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Each year, a growing number of patients with kidney, heart, liver, and other conditions find themselves waiting for an organ donor to help save their lives. To help generate ideas about how to narrow the gap between the people on the waiting list and the individuals who volunteer to donate, the American College of Surgeons cosponsored a symposium that the Joint Commission on Accreditation of Healthcare Organizations presented in March. A summary of that meeting appears on page 31.

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From my perspective

When shopping for a new car or choosing the right university for our children, many of us feel compelled to read publications that rank the quality and performance of these high-ticket items. Ratings for most consumer goods and services have been widely available to the public for decades. Not so with regard to health care. That situation is about to change.

The first signal of movement in this area was seen when the Centers for Medicare & Medicaid Services indicated to the public that it would start evaluating nursing homes and then make its findings available to the public. Additionally, several private-sector coalitions that represent the interests of employers who offer health care benefits to their workers are seeking data that will assist them in choosing cost-effective providers. And, as patients become more responsible for their own health care decisions, they are looking for quality indicators that will allow them to make informed choices.

One result of the evolving movement toward rating the quality and performance of health care providers is the emergence of a new lexicon to describe various activities and concepts. Terms such as value-based medical purchasing, consumer-driven health, care-focused purchasing, pay for performance, and “score cards” for health care professionals and providers are becoming commonly used phrases in discussions about our health care system.

Why now?

An obvious question is, why has it taken so long for health care to be evaluated based on hospital and surgical outcomes? One reason is that it is extremely difficult to objectively determine the quality of care provided using the existing administrative and insurance data, all of which have inherent qualitative defects. In moving more deeply into this controversial arena, we must all realize that any attempts to evaluate hospital and surgical outcomes must employ and analyze data that are science-based and risk adjusted.

An article in last month’s Journal of the American College of Surgeons points out that measuring the quality of surgical care is a complicated process that requires different data than this profession has typically analyzed during morbidity and mortality conferences. Benchmarks that must be used in evaluating health care to arrive at the sort of rankings that are now in demand include the volume of cases, processes of care, and outcomes. For example, as the authors of the article note, some procedures are performed relatively infrequently but have very high risks associated with them, while the opposite is true for other operations.* In other words, we need to look at both the outcome and the circumstance surrounding the procedure.

In the past, some surgeons and institutions have done an excellent job of evaluating performance indicators and surgical outcomes. For example, since 1987, six New England hospitals have main-

tained a clinical registry on their performance of coronary artery bypass graft and other cardiac procedures. In addition, the Society of Thoracic Surgeons has a large database that tracks data on operations performed by its heart surgeons, and several states—including Pennsylvania and those in New England—have measured outcomes in cardiothoracic surgery.

Likewise, the transplant community, as mandated by the federal government, has effectively used outcomes to evaluate the quality of care in this field. Additionally, many individual surgeons and institutions have developed and maintained their own databases in an effort to monitor their outcomes.

The shortcoming of all these repositories, however, is that they focus only on specific operations or specific disease processes. Additionally, the vast majority of small group and solo practices have lacked the resources needed to adequately assess their level of performance and quality.

The College’s role

The American College of Surgeons is actively pursuing efforts to help surgeons in all specialties to better meet the imminent demand for quality and performance indicators. Through a grant from the Agency for Healthcare Research and Quality, the College is taking the National Surgical Quality Improvement Program developed by the U.S. Department of Veterans Affairs into the private sector and is demonstrating its validity in assessing surgical outcome in a risk-adjusted way. We will be marketing this program to private hospitals to assist them in their efforts to compare their outcomes with those of other institutions.

Concomitantly, our Committee on Informatics and the Division of Education’s Task Force on Systems-Based Practice are developing programs that will allow surgeons to track or log their cases on their personal computers or hand-held devices. These tools will enable practicing surgeons to assess their scope of practice and short- and long-term outcomes.

We are also working with other organizations to evaluate best practices, including the American Medical Association’s Physician Consortium for Performance Improvement, the National Quality Forum, and the Joint Commission on Accreditation of Healthcare Organizations.

As a profession, we need to look to the future and continually ask ourselves whether we can find a better way to deliver surgical care. Clearly, we have yet to uncover the best treatment for many disease processes. The clinical trials conducted through the American College of Surgeons Oncology Group and the College’s Division of Research and Optimal Patient Care will help us to determine how we can more effectively treat cancer, hernias, and other surgical problems and conditions. These discoveries ultimately may reduce the variability in the performance and outcome of procedures across the spectrum of surgical care.

These are changing times, and surgeons can no longer afford to put their heads in the sand and deny that the public and the government intend to hold us to a higher level of accountability. I urge all Fellows to learn about the new reporting and monitoring systems and to get involved in efforts to ensure that quality measurements are based on scientific evidence.

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.
In March, ACS Executive Director Thomas R. Russell, MD, FACS, and R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, traveled to Washington, DC, to meet with key officials at the Department of Veterans Affairs to discuss the College’s National Surgical Quality Improvement Program (NSQIP) program and health care quality issues in general. During the same trip, Drs. Russell and Jones met with congressional staff of the House Ways and Means Committee and the Senate Finance Committee to discuss the College’s quality initiatives and the NSQIP program.

Robert W. Oblath, MD, FACS, participated in the inaugural meeting of the Aetna Physician Advisory Board on April 2, 2004. The nine-member board of physicians, of which Dr. Oblath is a member, was established as a result of the settlement of a class-action lawsuit brought by physicians against managed care payors. The goal of the board is to give physicians the opportunity to provide guidance to Aetna on health care issues of national scope.

Webcast sessions from the 2003 Clinical Congress are now available online in the College’s E-Learning Resource Center at www.conferencecapture.com/acsteaser/index.html. The presentations include synchronized audio and slides that can be viewed from start to finish as they were presented at the meeting or at your own pace. The Webcast also provides the opportunity to review sessions, start and stop the presentations as necessary, and view each session an unlimited number of times. Online testing provides the opportunity to obtain CME credit for sessions reviewed, and a printable CME certificate is available upon successful completion of an exam and a brief survey.

The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Japan for 2005. The purpose of this fellowship is to encourage international exchange of surgical scientific information. It is available to a Fellow of the College under age 45 who holds a current full-time academic appointment in the U.S. or Canada. The traveler will be required to spend a minimum of two weeks in Japan, including participation in the annual meeting of the Japan Surgical Society, to be held in Nagoya, May 11-13, 2005. The complete requirements and application form are available at http://www.facs.org/memberservices/acsjapan.html or by contacting kearly@facs.org. The deadline for applications is June 1, 2004.
Although the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MPPDIMA) replaced scheduled physician payment reductions in 2004 and 2005 with modest increases in both years, it delayed resolving the fundamental problems with the physician fee schedule updating system. According to the Medicare trustees report issued in mid-March, Medicare’s sustainable growth rate (SGR) formula for determining annual fee schedule updates will produce cuts in the range of 4 or 5 percent each year from 2006 through 2012.

Joining the College and other organizations that are pursuing both administrative and legislative solutions to this problem, Reps. Bill Thomas (R-CA) and Nancy Johnson (R-CT), who chair the House Committee on Ways and Means and its Health Subcommittee, respectively, sent a letter on April 4 to the newly-appointed Administrator of the Centers for Medicare & Medicaid Services (CMS), Mark McClellan, MD. In their letter, Representatives Thomas and Johnson urge CMS to consider making administrative changes to the payment formula that will ease the pressure on the physician payment system and thereby make the ultimate cost of legislative reforms more affordable.

More specifically, they asked the agency to:

- Remove the cost of prescription drugs from the calculation of Medicare physician expenditures under the SGR.
- Adjust annual expenditure targets to allow for spending growth resulting from benefit and coverage expansions.
- Examine actuarial assumptions made about physician behavioral responses caused by changes in law, and account for other changes in law that affect physician income.

To read a copy of the letter to Administrator McClellan, please link to http://www.facs.org/ahp/views/sgr.html.

The College led 37 specialty societies in opposition to a recent General Accounting Office (GAO) report, which recommended that Congress consider consolidating all Medicare payments for assistant-at-surgery services under the hospital inpatient prospective payment system. In other words, no separate payment would be made for physicians or clinical staff providing these services.

The March 17 letter to the chairs and ranking minority members of the committees with jurisdiction over Medicare payment issues was drafted by the College and circulated among the specialty societies by the American Medical Association. It noted that the GAO’s recommendations reach far beyond the scope of the original congressional request and present serious implications for the quality and safety of surgical patient care. The full text of the letter can be viewed on the College’s Web site at http://www.facs.org/ahp/views/assistants.html#1.

The Food and Drug Administration (FDA) recently issued an announcement to surgeons recommending caution when using absorbable hemostatic agents, particularly on or near a bony or neural space or for permanent placement inside the patient. Since the mid-1990s, 110 adverse events associated with the material have been reported.
The FDA recommends that users of absorbable hemostatic agents review the device labeling, especially the contraindications, warnings, and precautions. They also suggest that physicians who use these agents on or near a bony or neural space should apply the minimum amount necessary to achieve hemostasis and remove as much of the agent as possible after hemostasis is achieved. Go to http://www.fda.gov/cdrh/safety/040204-hemostatics.html to view the alert.

Legislators in both the House and Senate are circulating sign-on letters to their colleagues encouraging support for increased fiscal year 2005 funding for the Trauma Care Systems Planning and Development Act. The letters, championed by Sens. Pat Roberts (R-KS) and Jack Reed (D-RI), and by Reps. James Greenwood (R-PA) and Luis Gutierrez (D-IL), urge legislators to support increased funding for the trauma program, which provides federal grants to assist states in developing, implementing, and monitoring statewide trauma care systems.

At press time, 31 senators and 90 House members had signed these letters. To encourage members of your state congressional delegation to sign on to the Roberts/Reed or Greenwood/Gutierrez letters, please access the College’s Legislative Action Center at http://capwiz.com/facs/mail/onedick_compose?alertid=5415381.

The College is also currently working to introduce and pass legislation to reauthorize HRSA’s trauma care program through FY 2009. The Trauma Care Systems Planning and Development Act of 2003, S. 239, was introduced by Senate Majority Leader Bill Frist, MD, FACS (R-TN), and Sen. Edward Kennedy (D-MA) and passed by the Senate last year. A companion House bill, HR 3999, the Trauma Research & Access to Urgent Medical Attention (TRAUMA) Act, was introduced March 18 by Representative Greenwood and Reps. Gene Green (D-TX), Sherrod Brown (D-OH), and Michael Bilirakis (R-FL). This bill would reauthorize the trauma program through FY 2009 and provide a $31 million authorization level.

On March 19, CMS announced details of its plan to implement a moratorium on physician investment in and referrals to certain specialty hospitals. The moratorium prohibits a physician from referring patients to a specialty hospital in which he or she has an ownership or investment interest, and the hospital may not bill Medicare or any other payor for services provided as a result of a prohibited referral. The moratorium was initiated as part of the MPDIMA. It became effective December 8, 2003, and it will expire June 8, 2005.

The moratorium applies specifically to hospitals that are primarily or exclusively engaged in the care and treatment of patients with cardiovascular or orthopaedic conditions and patients receiving surgical procedures. It also excludes from the moratorium (or grandfathers) hospitals that were in operation before or under development as of November 18, 2003. For more information online, go to http://www.cms.hhs.gov/media/press/release.asp?Counter=982.
What surgeons should know about...

