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About the cover...

Telemedicine is changing the “very concept of the operating theatre,” according to Ronald C. Merrell, MD, FACS, author of this month’s cover story on page 8. It is allowing surgeons to perform or assist with operations in other states, or even other countries, and is opening the door to new ways of educating students and residents.

(Photos courtesy of the author.)
NEWS

RAS-ACS symposium at Congress to examine truncated resident training

Rural, urban physicians have comparable incomes

COC colon cancer practice profile reports to be available online

Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings, October 9-10, 14, 2004

Paul E. Collicott, MD, FACS

NTDB™ data points: The bank’s window
by Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

Chapter news
Rhonda Peebles

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

During their February meeting, the Board of Regents unanimously and emphatically endorsed some very significant concepts related to the College’s involvement in the quality movement. I want to share with all of you some of the plans that emanated from that meeting and to outline the rationales behind them.

The quality imperative

Based on the stories you’ve shared with me in the course of my travels and the steady flow of pertinent articles in the lay and professional press, it is apparent that changes in health care delivery are occurring at an astonishingly rapid pace. Fueling this accelerated movement are growing public and governmental concerns about quality and exorbitant health care costs, which continue to consume a large share of the gross domestic product.

As a result, we clearly are entering an era in which patients will have more responsibility for and control over the care they receive. Furthermore, payors and insurers are demanding information that will allow them to evaluate the quality of care physicians, other health care professionals, and providers deliver so that they can ensure that their beneficiaries will receive the most effective care at the most reasonable cost. These trends are perhaps best reflected in the movement toward “pay for performance” or “pay for participation.” Under this concept, which has been applied in the manufacturing world, payment is based on the health care professional’s or facility’s efficiency and outcomes data for surgical procedures and, for that matter, treatments for chronic conditions.

Instituting this payment system is rather difficult at this point because we lack a truly appropriate methodology for evaluating much of what we do in health care. Certainly we all know physicians in our own institutions who routinely provide good care and are aware of medical centers that excel in treating certain types of conditions. However, our opinions are largely subjective and based on our limited experiences.

The College’s role

Hence, organizations like the College are obligated to develop objective measures for evaluating what we do and how well we do it. To that end, the Regents have determined that the College should undertake expanded efforts to accredit surgical facilities based on the effectiveness of care provided, particularly with respect to how they introduce new surgical procedures for our patients.

Presently, no organization bases accreditation on an examination of all of the systems of care involved in the introduction of new procedures and technology. The College must accept responsibility for ensuring that surgeons are appropriately trained in the application of these new approaches by verifying their competence and scrutinizing their credentials. Activities in this area...
will grow over time and will be developed within the ACS Division of Education and the Division of Research and Optimal Patient Care through its Continued Quality Improvement program. As we increase our efforts to credential and accredit surgical facilities and to verify the qualifications of surgeons, our National Surgical Quality Improvement Program will serve as an important measurement instrument.

Accreditation is not foreign territory for this organization. The College has a long history of involvement in this area, dating back to 1918 when we instituted a program for hospital standardization, which eventually evolved into the Joint Commission on Accreditation of Healthcare Organizations. Additionally, the College’s Committee on Trauma consults with and verifies trauma and burn centers, while our Commission on Cancer carries out reviews of and approval processes for cancer centers throughout the U.S.

**New activities**

One area of surgical practice that demands our immediate and critical consideration is bariatric surgery and the systems that support performance of these procedures in our hospitals and medical centers. We envision analyzing many other new and innovative operations as well, including those for the breast, minimally invasive procedures, spine surgery, geriatric surgery, and a litany of other types of procedures that surgical specialists provide.

Given the Board of Regents’ recent edict, much activity will ensue in the coming months. We anticipate that ultimately the College will be in a position to accredit surgical centers based on their record of providing safe, effective, and efficient care. Those institutions that the College endorses, we believe, will have significant clout in negotiating with insurers and other payors. Our goal, as in all endeavors, will be to ensure that the highest standards—those based on formal evaluation of outcomes data—govern the provision of surgical care.

