionalism in the evaluation process for all groups has helped us establish this behavior as a major concern of the culture of the institution overall. Our medical school includes students, house staff, and faculty, but these same concepts of evaluation are clearly applicable to individuals and institutions that have somewhat different sets of players.

3. Grievance process. Another specific and possibly helpful process resulting from these deliberations on professionalism has been the development of an informal grievance process for students and house staff who feel they have experienced some form of abuse or mistreatment from a superior. The usual formal grievance procedures are in place at this institution for specific transgressions that relate to gender discrimination, racial discrimination, and so on. However, our committee felt that a less formal process for correcting unprofessional behavior (including mistreatment of students) was needed, despite the fact that incidents were thought to occur relatively infrequently.

Our professionalism committee has now implemented such an informal process for dealing with these types of issues, a process that was designed to allow people to bring forth these issues comfortably. The individuals acting as intermediaries (or ombudsmen) in this process are currently the committee members who are not authority figures or teachers of those bringing the concerns forward. We anticipate that this approach will prove useful for both identifying and resolving problems that are less than major grievances. Admittedly, this process should be most applicable to the student in the student-
educator relationship, but our early experience has shown it may have broader applications. Informal complaints have included other situations and categories of individuals in our environment. Although used rather infrequently so far, establishing this process has demonstrated our institution’s commitment to professionalism.

4. Promulgating high standards of professionalism. At the outset of this project, several of the committee members felt that curricular changes focusing on professionalism would be a major final recommendation. After review of the available literature, and extensive committee deliberations, we concluded that all members of our academic community needed to become more aware of this problem, not just our students. Also, making an impact on teachers (clinical and otherwise), rather than students must be a top priority if we are going to “raise the bar” in this area. On the other hand, developing clinical teachers as role models in this area is just the beginning, and refinement of the curriculum, in terms of professionalism, will be a major activity as we move forward. Currently, we are planning new curricular materials relating to cultural competency, but this is only a beginning.

Our committee unanimously agreed that bringing visibility to the area of professionalism was the most effective approach for optimizing professional behavior at all levels. Because clinical leaders and other teaching faculty will always serve as role models in this area is just the beginning, and refinement of the curriculum, in terms of professionalism, will be a major activity as we move forward. Currently, we are planning new curricular materials relating to cultural competency, but this is only a beginning.

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Conclusion

What of the question posed in the title of this commentary? At this point, we have detected no serious breaches of professionalism by surgeons or other individuals in our environment, but we have identified enough minor concerns to respond in the negative. Our experience has convinced the committee that the entire topic of professional behavior deserves our close scrutiny.

As so many opposing forces participate in our health care and health education environment, surgeons must continue to vigilantly guard the values that have led us to our career choice. Whether some of the perceived transgressions in professional behavior are real or not, we must continue to take positive steps to maintain the ethics of our noble profession and specialty. As strong patient advocates, surgeons will, I believe, take the lead in this process.

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Dr. Lawrence is professor of surgery emeritus and chair of the committee on professionalism at the Medical College of Virginia, Virginia Commonwealth University, Richmond. He was Chair of the ACS Commission on Cancer, 1979-1981.
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times have a way of bringing out the best in people. Following the events of September 11, 2001, Thomas R. Russell, Executive Director of the American College of Surgeons, noted that “For every demon and villain to surface, thousands of heroes emerged.... Responding from the medical community [was]...a host of caregivers who actively participated in helping the injured.”¹ The same sort of response occurred during World War I, on a larger scale, when the fledgling American College of Surgeons and its founder, Franklin H. Martin, MD, FACS, played a major role in organizing the nation’s medical personnel to aid in the war effort.

Until the First World War, medical services were largely peripheral to the armed forces. Government funding was meager and the status of military physicians was extremely low.² When the College formally came into existence in 1913, the world was at relative peace, but the College, along with its leadership, faced significant resistance to its establishment. By the end of the war in 1918, governments were toppled, the map of Europe had dramatically changed, and the profession of surgery, as well as the ACS, had gained a considerable measure of respectability.

MEDICAL PREPAREDNESS

The Clinical Congress of Surgeons of North America met in London, England, from July 27 to August 1, 1914, under the direction of its Secretary-General, Dr. Martin. On the last morning of the conference, Dr. Martin awoke at the Hotel Cecil with “a sense of impending horror.” He recalled that at dinner the previous evening, the mood had been care-

RESPONDING TO CRISIS:
Franklin H. Martin, the ACS, and The Great War

by John S. O’Shea, MD, FACS, Brick, NJ
free, without even a mention of political events. When news arrived that the great European powers were now at war, the 1,100 American physicians and spouses who had been attending the Congress were suddenly left to find their way home any way they could.  

Although the U.S. was able to avoid entering the conflict for another two-and-one-half years, Dr. Martin and other medical leaders were convinced that the country needed to prepare for such an eventuality. The representative national medical and surgical associations were asked, through their presidents, to participate in formulating plans for medical preparedness. An organizational meeting took place April 14, 1916, at the Union League Club of Chicago, and the Committee of American Physicians for Medical Preparedness was formally created. As an aid to the general committee in surveying the medical resources of the country, an advisory committee was also selected in each state.  

In his capacity as Secretary-General of the ACS, Dr. Martin traveled to Washington, DC, to offer the College’s services to U.S. Surgeon General William C. Gorgas, MD, in connection with the work of reorganizing the Army Medical Corps. A list of ACS Fellows of military age was provided to Major General Gorgas, from which 2,000 Medical Reserve officers were chosen. On April 20, 1916, in a conference with President Woodrow Wilson, J. M. T. Finney, MD, FACS, then-President of the ACS, formally offered the services of the American Physicians for Medical Preparedness in order to “make a comprehensive survey of the medical resources of the country…make a complete invoice of such resources…provide every soldier and sailor in the service of the Federal Government protection in sanitary matters, as well as proficient medical and surgical care.”  

On August 29, 1916, an act of Congress established the Council of National Defense, which included the Secretaries of War, the Navy, the Interior, Agriculture, Commerce, and Labor, for the coordination of industries and resources for national security and welfare. In addition, the bill stated that “the Council of National Defense shall nominate to the President, and the President shall appoint, an Advisory Commission, consisting of not more than seven persons, each of whom shall have special knowledge of some industry, public utility, or the development of some natural resource, or be otherwise specially qualified, in the opinion of the Council, for the performance of the duties hereinafter provided…”  

On October 11, 1916, Dr. Martin was notified by telegram that President Wilson had appointed him to serve as one of the seven civilian Advisory Commissioners. He was part of an exceptional group that included: Bernard Baruch, New York financier and economist, known for his comprehensive knowledge of wartime economies and industry; Samuel Gompers, president of the American Federation of Labor; Hollis Godfrey, professional engineer and president of the Drexel Institute of Philadelphia; Daniel Willard, president of the Baltimore & Ohio Railroad; Julius Rosenwald, president of Sears Roebuck & Co. of Chicago; and Howard Coffin, Detroit automobile engineer (see photo, page 22). The Council of National Defense and its civilian Advisory Commission had been created because, in the words of President Wilson, “Congress has realized that the country is best prepared for war when thoroughly prepared for peace.”  