The new Medicare drug benefit and related reforms: Part II

by Beth Fuchs, PhD, and Julie James, Washington, DC

Editor’s note: On December 8, 2003, President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA) into law, making the largest expansion in the Medicare program’s history. Previous issues of the Bulletin have included detailed information on the physician-specific provisions of this legislation, such as those affecting the fee schedule conversion factor and geographic adjustments to physician payments.

This is the second in a two-part series of articles intended to answer some of the questions surgeons may have about the new prescription drug benefits, private plan options, and other aspects of this important new law. Part I was published in the April issue of the Bulletin.

What impact will better drug coverage for Medicare beneficiaries have on surgeons and their practices?

Improved coverage of prescription drugs will help to ensure that Medicare patients have access to the full range of therapeutic options for the treatment of illnesses and injuries. However, there may be other, more subtle effects on the practice of surgery. First, coverage for outpatient prescription drugs may bias treatment options toward medical interventions rather than surgery. The significance of this incentive is difficult to gauge at this point. Second, making drug coverage available to Medicare beneficiaries without requiring them to enroll in private managed care plans may result in fewer beneficiaries in private plans. Surgical practices are likely to have different views regarding whether the traditional Medicare fee-for-service program or private plans offer the most desirable setting for providing surgical services to Medicare patients.

What does the law do to promote evidence-based medicine with respect to the use of prescription drugs?

The MPDIMA explicitly promotes evidence-based medicine as it relates to outpatient prescription drugs through two provisions. First, prescription drug plan sponsors who elect to establish drug formularies must appoint a pharmacy and therapeutics (P&T) committee. The P&T committee, in developing and reviewing the formulary, is required to base its clinical decisions on the strength of scientific evidence and standards of practice. Second, the MPDIMA authorizes $50 million for the Agency for Healthcare Research and Quality to conduct and support research with respect to the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services (including prescription drugs) that are provided under Medicare. (Such research may also be provided as it relates to Medicaid, and the State Children’s Health Insurance Program [SCHIP]). However, the $50 million authorization will do little good unless money is also appropriated. In the appropriations for this fiscal year, Congress has given the agency $12 million to conduct research on the comparative clinical effectiveness, cost-effectiveness, and safety of drugs, biological products, and devices. The President’s budget for this coming year (FY 2005) does not include any...
new money for this effort, although key members of Congress are expected to push for some funding.

In addition to adding the new drug benefit, the MPDIMA also changed the private plan options that beneficiaries may choose as an alternative to traditional Medicare. What did it do?

The Medicare+Choice program, which provides for private plans to participate in Medicare, is renamed Medicare Advantage (MA). The law provides higher capitation payments for MA plans beginning in 2004. Beginning in 2006, MA plans will be paid under a new competitive method where plan bids will be compared to benchmarks calculated for each area based on the costs of fee-for-service Medicare. If a plan bid is higher than the benchmark, the enrollee will pay the difference. If it is lower, 75 percent of the difference will go to the enrollee as extra benefits or as a rebate against premiums; the remaining 25 percent will be retained by the government. In addition, beginning in 2006, new MA regional preferred-provider organization (PPO) plans will be established to compete with local MA plans. Unlike local MA plans, regional PPO plans must serve entire geographic regions (between 10 and 50 regions to be defined by the Centers for Medicare & Medicaid Services). In general, regional plans will be paid in a manner similar to local MA plans, but shared risk arrangements and bonus payments will be available to encourage plan market entry and retention.

What is the likely impact of the new MA program on traditional Medicare?

Clearly, the MPDIMA contains financial incentives to encourage private plan participation in MA and assumes that enrollment in MA will grow. One of the most controversial provisions in the debate about the MPDIMA was whether or not to move Medicare to a “defined contribution” system, where the government would provide a fixed dollar contribution toward a plan premium and beneficiaries would pay the difference based on their choice of plan. The major change would be that traditional Medicare would be included in the plan competition. If traditional Medicare was more costly than the private plan options, then enrollees wishing to remain in traditional Medicare would have to pay higher premiums. Those individuals in favor of such an approach believe that competition is the best way to address Medicare costs; those individuals opposed believe it will force beneficiaries into managed care plans and lead to the demise of the traditional fee-for-service program.

As a form of compromise on this issue, the MPDIMA establishes a six-year experiment to test a defined contribution approach called the “Comparative Cost Adjustment Program” (also referred to as “premium support”). Beginning in 2010, the demonstration is to be conducted in up to six metropolitan areas that meet certain criteria. The impact on Part B premiums will be phased in and in no case could be greater than 5 percent annually; Part B premiums for low-income beneficiaries will be unaffected. The consensus among health policy and political experts is that this demonstration will never take effect.

What other significant changes were made to the program by the MPDIMA?

Another important change to Medicare was the decision to relate the new drug benefits and the part B premium to income. Traditionally, Medicare benefits and premiums have not varied based on income. Although some low-income individuals have had their Medicare premiums and cost-sharing paid for by state Medicaid programs since
the late 1980s, the new law shifts the responsibilities for low-income subsidies relating to prescription drugs from Medicaid to Medicare, which means that Medicare will be providing richer benefits to some beneficiaries than to others for the first time.

In addition, the new law provides that the Part B premium will vary based on the modified adjusted gross income of the beneficiary. The change, which will be phased in over a five-year period beginning in 2007, means that the federal premium subsidy, which currently covers 75 percent of Part B costs, will decrease to 65 percent for individuals with incomes between $80,000 and $100,000; 50 percent for individuals with incomes between $100,000 and $150,000; 35 percent for individuals with incomes between $150,000 and $200,000; and 20 percent for individuals with incomes over $200,000. The income thresholds for couples will be twice those for individuals. Income thresholds will grow annually by the increase in the consumer price index.

What is the cost of these changes to the federal government, and how will it affect funding for other parts of the Medicare program?

Congress and the President initially allocated $400 billion in new federal spending over a 10-year period for Medicare reforms, including the prescription drug benefit. At the time of passage, the Congressional Budget Office estimated the 10-year cost of the new law at $395 billion. Recently, however, Administration budget experts have indicated they believe its cost will be closer to $534 billion over the span of 10 years. These new cost estimates and the burgeoning federal budget deficit already are beginning to create pressure to restrain federal spending. Concerns about the economy may make it more difficult than it has been the past few years to address problems in other parts of the Medicare program, including the long-term problem that the sustainable growth rate formula poses for annual updates in Medicare physician fees. In fact, the President’s budget for fiscal year 2005 proposes to impose budget rules to require that any new Medicare (or other entitlement) spending be offset by equivalent reductions elsewhere in Medicare or other entitlement programs.

Acknowledgment

The authors would like to thank Richard Lauderbaugh, JD, and Mike Hash, principal partners at Health Policy Alternatives, Inc., for their contributions to this article.
Reflections on the establishment of Ohio’s Trauma System: A 20-Year Effort

by

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and James Hurst, MD, FACS, Cincinnati, OH
In 1982, the Cleveland Academy of Medicine introduced a resolution to the house of delegates of the Ohio State Medical Association (OSMA) calling for the establishment of a statewide trauma system. On November 1, 2002, a derivative of this proposed statewide system was implemented. This article traces the trials and tribulations of the 20-year crusade to establish a trauma system in Ohio.

Initial steps

As a first step in this process, OSMA’s house of delegates reviewed the Cleveland resolution. Although the reference committee to which it was assigned approved the proposal, the members were unprepared to make a decision at that time. Therefore, the resolution was referred to the OSMA council for further evaluation, with a report due back to the delegates the following year.

To help gain a clearer understanding about how neighboring states succeeded in implementing a trauma system, the Ohio Committee on Trauma (COT) invited Charles Wolferth, MD, FACS, Chair of the Eastern Pennsylvania COT, to speak at the American College of Surgeons’ Ohio Chapter’s trauma breakfast during its 1983 annual meeting. After listening to Dr. Wolferth’s presentation, the Ohio COT decided to form a broad-based task force under the aegis of the OSMA.

The task force was charged with evaluating the current status of trauma care and need for an organized trauma system in Ohio. The group met regularly for two years and wrote a set of guidelines, which defined a trauma system based on the College’s Guidelines for Optimal Care of the Injured Patient. The task force included representatives of the state chapters of all the surgical societies whose member are involved in trauma care, the Ohio chapter of the American College of Emergency Physicians (ACEP), and the Ohio Hospital Association (OHA). Although most parties agreed on the final draft, the OHA board had questions about the draft and would not approve it.

At the 1984 annual meeting of OSMA, the council recommended that this matter be referred to the OSMA Committee on Trauma and Emergency Care. That committee addressed all the issues that the OHA had raised and revised the task force guidelines; however, the house of delegates defeated the final resolution at its next annual meeting in 1985.

Not to be deterred, the members of the trauma task force considered writing draft legislation for introduction in the Ohio House of Representatives, but the legislature was in the process of debating major revisions in the state’s emergency medical system’s board, and no elected official would step forward to introduce separate trauma legislation. The trauma bill was reluctantly put on hold after more than four years of intense effort by the Ohio COT, the Ohio chapter of ACEP, and many other dedicated professionals.

In 1982, a rudimentary prehospital EMS program was established in Ohio. The Cleveland Academy of Medicine was in the process of establishing a regional countywide trauma system and trauma registry, and the Columbus area was in the process of establishing a local/regional program for trauma care.

Before the introduction of the Cleveland resolution, EMS training fell under the auspices of the Ohio Department of Education. The state viewed EMS only as a training and licensure issue. The Department of Education EMS advisory panel was composed primarily of EMS personnel and fire chiefs. One of the authors of this article, Dr. Miller, was appointed as a representative from the Ohio COT to provide some voice from the medical community to this EMS panel. During the late 1980s, the state EMS board was moving toward the use of the national registry examination for licensure of EMS personnel throughout the state. Many volunteer EMS groups around the state, particularly in the
smaller rural programs, opposed use of the national registry examination.

In response to these concerns, the state Senate passed S.B. 98 in 1992. That law established an EMS board under the purview of the Ohio Department of Public Safety. This department took control of the board because it was the only Ohio government agency that provided the legislature with a mechanism to fund the EMS activities—namely, using revenue accrued from fines imposed for failure to obey the seat-belt laws. S.B. 98 established a new EMS board responsible for the organization and delivery of EMS services in the state. It also established a trauma registry, a system of regional physician advisory boards (RPABs) responsible for coordinating regional trauma activities, and a mandate to study and report back to the legislature within two years of enactment of the law on the need for a statewide trauma system. The RPABs and registry were unfunded mandates.

New Factors Arise

A strongly worded report prepared by the EMS board on the critical need for a statewide trauma system was basically ignored and produced little or no activity in the legislature. In 1997, three factors came to bear on the development of a statewide trauma system: (1) the Chairman of the Ohio COT resided in the state capital for the first time in more than 16 years; (2) the Ohio COT hired a lobbyist to work with and identify an appropriate sponsor for trauma legislation; and (3) the Central Ohio (Columbus) Trauma Foundation became politically active and supplied important pooled data to local newspapers. The press responded to the challenge by calling to the attention of the legislature the need for a statewide trauma system.