The current trends in health care demand that the College expand its efforts to verify the training and competence of surgeons who perform innovative surgical procedures and to accredit the hospitals and centers in which they are performed. They also require that all surgeons understand the quality imperative and what it means to their practices. By becoming involved in these activities, surgeons will be able to better manage their practices and provide appropriate, safe, and effective care to their patients.

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*Thomas R. Russell, MD, FACS*
Dateline Washington

prepared by the Division of Advocacy and Health Policy

Fellows testify at medical liability reform hearing

On February 17, Chad Rubin, MD, FACS, from Columbia, SC, testified on behalf of the College during a House Small Business Committee hearing on Medical Liability Reform: Stopping the Skyrocketing Costs of Health Care. Dr. Rubin told the committee that rising medical liability insurance premiums are dramatically affecting his group practice in South Carolina. He also told the committee how a similar problem in southern Illinois has forced his mother’s physicians to move out of state, so that she now must travel across state lines for medical care. Dr. Rubin’s testimony can be found on the College’s Web site at http://www.facs.org/ahp/testimony/medicalliability.html.

Other Fellows—Donald Palmisano, MD, FACS, on behalf of the American Medical Association, and Thomas Gleason, MD, FACS, on behalf of the Alliance of Specialty Medicine—also testified at the hearing. Congress will be debating medical liability reform legislation in the coming months.

Hard-fought medical liability reform victory in Georgia

After many years of grassroots advocacy, legislator and patient education, and shifts in political power, advocates for comprehensive medical liability reform in Georgia achieved passage of an important law. On February 16, Gov. Sonny Perdue (R) signed S.B. 3, which comprises the following reforms:

- A $350,000 cap on noneconomic damages.
- Elimination of joint and several liability.
- A heightened standard of proof for lawsuits pertaining to care provided in emergency departments.
- Restrictions on venue “shopping.”
- Implementation of expert witness qualifications.
- An “I’m Sorry” provision permitting physicians to offer condolences or apologies without those comments being admissible in court or considered admissions of guilt.

To view the full text of S.B. 3, visit the Georgia Assembly’s Web site at http://www.legis.state.ga.us/legis/2005_06/fulltext/sb3.htm.

Georgia surgeons were actively involved in efforts to pass this legislation, which took less than one month to go from introduction to enactment. More than 115 Fellows responded to requests from the College and the Georgia Chapter that they write to their respective state legislators through the Web-based Surgery State Legislative Action Center. Many other surgeons contacted their legislators directly by telephone and fax or visited the capital to meet with legislative leaders.

President issues budget proposal

The blueprints for President Bush’s fiscal year 2006 budget were released Monday, February 7. Of particular interest, the President pledged to promote accountability for health care quality, to create incentives for collecting data from providers on quality measures, and to make those data publicly available. With respect to improving patient access to affordable health care, the budget calls for:

- Income-scaled tax credits to help individuals purchase health
insurance and medical services. Small businesses would also receive tax credits for contributing to employee health savings accounts.

- Allocation of $4 billion to the states to establish purchasing pools for low-income citizens. Association health plans would also be established so that small businesses could negotiate lower-price coverage for their employees.
- A national outreach campaign, Cover the Kids, which would provide $1 billion in grants over two years to enroll more children in Medicaid and the State Children’s Health Insurance Program.
- A premium deduction for taxable income for all individuals who purchase a high-deductible health plan in conjunction with a health savings account.
- A competitive marketplace across state lines to help improve individual access to affordable coverage.
- Medical liability reforms to reduce costs and improve access.

The budget plan also called for increasing funding for the National Institutes of Health, but reducing monies for many programs that the Health Resources and Services Administration (HRSA) manages. Indeed, some HRSA programs would receive no funding under the President’s 2006 budget, including those centered on trauma-emergency medical services (EMS), EMS for children, and traumatic brain injury. Budget proposals for programs under the purview of the Department of Health and Human Services (HHS) are available at http://www.hhs.gov/budget/docbudget.htm.