As the first act of the Advisory Commission, a conference of deans of all accredited medical schools in the U.S. was held on January 6, 1917, at which time it was resolved that all medical students should be instructed in military medicine in order to ensure the future supply of well-trained medical officers. Medical students and interns were placed in the Enlisted Reserve Corps, allowing them to avoid the draft until their education had been completed, thus furnishing annually a group of 3,000 graduates who would be available for medical service during the war. Recommendations were also made to the general hospitals of the country that their staffs be organized to release as many as possible of their members for military service, and they were urged to gradually acquire reserve stocks of drugs, appliances, and supplies to be used if needed for the war effort.

**Mobilization**

American medical personnel provided services in Europe as early as the fall of 1914, when a group of Americans residing in Paris, headed by Harvey Cushing, MD, FACS, of Harvard University, converted the existing American Hospital at Neuilly-sur-Seine into a military hospital that became known as the “Ambulance Americaine.” This or-
ganization was supported and sponsored by the American Ambassador to Paris, Myron T. Herrick, who, along with George W. Crile, MD, FACS, developed the concept of the Base Hospital Unit, believing that “mediocrity well-organized is more efficient than brilliancy combined with strife and discord.”

Initially, the principal features of the base hospital model called for a unit that could support 80 to 100 beds and an operating room, including surgical instruments, surgical dressings, anesthetics, and the staff of surgeons and nurses required for the operating room and the care of patients, as well as the ability to carry out clinical research. American medical universities would provide these services and materials on a rotating, three-month schedule. The plan was expanded to provide support for a 500-bed hospital and was presented by Dr. Crile at the Symposium on Military Surgery at the October 1915 Clinical Congress of Surgeons of North America in Boston, MA.

By the 1916 Clinical Congress, held during the week of October 23, Dr. Crile was able to demonstrate the mobilization of a base hospital unit in Philadelphia’s Fairmount Park for the 3,000 surgeons, hospital superintendents, and nurses in attendance, with staff drawn from hospitals in Cleveland, including his own Lakeside Hospital. Following this demonstration, the Army Medical Corps assembled other base hospital units at Army training centers here and in Europe. In all, 129 U.S. base hospitals operated in France or England during the war (120 organized in the U.S. and nine organized in Europe). Six hospital units reached Europe before any other American military organizations and they were eagerly received by British and French officials, since both the military and civilian popul-
lations of those countries were in dire need of medical care.

FROM PREPAREDNESS TO SERVICE

Shortly after the 1916 Clinical Congress, President Wilson was reelected for a second term on a platform that included continued American neutrality. By his second inaugural address on March 5, 1917, however, the President knew that “to be indifferent to it [the European war] or independent of it was out of the question.” One month later, on April 6, Wilson again addressed the nation, this time to proclaim the existence of a state of war between the U.S. and the Imperial German Government.

On April 2, 1917, Dr. Martin was authorized by Secretary of War Newton D. Baker to appoint a General Medical Board to act as a cooperating agency between the Army, Navy, and Public Health Service Medical Departments and the medical officers who would be enlisted from civilian life. This board included the three Surgeons General of the regular forces, the Director of Military Relief of the Red Cross, and many of the nation’s medical and surgical leaders (see photo, above). The Regents of the ACS strongly supported the war efforts, and letters were mailed to Fellows urging them to join the military services of their respective countries. On April 22, 1917, the Regents also authorized the establishment of temporary offices of the ACS in Washington, DC, to enable Dr. Martin to carry out his duties as a member of the Council of National Defense.

CONSEQUENCES OF THE WAR

Besides the achievement of important clinical advances, the war left a number of legacies for the College and the profession of surgery in America.
Although it was a nascent organization at the time, the leadership of the American College of Surgeons foresaw the importance of a competent, well-organized medical force in the nation’s war effort. Just as some members of the medical establishment criticized the formation of the College as being at best unnecessary and at worst a vehicle of self-promotion, there were individuals who opposed Dr. Martin’s appointment to the Council of National Defense and sought to discredit him with President Wilson and other officials in Washington. These attempts, however, were unsuccessful. For his extraordinary efforts during the war, Dr. Martin was promoted to the rank of colonel and was awarded the Distinguished Service Medal, the highest honor given by the U.S. government for service rendered in a noncombat situation. Other recipients of this award included: Marshall Ferdinand Foch, Commander-in-Chief of the Allied Armies; Sir Douglas Haig, Commander-in-Chief of the British Armies; Marshall Henri Petain, Commander-in-Chief of the French Armies; and General John J. Pershing, Commanding General, American Expeditionary Forces. Dr. Martin and President Wilson maintained their congenial relationship and correspondence long after the war.

The American College of Surgeons emerged from the war a more mature organization, having gained in stature and respectability. An estimated 90 percent of the 3,795 Fellows and most of the Regents were in uniform in one capacity or another voluntarily. They served at considerable personal risk, as this was the first time in “civilized warfare” that hospitals were selected as the special target of attack by an enemy’s gun. The Red Cross was no longer sacred and the operating room, as much as an ammunition train or a depot of military supplies, could be the object of an aerial bomb.

It has been suggested that “medicine is the only victor in war,” and whether war is seen as incompatible with the healing profession or its fulfillment depends to a large extent on how the medical community responds to the crisis. In response to the crisis of World War I, the American College of Surgeons took a leading role in organizing, preparing, and deploying the nation’s medical resources. The Fellows who served acquired hard-earned clinical experience that allowed them to return to civilian practice as a more competent and efficient body of surgeons, and the leadership of the College gained an organizational experience that could now be applied to programs that would advance the profession of American surgery.