Under the leadership of state Rep. Robert Shuck (R) and the Central Ohio (Columbus) Trauma Foundation, a meeting was held to begin planning for the introduction of legislation to establish a statewide trauma system. Representative Shuck presented his perspective on why we were having difficulty achieving passage of effective trauma system legislation. He basically told us that we had been preaching to the choir for the last 10 years by carrying out all of the meeting and planning solely within the medical community. Representative Shuck put together a broad-based coalition not only of representatives from all aspects of the medical community having a role and interest in trauma care, but of unions, business leaders, and civic activists as well. Regular meetings of the planning group and open citizen forums were conducted throughout the state. Representative Shuck and his staff made an impressive effort in terms of educating themselves about all aspects of trauma care and trauma system development. They held the medical representatives' toes to the fire with regular meetings and expected attendance.

A Second Law

In 2000, we achieved passage of another law, H.B. 138. It was the intent of the planning group to develop an inclusive trauma system. Concerns had been voiced during the 10 years of the planning process that a statewide trauma system was just a power grab for patients by the Level I and II centers. This argument permeated every trauma system planning process. Representative Shuck and the planning group were determined to pass legislation that would produce an inclusive system.

One of the issues of significant concern to them was the ability of Level III hospitals to meet ACS guidelines. Because the planning committee and the legislature wanted to avoid a two-tier system, the legislation supported ACS verification for all trauma system hospitals. There were also concerns about relegating the content and charter of trauma hospitals, particularly for Level III hospitals as has been done in some states, to a nonmedical forum such as the legislature with the...
full potential for possible political manipulation. Political trade-offs, however, were required for passage of the bill. These trade-offs were particularly related to verification of pediatric trauma centers. The Ohio Pediatric Hospital Association (OPHA), through its members, raised concerns that some of the pediatric hospitals would be unable to meet the two-year deadline required under the legislation for verification. Therefore, a clause was added to the law specifically allowing the Ohio Department of Health (ODH) to craft a one-time, two-year waiver of the ACS verification requirement for pediatric hospitals. This amendment allowed the OPHA and the pediatric hospitals to come on board and support the legislation.

The law clearly defined a trauma patient and mandated that within two years of passage all Category 1 trauma patients must receive definitive treatment at a state-designated and ACS-verified trauma center. A state trauma committee was established under the previous function-

Lessons Learned

- Persistence was probably the most important factor in advancing the state trauma system. Indeed, the process did not end with the final product, because it is imperfect, and touch-up legislation will undoubtedly be needed. For instance, a designating authority is still not in place, and the issue of population requirements versus hospital choice of participation in the trauma system remains to be addressed. What will happen in two years, after the grace period to receive ACS verification expires? Will those hospitals that are still unable to turn their desires into reality again be able to get legislative relief from the perceived onerous requirement of ACS verification? These questions remain unanswered.
- Community and legislative leadership is required. A broad-based coalition had to be established. As Representative Shuck so clearly expressed, “The medical community had been preaching to the choir for 18 years and had accomplished very little.” We needed an effective lobbyist and standard-bearer in the legislature, as well as a broad-based supportive coalition of trauma care professionals, business, labor, and community and political leaders. This is the group that was needed to guide the effort to get effective legislation in place.
- Effective trauma/COT leadership needs to be active in the state capital. Traveling 70 to 200 miles on short notice to testify at legislative hearings and to meet with community or business leadership to influence the legislature is a challenge. Having the resources readily available in the state capital was a very significant step toward passage of legislation.
- Monitoring the activities of the legislature requires an effective lobbyist. A lobbyist who can deal effectively with the legislature and become the project manager to get legislation passed is invaluable. Knowing when, how, and with whom to deal in the legislature is most important. Contacting and arranging for effective testimony at hearings and facilitating personal contacts are all-important functions of the lobbyist. Trauma programs and surgeons need to give not only verbal but financial support to the statewide efforts to establish a system.
- Lastly, the close working relationship between the Ohio COT and the Ohio Chapter of the College was an important factor in moving legislation forward. The Ohio COT has a voice in the Ohio Chapter’s Council and therefore was easily able to mobilize support from the entire chapter. The chapter’s annual meeting’s COT breakfast and regular trauma sessions allowed the COT to bring forth issues and gain support of the entire chapter throughout the process.

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ing EMS board with a mandate to develop rules for the implementation of this law.

The new state trauma committee established subcommittees to develop protocols and rules for prehospital care, registry, in-hospital care, and air medical activities under the state program. The committee was mandated to use ACS verification for trauma center identification. Additionally, H.B. 138 mandated that the ODH establish an injury prevention and rehabilitation commission to study these two areas of interest and to report back to the legislature.

The trauma committee promptly identified two deficiencies in H.B. 138 that required corrective legislation. First, the legislation lacked any language related to hospitals with provisional designation. This affected hospitals that had made an institutional commitment to ACS guidelines but had been unable to schedule a verification visit. After November 2002, they would be unable to receive patients and establish the patient database and quality assurance process needed for verification. Additionally, programs that failed ACS reverification visits but had minor correctable deficits and qualified for an ACS focused review would lose state trauma center designation.

The other deficiency in the legislation was the lack of a designating authority. Corrective legislation passed in 2002 that allowed the ODH to review the institutional commitment of a hospital in the process of undergoing initial verification or of the deficiencies identified by the ACS reverification visits and provide provisional designation for a limited time. For hospitals in queue, strict guidelines for the depth of the institutional commitments must be provided to the health department in order to receive provisional status. Additionally, the corrective legislation allowed the ODH to evaluate and determine whether the problems identified in the ACS reverification visit represented significant patient care issues. If not, the law allowed the institution to continue participation as a “trauma hospital” until a focused review occurred. The issue of a state designating authority remains unaddressed.

The state trauma registry is now up and running and initial data were provided on a voluntary basis. However, as of November 3, 2002, when the state trauma system was activated, mandatory participation by all facilities treating trauma patients was required. Hospitals that did not have ACS verification by that date and had evidence of institutional commitments to the management of trauma patients would be allowed to apply to the ODH for up to a two-year period of provisional status. All trauma patients, as defined by the regulations, must be taken to a state trauma hospital for care. The state trauma committee’s performance improvement program will now move forward to validate the improved care provided under this system in the state of Ohio.

So, this article summarizes our experience in creating Ohio’s trauma system. The lessons we learned in the process are outlined in the sidebar on page 14.

We hope our experience may be useful to others in the process of establishing their statewide trauma systems.

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West Virginia recently survived a historic medical malpractice insurance crisis, and the state appears to have emerged from this trying period with significant tort reform legislation. This law and the process by which we crafted it potentially could serve as a template for other states facing similar situations.

West Virginia is a rural state with a population of 1.8 million, and no single city has more than 100,000 inhabitants. Most areas of the state have a thin layer of health care resources, largely due to West Virginia’s rural nature. There are currently two Level I state-designated trauma centers and one Level II center. The state suffers from chronic unemployment and, as a result, many patients have either government-funded health care coverage or no insurance at all. Medicaid pays for 50 percent of all births. The state population recently became the “oldest” in the nation, leading to a large Medicare population, as well. Unfortunately, the people of West Virginia are the most obese, use smokeless tobacco with the greatest frequency, and have the highest rate of per capita pediatric and geriatric all-terrain vehicle mortality. The combined strain of all these factors nearly precipitated the collapse of West Virginia’s fragile health care system.

**Malpractice crisis epicenter**

The northern panhandle of West Virginia, located between the adjoining states of Ohio and Pennsylvania, found itself in a less than enviable position as the epicenter for medical malpractice lawsuits. A circuit court favorable to the plight of the plaintiff, and backed up by even more favorable state supreme courts, provided fertile ground for the plaintiffs’ attorneys. Additionally, there was an influx of suits from out-of-state attorneys seeking the same hospitable climate. Spurred by the publicity of seven-figure settlements, the juries began to award ever-increasing sums, trying to outdo newspaper reports of previous trials.

In the meantime, reimbursement steadily fell as HMOs and indemnity insurance plans began paying at rates lower than Medicare’s, ignoring an already flawed payment system. The northern panhandle physicians, already earning less than their counterparts in the rest of the state, also began to bear higher malpractice premiums than their colleagues.

The three neurosurgeons in the region steadily retreated from practice under the relentless assault of highly skilled plaintiffs’ attorneys. The first neurosurgeon left, taking early retirement; the second fled due to a lack of insurance availability; and the
third finally moved to another state to find affordable liability insurance and a more friendly climate.

**Fighting Back**

At this point, physicians began fighting back. The circuit court judge, who was much sought after by the plaintiffs' attorneys, came up for reelection. A record marred by questions regarding his personal life, his behavior in the courtroom, and an obvious vendetta for physicians was enough to convince the local press to join efforts with the medical community. Many physicians actually changed their voter's registration in order to cast a ballot in the primary. The incumbent was unseated in the primary. This nearly unprecedented event sent ripples throughout the rest of the state.

Nonetheless, liability insurance premiums continued to soar. Small business, homeowners, and auto insurance policies followed suit. The public slowly began to take notice.

The PHICO insurance company in Pennsylvania in the summer of 2001 suffered a barrage of eight- and nine-figure loss verdicts in Philadelphia and was taken into receivership by the state of Pennsylvania. Many physicians insured in West Virginia were affected. The largest group of reconstructive plastic surgeons in the state closed their doors for a week until they could locate a stable company to replace PHICO.

The pressure of declining reimbursement and the mounting overhead for insurance continued to erode the already thin supply of physicians in the rest of the state.

Physicians began exerting greater pressure on state legislators to intervene in the mounting crisis in obtaining affordable and available medical liability insurance as carriers began to abandon the state. Notices of intent to “not reinsure” were mailed to high-risk specialists. The migration of specialists out of the state increased and recruitment became impossible.

In the winter session of the 2002 state legislature, the state moved to correct the availability problem by expanding the state risk insurance pool to include physicians who otherwise could not obtain insurance. The affordability problem, however, remained uncorrected as premiums were set 10 percent above commercial rates.

As the year progressed, the reduction in availability of specialty care and the threat of liability exposure combined to increase the transfer of patients to the university centers. In the already overburdened Level I trauma center in the state capital of Charleston, the orthopaedic surgeons finally rebelled, faced with an avalanche of patients being transferred to their institution around the clock from outlying communities that found themselves without orthopaedic coverage or the courage to assume the risk of liability. The surgeons announced the decision to stop taking trauma call. Immediately thereafter, the hospital was downgraded to a Level III trauma center. The public perception based on the media coverage was that the hospital was essentially closed for all critical patients. The state capital was in an uproar as the legislature was about to convene for the 2003 session.

**Government Responds**

The governor took immediate action. He and his team put together a financial plan to divert state money through the hospital to directly offset insurance premiums for the orthopaedic surgeons. The trauma center went back to work, and in the rest of the state, physicians erupted in criticism. The northern panhandle physicians marched back into political combat. State senators and representatives, impressed by the circuit court judge election and the influence of physicians on their constituents, began to listen. Town meetings, editorials, articles, and television interviews, steeped in both data and emotion, were pervasive and persuasive. Around-the-clock contact with politicians began as the 2003 session neared.

Frustrated by the special financial “deal” enjoyed by the orthopaedists in Charleston and sensing a lack of political commitment to even the playing field and provide affordable insurance for all of the state’s physicians, a large group of northern panhandle surgical specialists stopped all their elective cases. Hospitals in the area, which were already struggling under inadequate reimbursement, began to suffer mounting losses in income. The hospital association’s involvement in the lobbying effort intensified dramatically.