On February 2, Senate Majority Leader Bill Frist, MD, FACS (R-TN), along with Sens. Edward Kennedy (D-MA), Patty Murray (D-WA), James Jeffords (I-VT), Hillary Clinton (D-NY), Jim Talent (R-MO), and Pat Roberts (R-KS), introduced the Trauma Systems Planning and Development Act (S. 265). The Senate Health, Education, Labor and Pensions Committee finished its work on the bill without making any amendments on February 9. The bill duplicates legislation that the Senate passed early in the 108th Congress, providing $12 million in funding for the HRSA Trauma-EMS program. Eighty percent of the funding is earmarked for state grants to develop, improve, and maintain state trauma care systems, 10 percent is provided for improvement of rural EMS services, and 10 percent is intended for other purposes.

The House is working on a companion bill, but at press time appeared inclined to reintroduce last year’s bill, which failed because of opposition from the American Academy of Pediatrics (AAP) and other organizations. The Trauma-EMS advocacy community is actively working with the AAP and key House and Senate committee staff to resolve the differences between the two bills in a manner that is acceptable to all interested parties.
Telemedicine and telesurgery in the operating room

by Ronald C. Merrell, MD, FACS, Richmond, VA
Surgery has been a powerful and effective steward of medical technology, bringing a steady stream of innovations to the public over the last century. After the codification of asepsis and surgical technique at the end of the nineteenth century, the operating room (OR) acquired a look, a feel, and a culture that essentially have been preserved. Despite the introduction of heart-lung machines, transplantation, radiofrequency ablation, lasers, stereotactic neurosurgery, laparoscopy, and a myriad of other technological leaps in surgical care, the OR has remained a very conservative environment strongly informed by tradition.

Operations are performed in a ceremonial manner, with special clothing (including hats, masks, and gloves), rituals of hand washing, red-line barriers restricting unwanted traffic and bacteria, a generally reserved demeanor, and various protections to maintain equanimity in the face of chaos, tragedy, or simple tedious legerdemain. The very inaccessibility of the operating room, juxtaposed with the widely held understanding that it can be the most dramatic place in human endeavor, has led to the OR’s romanticization by filmmakers and reality TV writers. The severity of the operating room has even bred some humor. Credentials acquired by staying in a certain motel apparently include surgical ability, and dropped candy from the surgical gallery was the source of humor in a *Seinfeld* episode.

However, the accessibility of the operating room to the camera suggests a huge change in the conduct, capability, and very concept of the operating theatre. Our ceremonies, secrets, and private struggles with human disease happen in an open forum that can be, and is, shared electronically with many people rather than the privileged few who are present during the delivery of operative care. This expanded accessibility, made possible through telecommunications, is bidirectional, opening the door to opportunities to both import and export information.

**Telemedicine**

The use of electronic information and communications to support health care is termed “telemedicine.” Bird first used this term in 1962 to describe videoconferencing to permit physicians at a hospital to interact with patients at a clinic some distance away. For the next 25 years, telemedicine was a tool for support of faraway patients, connecting them and their caregivers to specialty consultation. However, telemedicine has evolved considerably in the last 15 years due to the rapid expansion of information science into medical practice.

So much information is available to support medical decisions or to report on the laboratory and radiological evaluation of each patient, and so much data accumulated in the longitudinal management of a chronic disease, that a physician cannot be expected to process and retain all the knowledge needed for responsible care. Patient information can be so voluminous that the data set begins to take on qualities of the actual patient as a simulacrum. Therefore, health care workers are perforce managers of information acquired through hospital computers, office computers, electronic medical records, filmless radiology files, PubMed®, electronic libraries, and, alas, e-mail. As information managers, we have become accustomed to an assault of digital, rather than analog, information.

Once patient care information is digitized, it becomes amenable to rapid, effective, highly useful electronic transmission from place to place. Therefore, the proliferation of telecommunications is eliminating the distance factor from many aspects of health care delivery. Telemedicine allows distant interpretation of radiology studies, pathology, and dermatology. Wireless VPN cards allow many physicians to make electronic rounds at home at any hour, improving continuity of care. Electronic rounds are also possible for home visits.