References


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In 1913, the founders of the American College of Surgeons were designated as Governors. In the early years, the Governors individually assisted the Executive Director with local problems and, as a body, elected their Officers and Regents. In 1950, when William L. Estes, Jr., MD, FACS, was elected Chair of the Board of Governors, he urged the Regents to consult the Governors in matters where a consensus of the Fellows might influence decisions. The Regents agreed, and from that time on, the Governors have been a vital and contributory force in the College’s administration.*

The Board of Governors

The 2004 Board of Governors (B/G) of the American College of Surgeons comprises 265 surgeons. Of those individuals, 150 are Governors-at-Large and represent chapters in the U.S. and Canada. Another 78 individuals represent 69 surgical specialty societies, and 37 are International Governors.

Courtney M. Townsend, Jr., MD, FACS, Galveston, TX, is the current Chair of the Board of Governors. Rene Lafreniere, MD, FACS, Calgary, AB, serves as Vice-Chair, and Julie A. Freischlag, MD, FACS, Baltimore, MD, serves as Secretary. Donald E. Fry, Albuquerque, NM; Mary Margaret Kemeny, Jamaica, NY; Mark A. Malangoni, Cleveland, OH; and Valerie W. Rusch, New York, NY (all MD, FACS), also serve on the B/G’s Executive Committee.

The B/G meets each October during the ACS Clinical Congress to review the activities of the College. Additionally, in a special general session during their annual meeting, the Governors have the opportunity to address the leadership of the College—that is, the Chair of the Board of Regents, the ACS Executive Director, and the ACS President—regarding issues of concern to the surgeons they represent. Following this annual session, the Governors provide an update for their respective chapters and specialty societies through which

they share information on current College and Governor activities and future plans.

B/G Committees

While the annual meeting of the Board of Governors each October provides a vital communications link between the College and the individual Governors, the real work of the B/G is carried out by its committees. These committees have evolved over the last 20 years based on the perceived need of the Governors to work on specific, targeted areas of concern.†

Currently, there are six committees of the B/G:

- **Committee on Bloodborne Infection and Environmental Risk.** Kenneth R. Sirinek, MD, FACS, San Antonio, TX, serves as Chair. The purpose of the committee is to maintain a current inventory of environmental risks that surgeons would encounter and develop educational programs regarding risks, epidemiology, incidence, prevention, recognition, and treatment. Subcommittees include those addressing viral risks, non-infectious disease and surgical environmental risks, biological terrorism, chemical terrorism, and nuclear/radiation terrorism.

- **Committee on Socioeconomic Issues.** Robert V. Stephens, MD, FACS, Phoenix, AZ, serves as Chair. The committee seeks to identify societal and economic factors that affect the work and well-being of the Fellows and their ability to provide optimal care for their patients. The committee will provide guidance to the B/G regarding proposed actions that may promote the vitality, visibility, and future of the surgical profession. Subcommittees address workforce and work hours, the Giving Back Project, and patient education.

- **Committee on Surgical Practice in Hospitals and Ambulatory Settings.** Jeffrey E. Doty, MD, FACS, Saratoga, CA, serves as Chair. The committee seeks to provide the College with information regarding important issues that affect the delivery of surgical care in hospitals and ambulatory surgical units, and to develop and support programs that will improve the care of surgical patients. Subcommittees address ambulatory surgical care and operating environment/patient safety.

Keeping current

What’s New in ACS Surgery: Principles and Practice

The following column is a special feature from What’s New in ACS Surgery, the free monthly e-mail review of general surgery from the only ACS-sponsored textbook of general surgery, ACS Surgery: Principles and Practice. The 2004 edition of ACS Surgery has arrived. See the box below for a special announcement for ACS Fellows, Associates, and Candidates.

Laparoscopic treatment of esophageal achalasia
Nathaniel J. Soper, MD, FACS, Northwestern University Feinberg School of Medicine, Chicago, IL.

The approximately 90-year-old operative procedure of choice for idiopathic esophageal achalasia (after technical modification) remains surgical myotomy of the lower esophageal sphincter (LES), as initially reported by Ernest Heller in 1913. Until about a decade ago, this operation could be done only by laparotomy or thoracotomy, with overall good to excellent results in more than 80 percent of patients. A prospective, randomized trial showed that open myotomy resulted in better long-term results than endoscopic pneumatic dilatation.1 Given the perceived morbidity of open surgical treatment, however, most patients were treated nonoperatively.

Over the past decade, both laparoscopic and thoracoscopic approaches to Heller myotomy have been reported in many patients. It has been shown that prior use of botulinum toxin, esophageal dilatation, or both leads to fibrosis of the submucosa, which, in turn, leads to a more difficult myotomy with longer operating time and a higher risk of intraoperative perforation but without a negative impact on long-term effectiveness.2 Several nonrandomized comparisons of the laparoscopic and thoracoscopic approaches have demonstrated conclusively that the laparoscopic approach is associated with shorter operative time and hospitalization, lower morbidity, and lower incidence of postoperative reflux.3,4 Compiled series of laparoscopic myotomies have noted symptom improvement in 85 to 100 percent of patients. In these series, the rates of morbidity and mortality were extremely low, and the rates of symptomatic gastroesophageal reflux disease (GERD) were 0 to 16 percent, albeit with relatively brief clinical follow-up (averaging less than two years in most series).3,8 As a result of these excellent outcomes, more patients are being referred for primary surgical treatment of achalasia than previously.8

Other options exist, of course. Treatment rendered via the endoscope has been available for a number of years. There was a relatively brief period of enthusiasm for injection of botulinum toxin directly into the LES. Botulinum toxin inhibits the release of acetylcholine from the presynaptic nerve endings and has been shown to significantly ameliorate the symptoms of achalasia in up to 85 per-

Announcing ACS Surgery: Principles & Practice 2004

The 2004 edition of ACS Surgery has arrived. New this year: chapters are now organized into an intuitive “by body system” approach to speed access to the latest procedures, techniques, and problem-solving recommendations from master surgeons. More than 40 percent of the material either is new or has been updated since last year’s edition. Also new is online coverage at www.acssurgery.com of such key issues as patient risk assessment and malpractice avoidance.

• ACS members are entitled to special discounts plus a $30 special offer. Visit http://www.acssurgery.com/learnmore.htm or call 800/545-0554 for more information. (This offer expires December 31, 2004; mention code S46S1F5.)
• Free, convenient ACS Surgery updates by e-mail—no subscription necessary. Each month we’ll bring you a synthesis of the latest contributions from the ACS Surgery team of master surgeons, and we’ll do it for free. Simply visit http://www.acssurgery.com/wnis/wnis_sign.htm to register to receive What’s New in ACS Surgery by e-mail.
cent of patients. Unfortunately, further experience has shown that the long-term results of this treatment are disappointing, with symptom recurrence in more than half of patients by six months. Furthermore, young patients rarely respond to this therapy.