Simultaneously, a governor’s action committee was appointed to develop recommendations to stabilize trauma and emergency care in the state and build a system for the state’s future. This team’s emphasis on quality patient care did not go unrec-
Recognized and provided balance to the criticism of the physician walkout.

The stage was set for the 2003 legislature to convene in Charleston while national and international news teams were interviewing physicians in the northern panhandle.

The governor introduced a significant tort reform bill, as did the House of Representatives and, subsequently, the Senate. The Chair of the Senate Judiciary Committee, coincidentally, was from the northern panhandle.

**Major Provisions**

Some people consider what emerged in West Virginia to be the most significant tort reform legislation in the last decade in the U.S. Embedded in the bill is a significant protection piece for trauma and emergency cases treated in state-designated trauma centers of all levels, providing a powerful incentive for hospitals to be part of an inclusive statewide trauma system.

Critical portions of the tort reform bill include a $250,000 cap on noneconomic damages and a $500,000 cap on all damages for treatment of emergency conditions for patients who receive care at a designated trauma center. Joint liability has been eliminated, and each individual defendant bears liability equal to his or her percentage of fault. Collateral payments, which had not been allowed in court before, may now be presented. The “ostensible agency theory” of liability was abolished. Additionally, a committee was established to develop a patient injury compensation fund to provide for economic damages that exceed financial limits set in the bill.

The new law also requires that an expert witness maintain a current license to practice medicine and be engaged in the medical specialty in which he is testifying. The expert witness must also devote 60 percent of his annual professional time to active clinical or teaching practice in the particular specialty. Important from the perspective of the state government was the creation of a physician mutual insurance company. The state is underwriting the start-up cost. The state is also providing a small tax credit to help offset physician insurance premiums over the next two years. Additional protection of real and personal property in the event of a bankruptcy settlement for physicians was added to allow the physician to exempt up to $250,000 per household in real or personal property. Importantly, the state medical board was empowered to more vigorously investigate physicians.

**Closing Thoughts**

What lessons did we learn over the past three years?

1. It is obvious that physicians can no longer be bystanders in local, state, or national politics where such governments affect their lives and the well-being of their families and patients. They need to become closely acquainted with their political representatives as well as newspaper publishers and reporters for print and televised media.

2. Very often the image of the physician as the high-tech miracle worker (who never fails) contributes to patients’ unrealistic expectations. Docudramas in print and on television only contribute to this perception, as they seldom portray less than dramatic or successful outcomes.

3. The general public tends to view physicians as “personally unaffected” by insurance losses and the assault by plaintiffs’ attorneys in the courtroom.

4. The public operates under the misconception that jury awards do not affect health care insurance availability and affordability or, for that matter, physician availability.

A physician needs to be a real human being and a friend in the eyes and hearts of their patients. It is only through a true alliance of the physicians, their patients, and the media that political reform can be achieved.

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Survey offers a profile of surgical practice in 2004

Maintaining the health of a surgical practice in the current socioeconomic environment is increasingly challenging, due, to no small extent, to actions and policies implemented by federal and state governments, as well as by private insurers. Quantifying the effects of these forces on the surgical workforce and other factors that influence patient access to care has been exceedingly difficult, however.

To provide policymakers with a better appreciation of the day-to-day obstacles that make it more difficult for surgeons to provide care for patients and, ultimately, to help persuade them of the need for regulatory relief, the College initiated a data collection effort last fall. About 3 percent of the College’s active U.S. members had responded to this “convenience” survey at press time, and a preliminary profile of today’s surgical practice is beginning to emerge.

The “typical” surgeon

The majority of respondents (66 percent) are in solo (28%) or small group practices of two to 15 surgeons (38%) (see Figure 1, page 20). Only 12 percent of them said they are in academic practice. About 60 percent of the respondents are between the ages of 40 and 59 (Figure 2, page 20), and 12 percent are female. At least 73 percent have been out of residency more than 11 years. Reflecting the College’s membership generally, about 42 percent were general surgeons. Interestingly, about 20 percent of the respondents are in dual medical career families.

The “typical” practice

About half of the survey respondents indicated that they spend 11 to 20 hours a week performing elective procedures. The same number said they spend 11 to 20 hours per week in the office. More than one-quarter of surgeons responding said that trauma surgery accounts for more than 25 hours of their work week. The majority (51%), however, spend less than 10 percent of their time providing trauma care.

As expected, Medicare is the predominant payment source for surgeons, with 75 percent saying it accounts for more than one-fifth of their revenue. Preferred provider contracts and traditional private fee-for-service plans follow in importance. Generally speaking, surgeons care for relatively few Medicaid patients; 70 percent of respondents say Medicaid patients comprise less than 5 percent of their practice. In fact, self-pay and uncompensated patients comprise as much or more of a typical surgical practice—with more than 30 percent of...
respondents saying that these patients account for 6 to 10 percent of their practice (Figure 3, this page).

**Access and supply**

Patient access to care is a dynamic picture determined by the number of incoming and outgoing surgeons, surgeon productivity, and the projected demand for care.

Retirement patterns are difficult to predict, but, according to the survey, 63 percent of the respondents plan to retire before age 65. At the same time, the number of surgeons entering the profession has remained relatively stable for decades. Recruitment patterns may be more revealing. More than half of the survey respondents have tried to recruit new surgeons to their practice, and more than half of them (53%) found that it took more than a year to find replacements (Figure 4, page 21).

There are few indications that the current supply of surgeons is inadequate. In fact, more than 46 percent of the surgeons responding to the survey indicated that they have increased or intend to increase the amount of time they devote to patient care (Figure 5, page 21). This, coupled with the report that 40 percent are planning to spend less time with each patient, suggests that as the volume of patients increases, the amount of time with individual patients could decrease (Figure 6, page 21). Of course, much of this shift has been driven by a need to increase efficiency in order to stabilize practice income during a time of declining reimbursement, and there is some question about how long this trend can continue as the elderly population grows. While there are some indications that wait times for first office visits are increasing, the vast majority (76%) of new patients are able to get an appointment within two weeks or less.

More than 80 percent of surgeon respondents said they take trauma or emergency call. Yet 48 percent said that they are seriously considering limiting their on-call and trauma coverage (Figure 7, page 21). Greater than 70 percent of these surgeons say they are on call at least 40 hours a month. An apparently growing number of those who take emergency call, nearly 40 percent, say they receive a stipend to do so.

It appears that surgeons are taking a number of
steps to increase their practice’s productivity. Given the importance of Medicare to their practices, very few surgeons (less than 1%) have stopped seeing elderly patients altogether, despite the continued decline in reimbursement. A slightly larger percentage—7 percent—of respondents said they limit the number of Medicare patients they see (Figure 8, this page).

However, a significant number of respondents indicated that they have stopped performing poorly
reimbursed or high-risk services (48% and 38%, respectively) (Figure 9, page 21). About one in two has or will limit the number of Medicaid patients they will see (Figure 10, this page). Nearly one-third said they have reduced the size of their office staff (Figure 11, this page), and about 46 percent say they are making greater use of physician-extender staff (Figure 12, this page). Few say they have relocated, but 16 percent indicate that they are seriously considering relocating to a more favorable climate (Figure 13, this page). For a complete overview of surgeons’ activities, see Figure 14, page 23.

Conclusions

Although the data collected in the survey do not reflect any widespread patient access issues, narrative responses given to the open-ended questions do give cause for concern. These comments echo a common theme of frustration with the current state of practice and how hassle factors with payors and regulators are perceived as standing squarely between surgeons and their patients.

Other observations and conclusions include:

1. Medicare is the primary payor for surgical care. This finding confirms long-held suspicions that past studies of payment adequacy focusing on surgeon participation in the program are misleading; most surgeons are unable to stop caring for the elderly population.

2. Poor reimbursement rates are more likely to affect access to care for Medicaid patients, people requiring services that are inadequately reimbursed, and individuals who need high-risk operations.

3. Trauma and emergency care remain an important component of surgical practice, although there are indications that more surgeons may re-
strict the number of hospitals where they practice and their call schedules as the volume of patients increases.

4. The College's concern is that more restricted practices may mean fewer surgical educators, less time with individual patients, a narrower menu of services, more hours spent on paperwork, and fewer mentors for young surgeons.

5. Future capacity is difficult to project. So far, patients have largely been insulated from practice patterns that are shifting in response to current socioeconomic trends. It is unclear how much farther surgeons can trim their overhead and increase their own productivity.

**We still need your help**

The College will continue to monitor these trends and advocate for policy changes that will bring more balance to the system and ensure continued patient access to high-quality care. Those Fellows who have not yet participated in the survey are encouraged to visit the College’s Web site to complete the online workforce access survey at http://www.facs.org/ahp/workforcesurvey/index.html.

**Acknowledgement**

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The issue of spiraling medical malpractice insurance rates and its ramifications for patients finally captured the attention of the American public last year. The nature of the crisis has become increasingly clear to the average person. Polls now show that more than 70 percent of Americans want tort reform.

States act
As the situation grew more desperate, several states in which skyrocketing malpractice premiums were front-page news took unprecedented steps to rein in lawsuits. The momentum toward passing vital medical liability reforms will continue in 2004, because state legislatures are beginning to act early rather than wait for a full-blown health crisis to take hold.

Texas demonstrated the power of public support for reforms in 2003. In a landmark vote, Texans decided to change their state constitution to allow the legislature to put a cap on damage awards in lawsuits, particularly the subjective
noneconomic (pain and suffering) damages that are driving up jury awards and insurance premiums.

Other states moved forward as well. To further preclude the possibility of a crisis, the Idaho legislature, in a bold example of leadership, took the preemptive step of lowering the state’s noneconomic damages cap. Arkansas and West Virginia, two states where shuttered medical practices and hospital wards had sometimes forced residents to travel into nearby states for health care, also enacted solid tort reform (see related story on page 16).

These legislative actions were based on the realization that the cost of medical malpractice insurance is primarily determined by the insurer’s loss experience. Insurers in states that do not limit the amount of money a jury may award a plaintiff for intangibles, such as pain and suffering, face a greater risk of large awards.

**Dubious claims**

Additionally, the current tort system provides an incentive for patients and lawyers in these states to try to hit the jackpot by filing claims of dubious merit and hoping for a sympathetic jury. Nationally, nearly 80 percent of claims are ultimately determined to be without merit, but the insurer still must spend an average of about $25,000 each time a claim is filed to vindicate its policyholders. Not surprisingly, in the last several years malpractice insurers paid out about $1.30 for every premium dollar they collected in today’s lawsuit-happy society.

The cost of dubious lawsuits ignites a financial chain reaction that extends far beyond insurers, physicians, and patients, however. In addition to paying higher insurance premiums because of lawsuit risks, physicians are performing more tests and using expensive defensive medicine techniques to protect themselves. Because most Americans receive their health insurance through their employers, businesses of all kinds are either paying more for health insurance or asking employees to saddle part of the load. This translates into higher costs throughout our economy and family budgets stretched to the breaking point.

**Good news/bad news**

The good news is that even though the march toward tort reform is sometimes slow, the movement has continued to be positive. No state has passed legislation rescinding advances made in past years, and many have pushed tort reform proposals to the front of their agendas.