**Use in the OR**

In a time of rapid expansion of information science, telecommunications, and telemedicine, it is not surprising to find surgeons in the vanguard of telemedicine activities by using the technology in the operating room. Perhaps the most dramatic example of telemedicine in the OR was the robotic cholecystectomy that Dr. Jacques Marescaux performed in September 2001 from the office of Dr. Merrell (left) can communicate from the operating room at VCU to multiple locations simultaneously, including the American Telemedicine Association Annual Conference in Orlando (top right), Moscow, Russia (center right), or a high school auditorium in Richmond, VA (bottom right).
French Telecom in New York, NY, upon his patient in Strasbourg, France. This event truly shattered the image of the OR as a place of sublime isolation.

In a recent analysis of trends likely to influence the operating room in the near term, the U.S. Department of Defense held workshops that resulted in five white papers considered to be a roadmap for research programming. One paper focused on telemedicine, others were on informatics, processing, technology, and patient safety, which, in light of recent criticism about medical errors and quality, is a strong element in all the reports. Certainly that is the case in telemedicine. Just-in-time information, accurate record keeping and transmission, the ability to obtain intraoperative consultation, teaching from the OR, and collaboration in the OR with a virtual surgical team all contribute to enhanced quality and patient safety.

Most operating rooms are now fully wired into the hospital’s medical information. This sort of networking allows importation of radiological images of the patient and, in some instances, importation of pathology images. Ultrasound, laboratory reports, previous text descriptions such as other operative notes or office notes, and demographics arrive from within the hospital system, which can usually provide text and decision support materials as well. The systems should be able to access image files and other materials useful in operative management. These features are all within the security of the computer firewall of the medical information system with very limited interface with outside sources. To extend interaction through telecommunications, specific attention must be directed to opening the information system or running a parallel telecommunications line to make the OR interactive with other sites.

Telemedicine from the OR can be as simple as teaching a class from another part of the campus or another continent. Once the data are digital and applied to transmission software, the interaction can take place anywhere. Bandwidth defines the nature of the interaction via Internet modem, Integrated Services Digital Network (ISDN) phone line, T1 phone connection, broadband Internet, or satellite. The sending site may be requesting intraoperative consultation or may be participating in a surgical proctoring session.

There is a striking tendency in medicine to create new technical terms, and telemedicine is no exception to this rule. Transfer of cognitive advice specific to the patient is called “telepresence,” while advice to a surgeon is “teleproctoring.” Telecommunications can also allow a surgeon to join a distant surgeon as a physical part of the operation through robotics, termed “telesurgery.”

Telemedicine can open the operating room to a wide audience of students and fellow surgeons without crowding or contaminating the precious space of the operating room. Operations that could only be seen by visiting the office center of the inventor can now be readily viewed by Web cast or another videoconference technique. Through these broadcasts, the ability to consider and potentially apply a new surgical technique is truly global and the diffusion of surgical innovation is greatly accelerated. The quality of video continues to improve, while the cost continues to decline. Being an early adaptor of a technique formerly involved expensive travel and time away from practice for the innovator or the potential adaptor. Travel to educational conferences can be done more selectively by individuals who first learn about the innovation and its applications through video conferencing. Broadcast surgery can introduce new
Robotic telesurgery caused many surgeons to carefully reflect on the technology, the ethics, and the proliferating possibilities of telemedicine. Of course, it is unlikely that many patients will seek out a robotic surgeon. Nonetheless, it is truly remarkable that the transatlantic cable committed to the project could put Dr. Marescaux only 155 milliseconds away from his patient. This delay does not significantly affect surgical performance; but the delay back and forth to a geostationary satellite is about 500 milliseconds, and that lag begins to interfere with surgical skills.