The most effective nonsurgical treatment for achalasia is forceful dilatation of the LES under endoscopic guidance. The objective of this treatment is to produce a controlled tear of the LES to render it incompetent. The trick is to tear the muscularis propria (located external to the mucosa) without perforating the mucosal layer itself. The safest and most effective means of dilatation is achieved using controlled pneumatic pressure balloons capable of dilating the LES to a diameter of up to 3.5 cm at a pressure of 10 to 12 pounds per square inch. The immediate success rate of this procedure is approximately 70 percent with a single dilatation but can approach 90 percent with multiple dilations. Esophageal perforations do occur. In addition, complications are seen in up to 10 percent of patients undergoing this procedure. After pneumatic dilatation, good to excellent symptomatic relief has been reported in up to 90 percent of patients; unfortunately, the data for long-term results are less promising; less than half the patients have good results five years post-treatment. Comparisons of botulinum toxin and dilatation in prospective randomized trials have revealed pneumatic dilatation to be clearly superior.

Regarding laparoscopic myotomy itself, several issues remain unresolved, including whether a fundoplication should be performed concomitantly and, if so, what type of fundoplication should be performed. Although prospective randomized trials currently are under way to answer these questions, neither matter has been settled. The rationale for considering concomitant fundoplication is the assumption that complete division of the LES renders it incompetent. Acid propelled retrograde into the aperistaltic esophagus of achalasic patients is not effectively cleared, thus magnifying the negative effect of postoperative reflux. The group from Vanderbilt has advocated performing anterior myotomies just to the level of the gastroesophageal junction without disrupting the lateral and posterior phrenoesophageal attachments. In their series of laparoscopic myotomies without fundoplication, postoperative pH studies revealed that 13 percent of patients had abnormal results. When myotomy is followed either by the Dor fundoplication (anterior 180°) or Toupet fundoplication (posterior 270°), abnormal pH results have been reported in up to 6 percent of patients.

Given the aforementioned discussion and rationale for performing fundoplication, the majority of experts advocate fundoplication at the time of laparoscopic myotomy. Because the documented rate of reoperation is high as a result of progressive recurrent dysphagia in patients undergoing open myotomy with complete (Nissen) fundoplication, most surgeons advocate a partial fundoplication at the time of myotomy. Those in favor of the Dor fundoplication cite that this wrap limits the dissection to the anterior plane and helps to protect against esophageal leaks. Proponents of the Toupet fundoplication state that this wrap may hold the myotomy open for the long term, since the fundus is tacked to both sides of the myotomy without bridging across it. Large series of both of these approaches indicate that the mortality rate is extremely low, that most patients return to work within 10 to 14 days, and that good to excellent results are seen in 90 percent or more of patients over the short term. Given these excellent short-term results, John Dent, a

This month at ACS Surgery Online

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

- Breast complaints, by D. Scott Lind, MD, FACS, Barbara L. Smith, MD, PhD, FACS, and Wiley W. Souba, MD, ScD, FACS.
- Oral cavity lesions, by David P. Goldstein, MD, Henry T. Hoffman, MD, FACS, John W. Hellstein, DDS, and Gerry F. Funk, MD, FACS.
- Bariatric procedures, by Eric J. De Maria, MD, FACS.
- Injuries to the chest, by Edward H. Kincaid, MD, and J. Wayne Meredith, MD, FACS.
gastroenterologist from Australia, said in his state-
of-the-art lecture for the International Society of Diseases of the Esophagus in 1998, “At this time in history, the best primary therapy for achalasia in a fit patient is a laparoscopic Heller myotomy and fundoplication.”

Technical details of laparoscopic myotomy warrant some mention. The anterior wall of the esophagus extending well up into the mediastinum must be exposed with division of the fat pad at the gastroesophageal junction and dissection of the anterior vagus nerve away from the underlying esophagus, because it crosses the lower esopha-
gus in this location. The myotomy is initiated on the distal esophagus at or just to the right of the midline, usually by simple blunt dissection to en-
ter the submucosal plane. This plane is then ex-
tended cephalad for a distance of approximately 7 cm from the gastroesophageal junction and is extended down onto the stomach for 2 to 3 cm. Many surgeons advocate the performance of in-
traoperative endoscopy to ensure completeness of myotomy and absence of small perforations. The fundoplication should then be performed to the cut edges of the myotomy, whether the wrap is performed anterior or posterior to the esophagus. Recently, there has been interest in the perform-
ance of myotomy using computer-assisted sur-
gery (robotics), given its three-dimensional video imaging and surgeon-directed optics.14

Idiopathic achalasia is a disease that can be pal-
liated but not cured. Symptoms are generally man-
aged by inhibition or destruction of the LES. Pa-
tients who have high operative risks should be treated endoscopically, either with botulinum toxin or endoscopic pneumatic dilatation. However, the majority of patients should be treated by the mo-
dality that appears to have the best combination of low initial morbidity, high success rate, and good long-term outcome. This appears to be laparoscopic myotomy with partial fundoplication. Prospective, randomized trials will be necessary to settle some issues of the details of therapy, such as the require-
ment for and type of fundoplication.

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College news

Winners of 2004 Residents Trauma Papers Competition announced

The ACS Committee on Trauma announced the winners of the 2004 Residents Trauma Papers Competition at its annual meeting in Tucson, AZ, March 11-13, 2004. This year, 13 regional winners received prize money of $500, with additional first-place prize money of $1,000 and second-place prize money of $500. The Residents Trauma Papers Competition is funded by the Eastern and Western States Committees on Trauma, and Region VII (Iowa, Kansas, Missouri and Nebraska), Wyeth Pharmaceuticals, and the American College of Surgeons.

This competition is open to surgical residents and trauma fellows in the U.S., Canada, and Latin America. Papers are submitted to the individual state or provincial chair. Winning papers are selected and sent to each Region Chief so they can conduct a regional competition. Papers describe original research in the area of trauma care and/or prevention categorized in either basic laboratory research or clinical investigation.

Winning papers from 13 regions were presented at the scientific session at the Committee on Trauma meeting, and the final four winners were announced at the trauma banquet. Winning senior authors and their spouses received an expense-paid trip to the meeting.

Gregory J. Jurkovich, MD, FACS, Chair of the Regional Committees on Trauma, served as moderator.

The 2004 final winners are as follows:

**First Place—Basic Laboratory Research:** Rachel G. Khadaroo, Bsc, MD, Toronto, ON: The Cellular and Molecular Mechanisms Regulating Oxidative Stress-Induced Priming of Macrophage: The Role of the SRC Family of Tyrosine Kinases.