The bad news is that some state legislatures and members of Congress have not yet gotten the message and wait until the last moment to enact minimal reforms that provide more political cover for them than long-term relief for surgeons and patients. Effective tort reform legislation failed to pass in Missouri, Nebraska, Oregon, Washington, and Wyoming, while laws with significant loopholes were passed in Florida and Nevada.
The American College of Surgeons is extremely concerned about the medical liability crisis and its effects on surgical practice and patient access to care. To help ensure that the surgical community’s voice is heard on this issue, the College and the American College of Surgeons Professional Association (ACSPA) are carrying out several important efforts. They are as follows.

1. Forming Doctors for Medical Liability Reform (DMLR). The ACSPA has joined with a number of medical and surgical specialty societies to form a coalition of more than 230,000 specialty physicians who support federal medical liability reform. The DMLR effort is focused on bringing the message about the need for medical liability reform to those states that have a U.S. senator who is helping to block passage of national medical liability reform legislation.

2. Expert witness standards. The Board of Regents recently revised and strengthened the College’s “Statement on the physician acting as an expert witness.” An affirmation statement embracing the expert witness qualifications and behavior standards set forth in the statement was also approved for voluntary use by Fellows involved in medical liability litigation.

3. Disseminating patient information brochures. The ACSPA recently sent all Fellows a packet of brochures that can be used to enlist the support of surgical patients in asking senators to support medical liability reform.

4. Distributing buttons. The ACSPA recently sent all Fellows buttons that read, “Will a surgeon be there?” Surgeons are encouraged to wear these buttons to draw public attention to the medical liability crisis.

5. Building the Legislative Action Center. Thousands of surgeons have used the ACS Legislative Action Center (which can be found on the ACS Web page www.facs.org) to write letters to both U.S. senators and representatives and state legislators, urging them to support medical liability reform.

6. Developing Chapter Leadership Conference programs. The medical liability reform crisis will be a major focus of the May 2004 ACS Chapter Leadership Conference in Washington, DC. Surgeons from across the country will be going to Capitol Hill and urging representatives and senators to support federal medical liability reform.

7. Chairing the Health Coalition on Liability and Access (HCLA). The HCLA, chaired by ACS staff, is the largest coalition specifically dedicated to advancing federal medical liability reform.

Looking ahead
So what does 2004 hold for medical liability reform? First and foremost, the issue probably will receive even more attention at the national level than it did in 2003. Candidates for President, Congress, and state legislatures across the nation will have to address the issue when they run for office this year. Reform will be a key campaign issue, particularly in the nearly two dozen states the American Medical Association says are in a full-fledged health care crisis driven by insurance rates that can be as much as four times more than physicians pay in stable states such as California.

Overall, there will be a continued effort by physicians, patients, and the business community to keep moving forward. More policymakers are realizing that physicians are avoiding risky cases and spending hours upon hours dealing with legal issues, time that would be spent more productively helping patients.

Progress was made in 2003, and 2004 promises to bring further advances. We can be certain that the issue will not go away and that even more states will become involved in the coming year. But until politicians find the resolve to take lawyers out of examining rooms, the struggle ahead will be hard-fought and runaway litigation will continue to impair access to health care.

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Statement on the surgeon and HIV infection

In 1980, the human immunodeficiency virus (HIV) was identified as the causative organism of acquired immunodeficiency syndrome (AIDS). Since its discovery and characterization, HIV infection has attained extraordinary attention among surgeons and other healthcare workers (HCWs) as a potential source of occupational infection. Epidemiological information has not been easily accessible because of barriers to testing that have arisen out of the stigma and socioeconomic consequences if an individual tests positive.

Because the disease is blood-borne and transmissible, and due to the nature of surgical work, a concerned surgical community has become involved and has offered leadership in developing enhanced sterile surgical barriers, and improved surgical techniques and procedures. Surgeons are at-risk for exposure to HIV and are concerned about this risk. Patients have been concerned about their potential risk of exposure to HIV infection from blood transfusions, other patients, health care workers, and surgeons.

In the U.S. and Canada, the only identified HIV transmission from a healthcare worker to patients occurred in a dentist’s office in Florida. Proof does not exist as to how this transmission of infection occurred. The differences between sterile technique in a dentist’s office and that in a surgical environment are enormous, and they must be differentiated in any epidemiologic analysis. There has been no documented transmission of HIV infection in the performance of surgical treatment from a surgeon to a patient to this date.

Reasons for the low risk of HIV transmission from the surgical team are readily available and include routine utilization of sterile surgical technique and universal precautions. The surgical team is continually aware of the dangers of transmission of infections, which is inclusive of, but not limited to, HIV infection. In addition, we now know that the blood concentration of viral particles in patients who are infected with HIV is low. Surgical barriers and surgical techniques should be further developed.
whenever possible to avoid intraoperative injury and to further diminish any possible risk of transmission of HIV or other pathogens.

Guidelines published in July 1991 by the Centers for Disease Control and Prevention (CDC) have been widely distributed and have not been amended or changed since that time. The College has expressed concern that these actions were not based upon direct scientific data, were not cost-effective, and were intrusive to the extreme. We continue to feel that the recommendations of defining “risk-prone procedures,” as was recommended by the CDC, cannot be determined in a scientific or rational way. We have felt, and continue to feel, that these recommendations were irrelevant and counterproductive. In formulating these guidelines, the CDC ignored the overwhelming testimony of the scientific community, and the fact that all currently available data indicate that transmission from surgeon to patient in a hospital setting continues to be a hypothetical event.

While basic, clinical, and epidemiological research continues, a number of issues remain unresolved. The surgical community emphasizes that available scientific data indicate that transmission of HIV infection from physician, surgeon, or nurse to patient is extremely rare. The overall risk of transmission of HIV from infected surgeons to patients appears to be so low that costly measures, such as testing and limiting of work, are not justified. This is especially true now that antiretroviral therapy has advanced to a level to make many infected individuals virtually free of virus in their blood.

We continue to believe in operating room behavior that will minimize the risk of transmission of HIV or any other blood-borne or environmentally transmissible pathogen. We believe in enforcing a high standard of infection control and universal precautions, which remain the best strategy for protecting patients and surgeons from accidental exposure. We should continue to emphasize the absence of scientific data about any transmissions in the operating room environment, so that a healthy atmosphere can be maintained in the minds of patients and the public regarding the problem of HIV transmission. Any regulatory efforts should be based solely on documented scientific data and not on unfounded hysteria.

When a high-risk exposure event has occurred to a surgeon in the performance of a surgical procedure, the CDC recommends postexposure antiretroviral chemoprophylaxis. There is statistical evidence that indicates possible prevention of occupational infection, which has been observed from hollow needlestick exposures and has been extrapolated to have potential benefits following solid needle and other percutaneous or mucous membrane exposures to HCWs.

While therapy for HIV infection has not resulted in eradication of the disease, effective combination antiretroviral therapy is available that reduces antigenemia from the infection, improves quality of life, and appears to significantly improve life expectancy. Surgeons should know their HIV serologic status in the same way that they would want to have knowledge of any other disease about which they may have personal concerns. This personal and confidential information about HIV infection would allow the surgeon to obtain important treatment and counseling for his or her own personal health, and should not be used for any determinations of credentialing or privileging for surgical practice.

Based on data that are currently available, we
make the following recommendations:

1. Surgeons have the same ethical obligations to render care to HIV-infected patients as they have to care for other patients.

2. Surgeons should utilize the highest standards of infection control, involving the most effective known sterile barriers, universal precautions, and scientifically accepted infection control practices. This practice should extend to all sites where surgical care is rendered and to all patients who receive surgical care.

3. Based on data in the current literature, HIV-infected surgeons may continue to practice and perform invasive procedures and surgical operations unless there is clear evidence that a significant risk of transmission of infection exists through an inability to meet basic infection control procedures, or the surgeon is functionally unable to care for patients. These determinations are to be made by the surgeon’s personal physician and/or an institutional panel so designated for confidential counseling. Such a panel should be composed of infectious disease specialists, surgeons, and other health care professionals who are knowledgeable about blood-borne infections.

4. Postexposure prophylaxis with antiretroviral chemotherapy is recommended. Counseling and recommendations for surgeons are available through the National Clinicians’ Postexposure Hotline at 1/888-448-4911, or at http://www.ucsf.edu/hivcntr.

5. Surgeons should know their own status for HIV infection, as they would be knowledgeable about any other disease or illness that is of concern to them personally. Treatment of HIV infection, while not curative, has been effective and is recommended. Knowledge of the HIV infection status of the individual is not to be used in the determination of suitability of the surgeon for surgical practice. The HIV status of a surgeon is personal health information and does not need to be disclosed to anyone.

6. Various College committees should continue to consider the concerns and problems of HIV-infected surgeons and their families in their deliberations. The College committees will continue to monitor new developments in HIV infection and its treatment to optimize patient safety and safety in surgical practice.
Socioeconomic tips

Changes to CMS Medicare Internet resources

by the Division of Advocacy and Health Policy

The Centers for Medicare & Medicaid Services (CMS) has redesigned its online educational material for physicians. The Web page, Physicians Information Resource for Medicare (http://www.cms.hhs.gov/physicians), is a portal to CMS Web links to help you and your staff access current Medicare regulations, publications, and databases. The Web links are categorized under the topics of participation, enrollment, education, program integrity/medical review, regulations, payment, Medicare secondary payer, and contacts. The following is a description of some items that may be of special interest to surgeons.

Medicare coverage database

CMS has incorporated its national coverage determinations, the draft and final versions of Medicare Part B carriers’ local carrier determinations (formerly called local medical review policies), and national coverage analyses into the Internet-based CMS Medicare coverage database (http://www.cms.hhs.gov/coverage/default.asp). A search of the database will allow you to determine whether CMS or Part B carriers are considering or have developed national or local payment decisions for procedures surgeons perform.

CCI edits

The national Correct Coding Initiative (CCI) edits are now available for free download from the CMS Web site at http://www.cms.gov/physicians/cdeditits. The CCI edits identify pairs of services that normally should not be billed by the same physician for the same patient on the same day and identify whether specific Current Procedural Terminology and Healthcare Common Procedure Coding System modifiers may be used to override certain edits. Surgeons and their staffs should check this Web page on a quarterly basis (January, April, July, and October) to download the most current version of the CCI edits.

Around the corner

June

• Economedix teleconferences are scheduled as follows: CPT Coding Updates for Surgeons (June 9 and 12) and E/M Coding...Beyond the Basics (June 23 and 26). For more information and to register, go to http://yourmedpractice.com/ACS-Teleconference.

• ACS-sponsored basic and advanced coding courses and practice management course for surgeons will be held June 24-26 in Atlanta, GA. Visit the ACS coding and practice management course Web page at http://www.facs.org/dept/ahp/workshops to register.

New policy page

To help physicians better understand regulatory and policy changes, CMS recently introduced the publication, “Medlearn Matters...Information for Medicare Providers.” This series of articles translates regulatory language into an easily understood format. Each article provides guidance about the effective date of a policy change, which provider groups are affected by the policy, what providers need to do to comply with the policy, and a brief explanation of why the change will be implemented. The articles can be viewed and downloaded in Adobe Acrobat format (PDF) at http://www.cms.hhs.gov/medlearn/matters.