In Canada, Mehran Anvari, MD, FACS, has found that robotic surgery is rather practical in the huge expanse of his country because travel is difficult much of the year and it is sparsely populated. His program has performed several score procedures and is clearly moving beyond the demonstration to full integration in health planning. In urban practice, there is still a strong motive for telesurgery as an extension of consultation. When a surgeon is called to the operating room to aid a colleague in resolving an unusual anatomical problem, he or she often must scrub and take a closer look. If the consultant needs to physically intervene, the most common form of intervention is to be-

**Other uses**

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**Images from remote location in Ecuador (left) and images as transmitted for viewing by Medical Informatics and Technology Applications Consortium staff in Richmond, VA (right).**
come the assistant to the primary surgeon.

Consultation by telemedicine can follow the same sequence. When it is time for a physical intervention, it is unlikely the consultant will simply complete the operation through robotic surgery. It seems much more likely that the consultant will want a robotic arm to assist and perhaps perform a few maneuvers. This application of robotic surgery seems much more likely for wide application than complete robotic surgery.

The invitation of a consultant to the operating room is easy in a large metropolitan medical center, and such requests are tendered rather often. We might feel critical of a colleague who sustained a complication that may have been mollified with the assistance of another expert. Of course, attaining expert help is not always practical in rural practice. All surgeons have gone to the waiting room on rare occasions to advise a family of a negative outcome despite our best efforts. With regard to teleconsultation, we might expect, in the near future, that families would expect doing our best to include calling a
teleconsultant to avoid what seems to be an inevitably bad outcome.

**Important surgical innovation**

Telemedicine in surgery is not a novelty and is highly consistent with the innovations surgeons have brought to medical practice. Surgeons are quick to adopt appropriate innovations when it is practical and consistent with sound practice. The greatest cost in the early days of telemedicine was communications. However, over the last five decades, the cost of telecommunications has steadily dropped relative to the service delivered. At the same time, the cost of medical care has steadily risen with the accusation that the public is not living that much longer or better and that access to care is not getting any better. Telemedicine has the potential to merge the salutary economics of telecommunications with the challenging spiral of standard medical cost. Best practices can diffuse more rapidly and safety enhancement can be extended to every OR in the land.

The challenges to full application of telemedicine in the OR are not the technology, the cost, or privacy worries. The technology is well established; the costs are steadily dropping and are currently sustainable. The technology of encryption is getting better all the time, so challenges to patient privacy are surmountable. The only potential barrier is the persistent concept of the OR as the personal province of the surgeon and the operative team. The fact of the matter is that this concept is incompatible with the reality of the modern OR. The driver of telemedicine in the OR is not just the availability of the technology. Demonstrable benefits to patient safety are coming and patient demand will follow. It is likely that regulatory authorities will insist upon telemedicine capacity in the OR in the interest of safety and patient demand. However, before these drivers, there will be, as always, the indomitable labor of surgeons to improve our work through elegant technical solutions.

**Editor’s note:** This paper is based in part on a presentation that Dr. Merrell gave at the 2004 ACS Clinical Congress regarding the operating room of the future.

**References**


**Dr. Merrell** is professor of surgery, Virginia Commonwealth University, and director, Medical Informatics and Technology Applications Consortium, Richmond, VA.
THE BATTLE FOR TORT REFORM: The Maryland experience

by Scott E. Maizel, MD, FACS, Baltimore, MD

This article depicts the battle for tort reform waged in Maryland. It demonstrates how escalating liability premiums in the state forced the medical community and our diverse patient population to rally behind the cause and grab the attention of legislators. I anticipate that our rather bittersweet story will provide insights into the political process and into how to build momentum at the grassroots level in the fight for liability reform.

THE SETTING

The state of Maryland is located in the mid-Atlantic region and bordered by two states, West Virginia and Pennsylvania, both experiencing a professional liability crisis due to escalating premiums. So understandably, when Maryland’s largest private medical liability carrier, the physician-owned Medical Mutual Liability Company, was granted a substantial increase in rates beginning January 1, 2004, health care professionals throughout the state sounded cries of alarm. The lines were drawn for the next battle for tort reform in Maryland.