**First Place—Clinical Investigation:** Matthew Rosengart, MD, Seattle, WA: An Evaluation of the Effect of State Firearm Legislation on Firearm Mortality.

**Second Place—Basic Laboratory Research:** Manuel B. Torres, MD, Baltimore, MD: Protection from Lethal Endotoxic Shock after Testosterone Depletion Is Linked to Chromosome X.

**Second Place—Clinical Investigation:** Carlos V. R. Brown, MD, Los Angeles, CA: Preventing Renal Failure in Patients with Rhabdomyolysis: Do Bicarbonate and Mannitol Make a Difference?
College redesigns homepage to be more user-friendly

If you have been frustrated in the past because you have found it difficult to locate information on the College’s Web site, visit www.facs.org to review our newly redesigned homepage.

The content on the homepage has been greatly simplified and reorganized under major headings that reflect the various activities of the College. When you put your mouse on a link in the left-hand column of the new homepage, a highlighted drop-down menu will appear to show you what can be found under each link.

In addition, the College’s Web site is now powered by a Google™ search engine to make finding the information you need easier than ever. The “Table of Contents” feature has been maintained as another means of getting you to the information you are seeking as quickly as possible. And news briefs on items of interest to ACS members and the public will continue to be presented and updated on a regular basis.

Be sure to visit www.facs.org often to keep in touch with the many activities the College conducts on behalf of its Fellows and their patients.

BOARD OF GOVERNORS COMMITTEES, from page 36

- Committee to Study the Fiscal Affairs of the College. Julie A. Freischlag, MD, FACS, Baltimore, MD, serves as Chair. The purpose of the committee is to study all aspects of College finances in collaboration with the Board of Regent’s Finance Committee, especially in relation to membership dues, and to study other possible means of increasing the College’s income.

- In order to highlight the work of the B/G committees, the Bulletin plans to publish in the coming months a series of reports authored by individual committee chairs. These reports are intended to inform the Fellows about the activities of the B/G committees and to encourage them to seek out committee chairs to comment and provide perspective on issues affecting the ongoing work of the College.
Available on CD and DVD

Cine Clinic I:
Multispecialty/Endoscopic

Cine Clinic II:
Esophageal Surgery

General Surgery I
Pediatric Surgery
Clinical Workshop
Urological Surgery
General Surgery II
Unusual Problems in Surgery
Trauma
Vascular Surgery
Otorhinolaryngology
The Film and Video Festival
Bariatric Surgery
Colon and Rectal Surgery
Cardiothoracic Surgery

Visit our web site at www.cine-med.com

for a complete catalog of the Video Sessions and Cine Clinics, and all of the ACS video library products. If you prefer, call us at

1-800-633-0004
COC joins effort to advocate for cancer research funding

One Voice Against Cancer (OVAC), a coalition of more than 40 public interest groups, was formed to unify the cancer community and present a cohesive message to the Administration and Congress regarding the funding levels that are necessary to defeat cancer. As a member of OVAC, the American College of Surgeons’ Commission on Cancer (COC) signed a letter to members of Congress urging them to support cancer research and its application as a priority in the fiscal year 2005 (FY05) Labor, Health and Human Services and Education (LHHS) Appropriations bill.

Funding specifically requested in the letter includes:

- $30.25 billion in FY05 for the National Institutes of Health, an increase of 8.5 percent.
- $6.2 billion for the National Cancer Institute in FY05.
- $207.88 million in FY05 for the National Center on Minority Health and Health Disparities to advance its critically important work in coordinating and advancing health disparities research across the NIH.
- $25 million FY05 funding for the Centers for Disease Control and Prevention’s (CDC’s) National Comprehensive Cancer Control Program, $65 million for the National Program of Cancer Registries, and increased funding to expand the services offered by CDC programs providing community outreach, education, and awareness.
- $205 million in FY05 for the Nurse Reinvestment Act and the other nursing workforce programs at Health Resources and Services Administration.

For more information, contact Connie Bura at 312/202-5290 or via e-mail at cbura@facs.org.

New traveling fellow exchange announced

The International Relations Committee of the College announces a new traveling fellow exchange with the German Surgical Society and the German Chapter of the ACS. A Fellow from North America will travel to Germany to attend and participate in the annual meeting of the German Surgical Society in April 2005, and a German surgeon will attend and participate in the Clinical Congress in October 2005.

The complete requirements for the North American Fellow are posted on the College’s Web site at http://www.facs.org/memberservices/research.html, and will be published in the July Bulletin.

Correction

The May 2004 Bulletin article, “Survey offers a profile of surgical practice in 2004” (page 19) contains an error. Figure 3 on page 20 is mislabeled.

The vertical axis label should read “Percent of surgeons.”

The editors regret the error.
Martin R. Eichelberger, MD, FACS, founder and president of the National SAFE KIDS Campaign and director of emergency trauma and burn services at Children’s National Medical Center in Washington, DC, received the World of Children’s Cardinal Health Children’s Care Award. The award recognizes Dr. Eichelberger for his “significant lifetime contribution to the health and well-being of children.”

The National SAFE KIDS Campaign is a U.S.-based, not-for-profit organization dedicated to the prevention of unintentional childhood injury.

Gordon L. Hyde, MD, FACS, a vascular surgeon in Lexington, KY, has been named executive director of the International Doctors in Alcoholics Anonymous (IDAA). Founded in 1949, the IDAA is a fellowship of approximately 4,500 recovering health care professionals and their families whose primary purpose is “to support one another in recovery from alcoholism and other drug addictions.” (For further information, visit the IDAA Web site at www.idaa.org.)

The Society of American Gastrointestinal Endoscopic Surgeons (SAGES) recently awarded Gerald Marks, MD, FACS, the George Berci Lifetime Achievement Award. Dr. Marks is founder and director of Marks Colorectal Surgical Foundation and Marks Colorectal Surgical Associates in Wynnewood, PA. SAGES has previously honored Dr. Marks with a named annual lectureship and a distinguished service award.

Alan M. Mindlin, MD, FACS, was elected president-
elect of the 14,500-member Michigan State Medical Society during its annual meeting in May. Dr. Mindlin, an ophthalmologist from Pontiac, will be installed as the medical society's president in April 2005.

**Ajit K. Sachdeva, MD, FACS, FRCSC**, the College’s Director, Division of Education, presented the second annual Lloyd D. MacLean General Surgery Visiting Professorship at McGill University this past February. Dr. Sachdeva delivered two presentations in conjunction with the visiting professorship, Leadership Training for Surgeons: A Concept Whose Time Has Come, and Surgical Education and the Core Competencies: The Quest for Excellence.