Medicare resident and new physician guide

Though not as current as the resources available online and not specifically designed for surgeons, the publication, “Medicare Resident and New Physician Guide: A Comprehensive Guide Designed to Inform Physicians About the Medicare Program,” is a good resource about physician participation in continued on page 37
The ever-widening gulf between the number of people who are on waiting lists for organ and tissue transplants and the number of people who donate poses a public health crisis, according to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). As one of several efforts to generate ideas about how to ensure that people needing transplants receive them, JCAHO presented a two-and-a-half day symposium March 10-12 in Washington, DC. The American College of Surgeons and a number of other health care organizations endorsed the meeting, which included a broad overview of some of the issues raised during roundtable discussions that JCAHO recently convened to analyze the state of organ transplantation in the U.S. The March symposium was the next step in developing solutions to the worsening situation.

**Scope of the problem**

“The number one problem in transplantation is a shortage of donors,” said Clive O. Callender, MD, FACS, professor of surgery and vice-chairman of the department of surgery at Howard University College of Medicine, Washington, DC. The data illustrate the severity of the situation.

While the total number awaiting lifesaving transplant procedures grew about 19 percent between 2002 and 2003, the number of donors increased only 3.7 percent, according to Dennis S. O’Leary, MD, president of the JCAHO. Furthermore, the number of wait-listed patients increased from 31,694 in 1993 to 86,851 in 2003, but the number of transplants performed over that same period of time remained relatively flat—14,634 in 1993 versus 14,936 in 2003, said Akinlolo Ojo, MD, PhD, associate professor of medicine at the University of Michigan, Ann Arbor, and an investigator for the Scientific Registry of Transplant Recipients.

The typical wait for transplantation ranges from 230 days for a heart transplant to 1,263 for a kidney transplant, Dr. Ojo reported. Approximately 6.5 percent of the individuals needing a kidney transplant will die while on the waiting list. The same fate befalls 14.3 percent of the people waiting for a heart transplant.

Women and ethnic minorities top the percentage of people on the waiting list at 41 percent and 34 percent, respectively, Dr. Ojo said. Additionally, 12 percent of the people on the waiting list are age 65 and up, 3 percent are children under the age of 18, and 1 percent are non-U.S. residents.

Currently, minorities, like other Americans, donate in proportion to their population distribution, Dr. Callender said. However, minority populations are more likely to need transplants, particularly kidney transplants, due to a predilection toward diabetes. More specifically, 58.6 percent of the people on the kidney list are non-Caucasian Americans.

Due to these imbalances, some people consider the current waiting list process to be inequitable, Dr. O’Leary said. The system needs to be redesigned so that supply better meets demand.

Two speakers offered recommendations on how to bring about the necessary change. Malcolm Gladwell, author of The Tipping Point: How Little...
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Things Can Make a Big Difference, said, “It’s a series of small changes that brings about a major transformation.” Mr. Gladwell also said to change people’s beliefs about a concept, the idea needs to be reframed and reshaped in their minds. Finally, it is the people with social power who make “tipping points,” or states in which a collective of individuals agrees that radical change is necessary.

Wendy Hamilton, national president of Mothers Against Drunk Driving (MADD), described the strategies that MADD has used to bring about social change. Those techniques include: (1) putting a face on the problem; (2) recruiting passionate, dedicated volunteers; (3) staying mission-focused; (4) setting clear priorities; (5) basing priorities and programs on scientific research; (6) using the media to help advance positive change; and (7) being willing to change or evolve; and (8) never giving up.

Speak Up™

During a press conference at the meeting, the JCAHO announced the launch of a national campaign to educate the public and create a “tipping point” in society’s perception of organ donation. “We’re here today to empower living donors,” Dr. O’Leary said. This initiative expands the Joint Commission’s three-year-old, award-winning Speak Up program, which urges patients to play an active role in their own care.

“Living organ donors give the gift of life when there are no other alternatives. However, some have said that they were not fully aware of what surgery would entail and the short-term and long-term risks to which they would be exposed,” Dr. O’Leary said. “This Speak Up campaign will help potential donors better understand what to expect and what questions to ask.”

The Speak Up campaign for living organ donation encourages potential contributors to take the following steps: (1) ask their physicians and other health care providers for basic facts about the risks and safety of organ donation; (2) learn what questions they should ask their physicians; (3) talk with previous living organ donors; and (4) uncover more information about the issue.

A living donor, Ruth Parker, RN, applauded the JCAHO’s emphasis on potential donor education. “Donors need to become fully informed. I didn’t know what questions to ask,” said Ms. Parker, who is now coordinator of the Organ Procurement Organization at the Centers for Medicare & Medicaid Services. She noted that living donation is a serious operation with a lengthy and painful recovery process, but one which she would do again after seeing how much it helped the recipient. Donors should know both the joys and difficulties of the entire experience.

Participants in the press conference, left to right: Ms. Barry-Ipema, Ms. Parker, Dr. Delmonico, and Dr. O’Leary.
Francis Delmonico, MD, FACS, director of renal transplantation at Massachusetts General Hospital and professor of surgery at Harvard Medical School, suggested during the Speak Up press conference that a national database on organ transplantation should be developed. This repository could be used to cultivate the data that patients and donors can use to understand the risks and complications of transplant surgery, Dr. Delmonico said. “We need resources, perhaps government resources, to develop this complex database,” Dr. Delmonico added.

In conjunction with the Speak Up initiative, the JCAHO has developed a patient information brochure titled “Preparing to be a living donor,” which can be downloaded off the Joint Commission Web site, www.jcaho.org.

Targeting specific populations

While Speak Up is aimed at all potential donors, some awareness-raising programs take a more targeted approach, reaching out to specific populations, such as young people or minorities.

With respect to the latter, U.S. Surgeon General Richard H. Carmona, MD, MPH, FACS, said that a primary objective of the U.S. Public Health Service with respect to organ procurement and transplantation is eliminating disparities.

To help eradicate this sort of inequity, Dr. Callender co-founded the National Minority Organ and Tissue Transplant Education Program (MOTTEP). Since 1980, MOTTEP has operated in 15 U.S. cities with 500 volunteers reaching out to approximately 6 million people of all ethnicities, Dr. Callender said. National MOTTEP’s aims are to increase the number of minorities who sign donor cards and discuss their decision with their families.

MOTTEP has used four strategies to increase organ donor pledges. They are: (1) having transplant recipients, donors, candidates, and their families, as well as health care professionals, serve as messengers within the community; (2) delivering a culturally sensitive message through ethnically similar messengers known within the community; (3) helping communities to plan and implement awareness and educational activities; and (4) collaborating with religious, social, and civic organizations. MOTTEP has proven successful. Dr. Callender reported that African-American adults were significantly more likely to trust in physicians, to donate organs/tissues, and to understand the importance of donation after the MOTTEP presentation.

“The key to a thriving organ donation program is awareness,
awareness, awareness,” said Connie Payton, co-founder of two health care charities that emphasize public education, The Walter and Connie Payton and the Life Goes On Campaign. Ms. Payton, wife of legendary running back Walter Payton, who eventually died of liver cancer that spread to his lymph nodes before a suitable donor could be found, said her daughter Brittney and other teenagers with ties to the National Football League established Youth for Life: Remembering Walter Payton. This national program informs high school students about the lifesaving benefits of organ donation and the process of becoming registered donors.

Another national project is aimed at increasing awareness about organ transplantation among the 3 percent of the American population with serious intellectual disabilities. William Bronston, MD, facilitator of the National Work Group on Disability and Transplantation, said this problem came to light about 10 years ago when Sandra Jensen, a 32-year-old Californian with Down syndrome, fought to receive a heart-lung transplant. Dr. Bronston said the effort in Ms. Jensen’s case succeeded because advocacy groups reached out to the media, allowing the public to hear her case.

To help raise the level of awareness about access to and experiences with organ transplantation, the work group recently disseminated a survey to 1 million families of people with intellectual, physical, or mental disabilities to determine their knowledge about the organ donation process, Dr. Bronston said. Based on the rapidity with which the responses are being returned, the work group is finding that this is a relevant issue that needs to be addressed.

The Surgeon General expressed support for all efforts to enhance public education. “Americans are the most generous people on earth, and I believe they will donate if they are educated about the value of the ‘gift of life,’” Dr. Carmona said.

The media

Many of the program participants believe that the mass media perpetuate donor and recipient fears by running negative stories about organ transplants rather than educating people about the positive aspects of organ transplantation. An example is the U.S. News and World Report article about Jesica Santillan’s death after heart-lung transplant in which her blood type and the donor’s did not match. The author of that article, Avery Comarow, explained that the media feel obligated to present these types of stories to help people overcome the “human tendency to turn away from what we find upsetting.” Furthermore, he said, “You cannot generate more than a finite number of positive stories on any one topic.”

One woman who is awaiting her third kidney transplant, 22-year-old Kathryn Margolis, and her mother, Shirley F. Brown, are hoping that at least one media icon will help to spread the word about organ donation and how it saves lives. Ms. Margolis has written a letter to Oprah Winfrey, asking her to do a show that puts the human face on organ transplantation. To help support Ms. Margolis in this effort, symposium attendees were encouraged to write to the producers of The Oprah Winfrey Show. Surgeons interested in being part of this letter-writing campaign should send e-mail correspondence to the Oprah Web site at http://www.oprah.com/email/reach/email_showideas.jhtml. Copies of Ms. Margolis’ original letter are available by contacting Cathy Barry-Ipema via e-mail at cipema@jcaho.org, or Charlene Hill at chill@jcaho.org, in the JCAHO Communications Department.

Coordinated effort

Heightened public awareness would be just one contributor to a tipping point in organ transplantation. Another would be the development of a more coordinated approach to organ procurement. According to Dr. O’Leary, this collaborative ap-
approach will require a cultural change within the transplant community—one which promotes donation from the top-down.

Michael N. Diringer, MD, director of the neurology/neurosurgery intensive care unit at Washington University School of Medicine, St. Louis, MO, spoke about the role of physicians and other health care professionals in this evolving culture. Factors that traditionally have inhibited physician involvement in organ procurement include the sense of failure that accompanies acknowledging a “brain death” and a tendency to avoid prolonged, emotional conversations with families, Dr. Diringer said. He also noted that physicians often have a poor working relationship with organ procurement organizations (OPOs).

Physicians can serve as champions for organ donation by educating peers and trainees, reviewing and updating their hospitals’ neurological criteria for death, actively cooperating with the OPO, and facilitating early referral to the OPO, Dr. Diringer said. Working with the families of potential donors and the OPO will require physicians to become more effective communicators. Too often conversations with families are fragmented, vague, and inconsistent. This tendency often results in anger, frustration, and lack of trust, Dr. Diringer said. Physicians need to provide a consistent, understandable, and meaningful message.

Thomas C. Dolan, PhD, president and chief executive officer of the American College of Healthcare Executives (ACHE) said that his organization is trying to help hospital CEOs create the top-down dedication to organ donation that Dr. O’Leary described. ACHE has issued a policy position that “recommends that all health care executives work to increase the supply of available organs, tissues, blood, marrow for transplantation,” Dr. Dolan said. To help health care executives become more involved in the organ donation process, ACHE has added a page to its Web site focused specifically on raising organ donor awareness.

Paul M. Schwab, MA, MPA, executive director of the Association of Organ Procurement Organizations, spoke about the need for continual collaboration between OPOs and hospitals. “Leadership can be defined as the power of creating partnerships,” Mr. Schwab said. While OPOs can handle the day-to-day responsibilities of easing the burden of the critical care team, working with medical examiners, serving as gatekeepers for donation, and counseling families, hospitals must set the tone by taking a leadership position, he added.

Best practices

James Burdick, MD, director of the division of organ transplantation at the U.S. Health Resources and Services Administration (HRSA), said that U.S. Department of Health and Human Services Secretary Tommy Thompson launched a “Gift of Life Donation Initiative” in April 2001. As part of this program, HRSA formed the Organ Donation Breakthrough Collaborative, which was charged with uncovering best practices in organ procurement and transplantation, Dr. Burdick said. The team comprised more than 400 leaders representing 98 large hospitals and 42 OPOs, 30 senior representatives of national organizations with a stake in organ donation, and one international team from Quebec, Canada.

The collaborative has discovered that the hospitals with the highest donation rates focus on change and improvement, encourage rapid referral and linkage to the OPO, and pursue every donation opportunity, according to Teresa Shafer, RN, co-chair of the panel. Additionally, the most successful programs use an integrated approach in which hospital staffs and physicians, for example, have a relationship with the OPO coordinators. Based on this model, OPO staff should be assimilated into the hospital culture with opportunities to participate in hospital committees, daily rounds,
and so on. Ms. Shafer, who is chief operating officer of LifeGift Organ Donation Center, a Texas OPO, also suggested that hospitals establish protocols and policies for donation after cardiac death and develop unit-specific clinical champions of organ donation. The collaborative’s final report was issued late last year.

Jim Sayler, chief executive officer of Memorial Hermann Children’s Hospital, explained how his institution has become the largest donor hospital in the U.S. He noted in 1987, the hospital played a key role in the creation of an independent OPO, LifeGift Organ Donation Center in Houston, TX, and in 1995, it implemented an in-house coordinator program. The in-house coordinators have proven highly effective with respect to encouraging donations because they can spend extended time with families, building their trust.

Mr. Sayler said that senior staff set the tone and the stage for donation within the hospital, outwardly expressing the sentiment that “a problem is just something we need to solve.” Senior staff monitors outcomes, assumes joint accountability with the OPO for results, encourages physician interaction with OPO staff, and provides for integration of the OPO into hospital committees. “We respect the OPO’s mandate to maximize donation, and, in turn, they respect the proper use of our resources,” Mr. Sayler said. “We would never allow ourselves to be split up on issues.”

**Ethics and live donors**

When Joseph E. Murray, MD, FACS, performed the first successful renal transplant between identical twins in 1954, he challenged the ancient medical ethic of “first do no harm,” Dr. Delmonico noted. It simply is impossible to remove part of someone’s body without doing at least negligible damage. Nonetheless, the moral compass that directed the debate about transplantation half a century ago has readjusted. Transplants involving live donors are acceptable within the medical community and society as long as the donation is based on medical judgment that accounts for the probability of risk to the donor and benefit to the recipient and if donor and recipient give informed consent, he said.

Sensational, albeit rare, instances of donor deaths raise ethical concerns about live donation. As a result, the organ transplantation system needs to systematically review outcomes, Dr. Delmonico said. Indeed, the U.S. Secretary of Health and Human Services’ (HHS) Advisory Committee on Organ Transplantation has recommended that a database of health outcomes for all live donors (similar to the one he described during the Speak Up press conference) be established and funded through and under the auspices of HHS.

Additionally, the medical research community needs to look at alternatives to live donations. “We need a better solution than saying we go to the live donor,” Dr. Delmonico said. Indeed, we need to reach a point where “organ donation from the live donor is no longer necessary.”

To ensure that a transplant is carried out ethically, it is also important to verify that the donation is being made by someone who can handle the stresses of a major operation, said Charlie Thomas, a social worker at Good Samaritan Regional Medical Center in Phoenix, AZ. Psychosocial issues to examine include any psychiatric problems, financial status, possible coercion from the potential recipient or family members, coping skills, and care planning. Mr. Thomas suggested that every donor candidate receive a psychosocial evaluation and counseling from a qualified mental health professional and recommended eliminating financial disincentives through the development of donor leave, reimbursement of travel and sustenance expenses, and tax deductions. He also called for the development of methods to measure long-term psychosocial outcomes.

Five ethical principles should guide transplants involving live donors, according to Nancy Neveloff Dubler, LLB, director of the division of bioethics at Montefiore Medical Center and professor of bioethics in the department of epidemiology and population health at the Albert Einstein College of Medicine. These moral standards are justice, wise stewardship, respect for autonomy, support for informed choice, and fealty to “virtue ethics.”

Ms. Dubler also identified several emerging ethical dilemmas related to transplantation, including the growth in live donations and financial incentives to families that agree to cadaveric donations. Several incentives for live donors are
considered ethical at this time, including tax credits, reimbursement of expenses, recognition awards, paid medical leave, priority on the waiting list for previous live donors, life and disability insurance, and medical coverage for expenses, she said.

An ethical incentive is offered free of financial or emotional coercion, Ms. Dubler said. For example, “sale of organs in India is a fact of economic and medical existence—sale under economic duress,” she said. In the U.S., “family dynamics sometimes require donation when that would not be the free choice of the donor—donation under emotional duress.”

Alternatives

Alternatives to live organ donations do exist. One option is to ensure that people lead healthy lifestyles, so that they don’t develop the types of diseases that often can be cured only through transplant operations. “Seven out of 10 Americans die of chronic diseases, most of which are preventable,” Dr. Carmona noted, including those linked to obesity, alcohol and drug abuse, and tobacco use.

Robert Harmon, MD, MPH, president of the American College of Preventive Medicine and national medical director of Optimum/United Health Group, said, “Without more donated organs, disease management is one of our only alternatives.” Disease management services are provided in three stages, Dr. Harmon said. Primary services involve intervention before the onset of symptoms, an example being immunization. Secondary services include early detection and treatment, such as controlling hypertension to prevent kidney disease. The third level is tertiary care, or the management of complications and disability.

Mehmet Oz, MD, FACS, vice-chair of surgery and professor of cardiac surgery at Columbia University, New York, NY, spoke about prevention as it relates to heart disease. He noted that variables predictive of cardiac events include heart function, female gender, depression, and living alone. Dr. Oz also said that the public particularly needs to become more aware of the deleterious effects of obesity and gain a better understanding of which foods are the highest in calories and of the positive impact of moderate exercise.

David H. Sachs, MD, director of the Transplantation Biology Research Center and Paul S. Russell/Warner-Lambert Professor of Surgery at Harvard Medical School, spoke about another alternative—xenotransplantation. Dr. Sachs said the field of transplantation is inhibited by treatment-related complications, chronic rejection of transplanted organs and tissue, and the shortage of organs. He noted that other mammals could eventually be sources of organs and tissue, the most viable being nonhuman primates and pigs. In fact, studies currently are being conducted regarding kidney xenotransplants with pig donors and ape recipients. Efforts also are under way to genetically engineer pigs as xenograft donors.

Long-term project

As follow-up to this meeting and its roundtable discussions, the JCAHO intends to release a white paper on the organ transplantation issue later this year. “We don’t intend to stop until the problems are solved, so this project will probably continue for a long time,” Dr. O’Leary said.

SOCIOECONOMIC TIPS, from page 30

the Medicare program. The guide can be downloaded in Adobe Acrobat format (PDF) at http://www.cms.hhs.gov/medlearn/medicare%20resident-v2.pdf.

For surgical practices without Internet access, most of the information discussed in this article is regularly distributed in Part B carrier bulletins.
Fellow of the American College of Surgeons since 1974. Pediatric surgeon, surgeon-in-chief, vice-president of surgery, medical director, former Secretary of the College.

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“Becoming a Fellow of the College was my ultimate goal as a resident. My career has been enhanced by being a Fellow for the past 30 years and I have benefited from its numerous education programs. I feel that ‘giving back’ so the College can continue its educational and advocacy goals is one of the most important things I can do.

“The College is always striving to achieve contemporary goals; any gifts are put to good use. The College takes its fiduciary responsibilities very seriously and nothing is wasted.

“As a Fellow and as an Officer of the College, I have had tremendous experiences in my career as a surgeon and as an administrator. The opportunities to meet, and learn from, surgeons in multiple types of practice have been unparalleled.”

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

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

In February, the ACS Board of Regents awarded 10 American College of Surgeons Faculty Research Fellowships. These fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty and provide support in the amount of $40,000 per year from July 1, 2004, through June 30, 2006. The recipients are:

**Craig H. Selzman, MD,** assistant professor, University of North Carolina, Chapel Hill. Research project: Serum response factor and myocardial injury. Dr. Selzman’s fellowship—the Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons—is named to honor the founder of the College, and is funded by the Scholarship Endowment Fund of the College.

**Mark R. Hemmila, MD, FACS,** assistant professor, University of Michigan, Ann Arbor. Research project: The role of lipopolysaccharide binding protein in the pathogenesis of bacterial pneumonia. Dr. Hemmila’s fellowship, the C. James Carrico Faculty Research Fellowship for the Study of Trauma and Critical Care, is funded by the Scholarship Endowment Fund of the College.

All of the other fellowships are also sponsored by the Scholarship Endowment Fund of the College.

**Julia Tchou, MD, PhD,** assistant professor, University of Pennsylvania, Philadelphia. Research project: Characterization of genomic changes in breast cancer progression.

**John A. Curci, MD,** assistant professor, Washington University, St. Louis, MO. Research project: Regionalization of enzyme and cytokine in human abdominal aortic aneurysms.

**Aimen F. Shaaban, MD,** assistant professor, University of Wisconsin Medical School, Madison. Research project: Embryonic stem cell-derived hematopoietic progenitor cell transplantation in mice.

**Maciej S. Lesniak, MD,** assistant professor, University of Chicago (IL). Research project: Targeted adenoviral gene therapy for malignant glioma.
Matthew J. Eagleton, MD, assistant professor, University of Michigan, Ann Arbor, MI. Research project: Angiotensin II regulation of matrix homeostasis during abdominal aortic aneurysm formation.

Vikram S. Kashyap, MD, FACS, staff, vascular surgery, Cleveland Clinic Foundation, Cleveland, OH. Research project: The role of L-arginine transport in thrombus-induced endothelial dysfunction.

Bhavana Pothuri, MD, assistant professor, Columbia University, New York, NY. Research project: Notch and B-catenin and angiogenic factor interaction in endometrial cancer.

Charles Cha, MD, assistant professor, Yale University, New Haven, CT. Research project: Angiogenesis inhibition using siRNA gene silencing in solid tumors.

The application deadline for the 2005 Faculty Research Fellowships will be November 1, 2004. Further information regarding the scholarships, fellowships, and awards offered by the College for 2005 appears in this edition of the Bulletin (page 45) and on the College’s Web site, www.facs.org.

The Scholarship Endowment Fund of the American College of Surgeons was established in 1965 to provide income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are invited. Fellows wishing to make gifts to fund these vital programs are encouraged to contact the Development Office at 312/202-5376.
Resident Research Scholarships for 2004 awarded

In February, six American College of Surgeons Resident Research Scholarships for 2004 were awarded by the Board of Regents. The scholarships are offered to encourage residents to pursue careers in academic surgery, and carry awards of $30,000 for each of two years, beginning July 1, 2004. The recipients are:

Jose M. Prince, MD, University of Pittsburgh (PA) School of Medicine. Research project: Evaluation of the early regulatory response in liver injury from hemorrhagic shock. The scholarship is spon-
sored by Wyeth Pharmaceuticals.