Dr. MacLean was professor of surgery at McGill University in Montreal, QC, for more than a quarter century, and served as ACS President from 1993 to 1994. He is also the only Canadian to have held both positions as ACS President and president of the American Surgical Association.

Dr. Sachdeva

**ACS Research Scholar awarded Huddart Medal**

Chad Perlyn, MD (see photo, far right), was awarded the Arnold Huddart Medal at the annual scientific meeting of the Craniofacial Society of Great Britain and Ireland. The award is given for the best research presented by a young investigator.

Dr. Perlyn is a plastic surgery resident from Washington University, St. Louis, MO, and a 2003 Resident Research Scholar of the American College of Surgeons. He is performing research toward a PhD degree from the University of Oxford in the laboratory of Professor Gillian Morriss-Kay, an international leader in craniofacial development.

One branch of Dr. Perlyn’s research is entitled “The Effect of the Fgfr2 Crouzon-type mutation on palatogenesis.” His mouse model studies why individuals with a particular mutation of the fibroblast growth factor receptor 2 gene can have clefts of the palate in addition to other craniofacial deformities that are seen with these mutations. His model is for Crouzon syndrome, but may be applicable to other forms of more common syndromic clefting and non-syndromic clefts as well.
Announcing a new instructional CD-ROM

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

— Walter J. Pories, MD, FACS

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

— George S. Corson, MD

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

Bariatric Surgery Primer

Course objectives:

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

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

American College of Surgeons • Division of Education
with the American Society for Bariatric Surgery
The American Society of General Surgeons (ASGS) has developed an expert witness certification program. The certification attests to the physician having completed the conditions of the program and agreeing to abide by the rules and regulations governing the program.

The ASGS is an independent, national, democratic organization composed of highly qualified general surgeon specialists and subspecialists who perform general surgery procedures.

Certification requirements include the following:

- Is a member in good standing in the American Society of General Surgeons.
- Abides by the American Medical Association Oath of Hippocrates, American College of Surgeons Fellowship Pledge, and the American Society of General Surgeons Oath of Ethics.
- Has a comparable education, training, and occupational experience in the same field as the defendant/plaintiff physician.
- Active medical practice and teaching experience is within five years of the date of the event giving rise to the claim.
- Has completed an ASGS-approved expert witness course that includes ethical guidelines, professional responsibility, and provides a thorough review of the tenets of impartial expert witness testimony based on the widely accepted theories of clinical surgical science that are supported by respectable experts in the field of issue.
- Submits two letters of recommendation attesting to the competency, honesty, and professional, ethical, and moral character of the expert witness applicant, as well as good standing in the local and/or medical community from the applicant’s hospital board of trustees or department of surgery in the hospital where the surgeon has privileges, and the county or state medical society, or the AMA.
- Has 50 hours of Category I CME every two years. No more than 25 of those hours may be obtained at the applicant’s local hospital or teaching facility.

Further information regarding the ASGS expert witness certification program may be obtained by contacting ASGS, 4200 Commercial Way, Glenview, IL; tel. 800/998-8322, e-mail asgs-info@theasgs.org, or by visiting their Web site at http://www.theasgs.org.

"The College does so many wonderful things that many Fellows don't realize. Enrichment gifts from individuals allow the College to better fulfill its many purposes and missions."

—J. David Richardson, M.D., FACS, Louisville, KY

For information about joining the Fellows Leadership Society, please contact the College's Development Office via telephone at 312/202-5338, via e-mail at bliebig@facs.org, or visit the ACS Web site at www.facs.org/development/develop.html
ACS CodingToday features:

- Complete CPT, HCPCS Level II, and ICD-9 codes.
- Current Medicare Correct Coding Initiative bundling edits, national and local fee schedules, and Medicare policy information.
- Medicare information on global fee days and modifier usage.
- Automatic calculation of fees by geographic locality.
- Full text Local Medical Review Policies, fall 2003.

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

Special discount pricing: Only $199 for the first user, $50 for each additional user—a $590 value!
NTDB™ data points

“I’ll drink to that”

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

Summer has finally arrived. Large numbers of people take to the roads and travel countless miles driving at all hours of the day and night. Often they drive without adequate sleep or otherwise impaired. Impairment may be due to the aging process, sleep deprivation, recreational drugs, or alcohol consumption.

Just how big is the problem of alcohol as it relates to motor vehicle trauma? When looking at the records in the third annual report of the National Trauma Data Bank™ (NTDB), there are records representing 121,494 motor vehicle drivers. Of this number, 116,022 drivers were tested, and 23,345 were found to be positive for alcohol. This number shows that one out of every five injured drivers had alcohol on board. These results are depicted in the chart on this page.

Impaired driving is truly something that touches the lives of many people. According to the National Highway Transportation and Safety Administration (NHTSA), impaired driving will affect one in three Americans during their lifetimes. Motor vehicle crashes that are alcohol related kill someone every 30 minutes and result in a nonfatal injury every two minutes. In addition to the lives lost and families that are emotionally scarred, there is also a substantial financial burden. It has been estimated in another NHTSA report that alcohol-related crashes in the year 2000 were associated with more than $51 billion in total costs.

A public health problem of this magnitude requires aggressive prevention measures. There are several programs that have been proven to be effective. One such program is the use of sobriety checkpoints. According to a 2002 report published in Traffic Injury Prevention by the Centers for Disease Control and Prevention, sobriety checkpoints consistently reduced alcohol-related crashes by about 20 percent. These checkpoints worked whether they were used only for a short time or were used continuously over a number of years. Other sound prevention initiatives include enforcement of 0.8% blood alcohol laws, minimum legal age drinking laws, and “zero tolerance” laws for drivers under the age of 21. Those of you with children are well aware that it is never too early to discuss the negative impact of alcohol and drugs in their lives. So as summer gets into full swing let’s make sure that we get this valuable message out.

Throughout the year we will be highlighting these data through brief monthly reports in the Bulletin. For a complete copy of the NTDB Annual Report 2003, visit us online at 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.
American College of Surgeons Professional Association (ACSPA)

The American College of Surgeons Professional Association (ACSPA) continues to be active in a number of advocacy programs. Some of the ACSPA’s most recent activities are described below.