Anthony Y-D Tsai, MD, York Hospital, York, PA; research to be performed at The Children’s Hospital of Philadelphia. Research project: Prenatal mesenchymal stem cell transplantation for the treatment of muscular dystrophies. The scholarship is sponsored by Ethicon, Inc.

All of the other scholarships are funded by the Scholarship Endowment Fund of the College.


Christopher E. Simpkins, MD, The Johns Hopkins University, Baltimore, MD. Research project: Establishment of durable alloantibody suppression using combined plasmapheresis and intravenous immune globulin therapy in a rodent model.

Kimberly Jean Riehle, MD, University of Washington, Seattle, WA. Research project: Liver regeneration in SOCS-3 knock-out mice.


Memorial Day is this month. This is the day when we honor Americans who died fighting in wars. However, Memorial Day also signals the beginning of summer, a time to enjoy leisure activities, to travel, and to spend time with family and friends.

For those who live in the Midwest, this weekend also represent the start of boating season and the kickoff of the motorcycle cruising season. Harsh winters and wet springs make the roads treacherous for motorcycles. By the last Monday in May, conditions are such that the motorcycle riders come out in droves.

It is unfortunate that this time with family and friends is often marred by the tragedy we see from motorcycle-related crashes occurring during this holiday weekend.

When looking at the records contained in the Annual Report for 2003 of the National Trauma Data Bank™ (NTDB), there are over 25,000 records involving motorcycle injuries. While this number is overshadowed by the number of records representing other motor vehicle crashes, the mortality rate is actually less than one-half of one percent lower for a motorcycle crash than it is for a motor vehicle crash. As represented in the graph on this page, the percentage of deaths from motorcycle crashes is the third highest rate among the blunt injury mechanisms.

Taking a closer look at these records, almost one-half of all motorcycle injuries and deaths occur in patients between the ages of 35 and 54. These data correlate with statistics from the National Highway Traffic Safety Administration (NHTSA), which show a trend toward an older biking population. Since 1980, the median age of riders has gone from 24 to 38, as the baby boomers have aged.

There has also been an alarming upward trend in the number of motorcycle fatalities each year since 1997. Another disturbing statistic is that per vehicle mile traveled, motorcyclists are over 26 times more likely as passenger car occupants to die in motor vehicle crashes. This increase in yearly fatalities is multifactorial. Data from NHTSA’s Fatality Analysis Reporting System (FARS) attributes the increase to an increasing age of riders (also seen in the NTDB), the use of motorcycles with greater engine size, lack of hel-
met use (less than 50 percent in fatal motorcycle crashes), and alcohol consumption.

As we embark on this holiday weekend to honor the Americans who lost their lives in our wars, let us remember our families and loved ones by encouraging everyone to be responsible when out on the roads.

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 http://www.facs.org/trauma/ntdbannualreport2003.pdf. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB at mneal@facs.org.

2004 Oweida scholar named

Mohammad S. Siddiqui, MD, of Jonesville, VA, was selected to receive the 2004 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons.

The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylvania. The $5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees. The purpose of the Oweida Scholarship is to help young surgeons practicing in rural communities attend the Clinical Congress and benefit from the educational experiences it provides. The scholarship is awarded each year by the Executive Committee of the Board of Governors.

The requirements are posted to the College Web site, www.facs.org. The next application deadline for the 2005 Oweida Scholarship is December 1, 2004.

Faculty career development awardee announced

The second Faculty Career Development Award for Oncology of the Head and Neck, jointly sponsored by the American College of Surgeons and the American Head & Neck Society, was announced to the Board of Regents in February 2004. The awardee for 2004-2006 is Richard J. Wong, MD, assistant attending surgeon at Memorial Sloan-Kettering Cancer Center, New York, NY. He is also an associate professor of otolaryngology at Weill Medical College, Cornell University, New York, NY. Doctor Wong’s research project is entitled “Sensitivity of Head and Neck Cancer to Herpes Oncolytic Therapy.”

The purpose of the award is to provide support for clinical basic science or translational research in the study of neoplastic disease of the head and neck. It offers support at a level of $40,000 per year for each of two years.
ACS Scholarships, Fellowships, Award available

The American College of Surgeons is offering two-year resident research scholarships. Eligibility for these scholarships is limited to the research projects of residents in surgery or a surgical specialty.

**American College of Surgeons Resident Research Scholarships.** These scholarships are supported by the generosity of Fellows, chapters, and friends of the College, to encourage residents to pursue careers in academic surgery.

**Ethicon Scholarship of the American College of Surgeons for the Study of Surgical Wound Healing.** This scholarship is funded by a grant from Ethicon, Inc., to encourage residents to pursue careers in academic surgery. The scholarship is intended primarily to stimulate interest in the healing of soft tissue and minimally invasive surgery. Proposals may include the biology of wound repair, complications of wound repair, or the application of new technologies to clinical problems.

**Wyeth Scholarship of the American College of Surgeons.** Wyeth Pharmaceuticals has provided an unrestricted educational grant to the ACS to fund a Resident Research Scholarship. The purpose of the scholarship is to provide two years of laboratory experience to residents performing surgical research related to biological and physiological aspects of inflammation.

General policies covering the granting of the American College of Surgeons Resident Research Scholarships are:

- The applicant must be a Candidate Group member of the College who has completed two postdoctoral years in an accredited surgical training program in the U.S. or Canada at the time the scholarship is awarded, July 1, 2005, and shall not complete formal residency training before June 2007. Scholarships do not support research after completion of the chief residency year.
- The scholarship is awarded for two years, and acceptance of it requires commitment for the two-year period. The award is to support a research plan for the two years of the scholarship, July 1, 2005 through June 30, 2007. Priority will be given to the projects of residents involved in full-time laboratory investigation. Study outside the U.S. or Canada is permissible. Renewal of the scholarship for the second year is required and is contingent upon the acceptance of a progress report and research study protocol for the second year, as submitted to the Scholarships Section of the College by May 1, 2006.
- Application for these scholarships may be submitted even if comparable application to other organizations has been made. If the recipient accepts a scholarship/fellowship from another agency or organization, the ACS Resident Research Scholarship will be withdrawn. It is the responsibility of the applicant to notify the Scholarships Section of the College of competing awards.
- The scholarship is $30,000 per year; the total amount is to support the research of the recipient and is not to diminish or replace the usual or expected compensation or benefits of the recipient. Indirect costs are not paid to the recipient or to the recipient's institution.
- The scholar is expected to attend the Clinical Congress of the American College of Surgeons in 2007 to present a report on the research to the Scholarships Committee on October 7, and to receive a certificate at the Annual Meeting of Fellows.
- Approval of the application is required from the administration (dean or fiscal officer) of the institution. Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor who will be supervising the applicant's research should be submitted. Only in exceptional circumstances will more than one scholarship be granted in a single year to applicants from the same institution.

The closing date for receipt of applications is September 1, 2004. Application forms may be ob-
The American College of Surgeons is offering two-year faculty research fellowships, through the generosity of Fellows, Chapters, and friends of the College, to surgeons entering academic careers in surgery or a surgical specialty. The fellowship is to assist a surgeon in the establishment of a new and independent research program. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years, to support the research.

Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons. One of the fellowships is named to honor Franklin H. Martin, MD, FACS, founder of the American College of Surgeons.

C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care. One of the fellowships is named to honor C. James Carrico, MD, FACS, and is designated for research in trauma and critical care.

General policies covering the granting of the American College of Surgeons Faculty Research Fellowships are:

- The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.
- This award may be used by the recipient for support of his/her research or academic enrichment in any fashion that the recipient deems maximally supportive of his/her investigations. The fellowship grant is to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient’s institution.
- Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award.
- The College encourages the applicant to leverage the funds provided by this fellowship with time and monies provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.
- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the senior investigator (if applicable) supervising the applicant’s research effort should be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.
- The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.
- A minimum of 50 percent of the fellow’s time must be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

The fellow is expected to attend the Clinical Congress of the American College of Surgeons in 2007 to present a report to the Scholarships Committee on October 7, and to receive a certificate at the Annual Meeting of Fellows.
The closing date for receipt of applications is November 1, 2004. Application forms may be obtained upon request from: Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; or at the College’s Web site: http://www.facs.org/memberservices/facultyapp2005.pdf.

George H.A. Clowes, J r., MD, FACS, Memorial Research Career Development Award, J uly 1, 2005–J une 30, 2010

This award is developed through the generosity of The Clowes Fund, Inc., of Indianapolis, IN. The purpose of the award is to provide five years of support for the research of a promising young surgical investigator. The award consists of a grant of $40,000 for each of five years and is not renewable thereafter.

General policies concerning the granting of the George H. A. Clowes, J r., MD, FACS, Memorial Research Career Development Award are:

• The award is restricted to a Fellow or Associate Fellow of the College who has completed specialty training in a residency or an accredited fellowship in general surgery or a surgical specialty within the preceding seven years and has received a full-time faculty appointment at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. The applicant’s academic appointment may not be above the level of assistant professor. Applicants should provide evidence (by publication or otherwise) of productive initial efforts in laboratory research.

• The award may be used for salary support or other purposes at the discretion of the recipient and the institution. Indirect costs are not paid to the recipient or to the recipient’s institution.

• The American College of Surgeons Scholarships Committee will look favorably upon applicants who have received investigator-initiated, peer-reviewed research awards (for example, NIH K08 grants) or grants from industry sources. The committee will not consider applicants who have received research career development type awards from the American Heart Association or other professional societies. It is the responsibility of the recipient to notify the College’s Scholarships Administrator to request approval if another source of scholarship/fellowship funding is received.

• Approval of the application is required from the administration (dean or fiscal officer) and the head of the applicant’s department or administrative unit. This approval would involve a commitment to continuation of the academic position and facilities for research during the entire period of the award. Furthermore, it must be assured that at least 50 percent of the applicant’s time will be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

• The applicant must submit a detailed research plan and propose a budget for the five-year period of the award. The applicant also is required to submit a cover letter of approximately 400 words that describes the career objectives, how these career objectives will be achieved, and how the research protocol furthers the applicant’s career development. The Scholarships Committee of the College requires an annual progress report from the recipient on which annual renewal is based.

• While holding the award, the recipient is expected to attend the Clinical Congress of the American College of Surgeons in 2006, 2008, and 2010 to present reports to the Scholarships Committee.

• Upon completion of the five-year funding period, the recipient will be required to submit a summary of research progress and to provide information regarding current academic rank, sources of research support, and future plans.

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

Application forms may be obtained upon request from: Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; or at the College’s Web site: http://www.facs.org/memberservices/clowesapp2005.pdf.
CMS issues notice on teaching physician compensation

On March 12, 2004, the Centers for Medicare & Medicaid Services (CMS) issued a one-time notification that implements several provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MIPDIMA) related to graduate medical education. Of particular interest to surgical residency programs is a provision related to teaching physician compensation in nonhospital settings. CMS clarifies that "FTE residents in programs other than general family practice may be disallowed from cost reports...if the hospital did not properly incur the teaching physician compensation associated with direct GME."

The notification responds to recent audits performed by CMS intermediaries that have retroactively denied IME and DGME payments for the time residents spend in nonhospital settings where they are supervised by volunteer faculty. The College is working with a coalition of physician organizations to overturn this CMS policy. The complete notification can be viewed online at http://www.cms.hhs.gov/manuals/pm_trans/R61OTN.pdf.