DMLR
Doctors for Medical Liability Reform (DMLR) (http://www.protectpatientsnow.org/home.html) is a coalition of organizations, including the ACSPA, representing high-risk medical and surgical specialties. The new, separately incorporated 501(c)4 organization was formed to conduct an aggressive public education campaign on the need for federal medical liability reforms on a state-by-state basis. The campaign was launched in Washington state and North Carolina following a press conference to announce the new coalition. Other states that subsequently joined the campaign include South Carolina, Georgia, Florida, Illinois, and Pennsylvania. The coalition will continue to take this campaign to individual crisis states in which one or more senators must still be persuaded about the critical need to enact reforms.

ACSPA-SurgeonsPAC
As of January 15, 2004, the PAC has raised approximately $205,000 from nearly 800 College members. The PAC Board continues to raise funds through a variety of venues. An annual report of the accomplishments, contributions, and contributors will be distributed to all PAC participants. In 2003, the PAC donated to 55 candidates and leadership PACs.

The ACSPA Board of Directors approved the business plan for a new fund-raising tool. The establishment of a telephone education and fund-raising program will allow PAC members to speak directly to ACSPA members, providing them with legislative updates and informing them of the means available to them to participate politically. The goals and objec-
tives of this program are to educate mem-
bers, increase PAC contributions, and place
the organization in the “top five” politically
powerful physician groups. The use of this
tool could place the ACSPA-SurgeonsPAC in
a position within one to two years that would
otherwise take 10 years using the current
techniques.

Members of the PAC’s President’s Circle
and ACSPA leaders will have the opportu-
nity to attend the July Democratic National
Convention in Boston, MA, or the August Re-
publican National Convention in New York,
NY. The ACSPA-SurgeonsPAC is working
with three other medical organizations to
plan events at the convention.

American College of Surgeons (ACS)

Following is an update on College pro-
grams that were approved or discussed at the
Board of Regents meeting.

Statements approved

The Board of Regents approved the ACS
Statement on Prevention of Non-Traffic, Ve-
hicle-Related Injuries in Children. The state-
ment was developed to support proposed fed-
eral legislation that would direct the Na-
tional Highway Traffic Safety Administra-
tion to collect data on non-traffic, non-crash
events and to investigate ways to improve
the safety of child passengers.

The Board of Regents also approved the
ACS Statement on Universal Health Insur-
ance (http://www.facs.org/fellows_info/state-
ments/st-45.html). The statement was devel-
oped by the Health Policy Steering Commit-
tee as a step toward achieving universal
health insurance in the U.S.

The Board of Regents approved an “Ex-
pert Witness Affirmation.” Fellows may use
the voluntary affidavit when serving as phy-
sician expert witnesses to affirm their ad-
herence to the College’s principles regard-
ing the testimony provided in malpractice
litigation. The document reflects the newly
revised ACS Statement on the Physician Act-
ing as an Expert Witness (http://www.facs.org/
fellows_info/statements/st-8.html). The most
notable change to this statement was the
added requirement that the expert witness
hold current privileges in an accredited hos-
pital to perform any surgical procedures that
may be pertinent to the lawsuit in which he
or she testifies.

Affiliate membership

The Board of Regents approved an Affili-
ate membership category. Aside from the
surgeons who attend the ACS Clinical Con-
gress, a significant number of nonsurgical
physicians participate to avail themselves of
this meeting’s educational opportunities.
Offering an Affiliate membership category
is an alternate and less expensive method
for these individuals to attend the meeting
and benefit from the College’s educational
programs. (The membership fee will be less
than the registration fee, which will now be
waived for members of this category.) Affili-
ate members will have access to the members-
only section of the ACS Web site and online
access to the Journal of the American College
of Surgeons (JACS), ACS NewsScope, and ACS
CoC Flash. Affiliates will also be eligible for
ACS services, such as insurance products,
car rental discounts, textbook discounts,
personal digital assistant software and hard-
ware discounts, and other services that will
be available in the future.

Scholarships

The American College of Surgeons awards
approximately $1.5 million annually in schol-
arships. At its February 2004 meeting, the
Board of Regents was apprised of the names
of six individuals to receive ACS Resident
Research Scholarships, one to receive the
Oweida Scholarship, and one to receive the
ACS/Society of Thoracic Surgeons Health
Policy Scholarship.

In addition to scholarships, the ACS also
presents various awards annually. The Board
of Regents was informed that a recipient had
been selected for the ACS/American Head
and Neck Society Faculty Career Development Award for Oncology of the Head and Neck. Detailed information on these and other scholarships and awards can be accessed through the following Web address: http://www.facs.org/memberservices/research.html.

Development Program
During 2003, the College received more than $1.34 million in contributions. This represented a 12 percent increase from the previous year. In the same period, the total number of gifts increased 11 percent.

Board of Governors
A report on all of the Governors’ committees’ activities was submitted to the Regents. In addition, specific recommendations from three of the Governors’ committees were submitted to the Board of Regents.

The Committee on Blood-Borne Infection and Environmental Risk made recommendations relative to the ongoing disaster planning initiatives in our nation’s cities and communities. The distribution of disaster plans and the involvement of surgeons has been inadequate, according to the committee. Therefore, the committee proposed that the Governors take a more active stand in the areas of disaster planning and made the following recommendations:

• The Division of Education should develop an educational module on disaster planning and weapons of mass destruction that could be available to the Fellows through the ACS Web site. Slides could be available and information formats could be presented.

• The Committee on Trauma should develop a component on disaster planning for the Advanced Trauma Life Support® (ATLS®) course. Specifically, a chapter on new era disaster planning should be added to the ATLS manual.

• Training about weapons of mass destruction and mass casualties should be encouraged in surgical residency programs, and questions on this topic should be considered for inclusion in the Surgical Education and Self-Assessment Program.

• A manuscript should be generated as a joint effort with the Committee on Trauma as Part IV of the series that has already been compiled on disaster planning.

• The Governors should continue to encourage the College to bring these concerns to the Department of Homeland Security in Washington, DC. Perhaps a “blue ribbon committee” of Governors and other representatives from the College could go to Washington and express these concerns.

The committee also suggested that education on disaster planning be incorporated into the medical school curriculum.

The Committee on Chapter Activities presented a resolution encouraging the Program Committee to increase the number of presenters from underrepresented groups to participate in the College’s Clinical Congress education programs. The Board of Governors and subsequently the Program Committee approved this recommendation.

The Committee on Socioeconomic Issues recommended that the College support its development of a proposed Web site that would serve as a resource or clearinghouse for volunteerism opportunities. The eventual goal of this program would be to serve as a “match program” relative to the time commitment that is being sought by the individuals who use the Web site.

Communications
The ACS Candidate and Associate Society (CAS) began publishing an electronic newsletter, CAS-ACS News, in 2003. Content for the newsletter is developed by members of the CAS Executive Committee. Feedback from members of the CAS Communications Committee indicates that the newsletter is being well received and is piquing interest in the activities of the CAS. The CAS newsletter can be accessed through the following address: http://www.facs.org/cas-acs/resources/resources.html.

Another electronic newsletter launched in
2003 was ACS Cross Country. This publication highlights state issues that are affecting surgeons and surgical care at the local level. ACS Cross Country can be accessed at: http://www.facs.org/ahp/crosscountry.html.

With respect to the College’s print publications, the Board of Regents approved the recommendation to select Elsevier Science, Inc., to publish JACS with a renewed five-year contract beginning January 1, 2005, the first issue of the 100th anniversary year of the journal.

The addition of Surgery News, a monthly, tabloid-sized newspaper for surgeons in all specialties, is an integral part of the proposal the College has received from Elsevier. The newspaper would augment the College’s current catalog of publications and would be distributed to all surgeons, not just to members of the College.

Chapters
Plans and arrangements have been made for the 2004 Leadership Conference for Young Surgeons and Chapter Officers May 16-18 in Washington, DC. The theme of this year’s program is “Change: How to Lead the Charge.” The focus will be on fluctuations in our workplaces and professional relationships, in politics, and in private, not-for-profit organizations. For the first time, a preconference education program will be offered to young surgeon representatives and chapter officers.

Education
The ACS has partnered with the Association of Program Directors in Surgery to develop a Web-based system that would assist training program directors in assessing the six core competencies of residents as required by the Accreditation Council for Graduate Medical Education. Benefits for residency programs would include: the ability to assess the core competencies of residents using valid and reliable instruments; the use of a Web-based platform that would allow the program staff and faculty to electronically distribute, complete, and submit the assessment instruments; and the ability to send reminders and view the composite faculty ratings. The system would be made available for general use in July 2004.

A “Residency Assist” Web page (http://www.facs.org/education/residencyassist.html) has been created to serve as a resource for surgery program directors as they continue to make changes in their residency programs to comply with the 80-hour workweek restriction. The goal of this new Web page is to offer program directors practical information on approaches being used at various programs to offer state-of-the-art education and to provide summaries of key articles, invited editorials, and selected references on the subject.

The Board of Regents approved the development of a Resident Practice Management Course in CD-ROM format. The course will cover issues such as managing personal finances, balancing new personal debt with large existing educational debt, practicing in an unforgiving reimbursement environment, and learning the business side of medicine. The course is designed to educate surgical residents about the important socioeconomic areas that they will face during residency and the first years of practice. The course is also designed to appeal to a broad spectrum of surgical specialties in both private and academic practice.

In addition, the CAS chose as its theme for 2004 “Developing Leaders Today for Leadership Tomorrow.” Among its various responsibilities, CAS will assist in coordinating educational offerings to CAS members.

2004 Clinical Congress
Planning for the 2004 Clinical Congress is off to a strong start. The system to create the blueprint of the Clinical Congress from the approved program was completely overhauled. New steps were introduced to ensure an appropriate balance of the content during each day of the Congress, minimize content overlap, and provide optimum educational sequenc-
ing and flow for the respective surgical specialties.

A live surgery session on “Inguinal Hernia Repair” was presented during the 2003 Clinical Congress. The session was well attended and the feedback was positive. A live surgery session on “Bariatric Surgery” will be presented at the 2004 Clinical Congress.

Surgical Education and Self-Assessment Program (SESAP) 12 is in development. Its content is based on the general content outline of the recertification examination of the American Board of Surgery. A special postgraduate course focusing on SESAP 12 and preparation for recertification in surgery will be offered during the 2004 Clinical Congress.

The Committee on Young Surgeons will present the 2004 Initiates Program during the Clinical Congress. The title for the program is “Immigration and Surgery in America: The Ever-Changing Face of the American College of Surgeons.”

**Annual Meeting of Fellows and Martin Memorial Lecture**

The Executive Committee of the Board of Regents approved a time change for the Annual Meeting of Fellows and the Martin Memorial Lecture. Both meetings will take place the morning of Thursday, October 14. The Annual Meeting of Fellows will be held from 7:30 to 8:30 am and the Martin Memorial Lecture will be given at 8:30 am. President George W. Bush has been invited to deliver the Martin Memorial Lecture.
Chapter news

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

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

West Virginia secures trauma research grant

The West Virginia Chapter, in conjunction with the state’s Committee on Trauma (WV COT), has received a $250,000 grant from the Benedum Foundation to develop a statewide trauma data collection project. In cooperation with the state’s emergency medical services office and additional financial support through West Virginia state sources, a four-phase data collection system is moving toward completion. The project will integrate trauma data from regional trauma centers, smaller rural hospitals, regional medical command centers, and prehospital care providers through electronic patient care records. The collected data will be integrated into regional and statewide performance improvement measures to refine the developing rural trauma system in West Virginia.

(Note: This summary was prepared by David Kappel, MD, FACS, Chair of the WV COT.)

Chapter anniversaries

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Indiana conducts annual meeting

The Indiana Chapter conducted its 2004 annual meeting April 22-24. James Fleshman, MD, FACS, presented the Indiana Oration; the title of his talk was Laparoscopic Colectomy for Colorectal Cancer. An extensive paper competition for residents was held; awards presented and their respective recipients were as follows:

• Carol H. McCaskey Award: Avinash
Agarwal, MD, for Non-Alpha Gal Reactive Xenoantibodies to Porcine Microvascular Endothelium in Human and New World Primate—Saimiri Sciureus.  
  • Willis D. Gatch Award: Carol Palochko, MD,* for CXCR4 Is Expressed on Breast Cancer Stem Cells and Plays a Role in Clonal Selection and Initiation of Metastasis.  
  • Morton Bolman Award: John Sandoval, MD,* for Risky Business: A Post-Injury Survey of Parents’ Views on All-Terrain Vehicle Crashes in Children.  
  • Leonard Ensminger Award: Ben M. Tsai,* for Endothelial Monocyte-Activating Polypeptide II Causes Pulmonary Artery Vasodilatation via a Nitric Oxide Synthase Dependent Mechanism.  
  In addition, new officers were elected during the annual business meeting (see photo, page 55). *Denotes membership in the Candidate Group.

Next month in JACS

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

Collective Review

• Perioperative Risk Assessment in Elderly Patients

Original Scientific Articles

• Prognostic Significance of FDG-PET
• Use and Outcomes of Hepatic Resection
• Feeding Tube Placement in the Critically Ill

What’s New in Surgery

• Neurological Surgery
• Otolaryngology-Head and Neck Surgery