Maryland’s population of more than 5 million live primarily in its eastern and southern regions. The major centers of Baltimore and Annapolis are situated on the western shores of the Chesapeake Bay. The areas to the east of the bay extend to the Atlantic coast. The population centers of Baltimore and Washington, DC, to its southwest on the Potomac River create a metropolis, which is said to contain the greatest per capita density of lawyers in the nation. Further west, the state becomes more rural in character, with smaller communities and rolling hills leading to the modest mountains that border West Virginia.

In 2003, Rep. Robert Ehrlich, Jr., a Republican, was elected governor. He was chosen to preside over a Maryland General Assembly, which has an unbroken history of Democratic dominance. The president of the senate, Thomas Mike V Miller, Jr., has held that post longer than anyone and has served as a state senator for 30-plus years. And while the majority of the lawmakers in Maryland return to private businesses when the 90-day legislative session is over, Senator Miller and almost all of the other “movers and shakers” in the gov-
ernment are lawyers—trial lawyers. Only two physicians serve in the General Assembly—a Republican anesthesiologist in the Senate, and a Democrat emergency physician in the House of Delegates.

**The Year Begins**

With malpractice premium rates scheduled to increase for physicians, the state medical society, commonly called the MedChi, organized a rally on the steps of the statehouse for opening day of the legislative session, January 21, 2004. More than 2,000 physicians from across the state came to hear speeches by physicians, AMA president Donald Palmisano, MD, FACS, and patients. The governor made an unscheduled appearance on that cold morning, as well. All spoke passionately about the effects that the increases would have on access to health care for Marylanders. Cries of “tort reform now” and “save our docs” filled the air. In my capacity as President of the Maryland Chapter of the ACS, I had written what turned out to be the lead op/ed story in *The Baltimore Sun* that day. The letter declared it was “time for change” and that “the health care of all of the citizens of Maryland warrants this effort.”

Despite the participants’ enthusiasm, local television news programs only gave the rally 30 seconds or so of airtime, but granted three minutes of coverage to the “victims” of “rampant” medical malpractice shown testifying in a Senate conference room. There was no mention of the 60 buses required to bring in physicians from all over the state, nor of the transportation provided by the opponents of medical liability reform to bring the “victims” to Annapolis that day. It was clear that the money allocated by opponents to fight tort reform in the session would be spent in the next 90 days.

**The Session**

During the 90-day legislative session, general assembly committees conducted numerous hearings on tort reform. Hospitals, physician groups, the state medical society, and insurers banded together to form an Alliance to Preserve Access to health care. Formal testimony and informal discussions were held with leaders on both sides of the aisle in the statehouse and the governor’s office. Bills were introduced with much public debate. Privately, many insiders pronounced the legislation “dead on arrival.”

In the end, the session closed without a bill even being presented on the floor for a vote. Though some observers thought the effort for tort reform was underfunded or pursued too passively, the most prevalent assessment from lawmakers and physicians alike was that nothing would change until there was “blood in the streets”; that is to say, until the patients felt the pain and demanded reform themselves.

**The Growing Storm**

January’s optimism gave way to despondency when the session closed in April. All members of the Alliance to Preserve Access left Annapolis feeling the same sense of overwhelming frustration. During the summer months following the legislative session, the governor visited all of the hospitals in the state, talking with medical staffs and urging physicians to get involved, to contact their lawmakers, and to explain the repercussions of the problem to their patients.

In July, I met with representatives of Governor Ehrlich’s office to discuss the situation and review the issues relevant to the practice of surgery. Changing requirements for expert witnesses as promoted by the American College of Surgeons were included in the chapter’s list of necessary reforms. “Good Samaritan” reform to better protect surgeons who provide emergency care was also advocated. At this time, the governor clearly indicated his support, and we considered him a positive force for liability reform.

In separate meetings and through the press, lawmakers offered various tort reform proposals, most of which appeared to be self-serving and intended to preserve the status quo. The Maryland Chapter and other medical groups sent letters to the editor of the local newspapers decrying the measures. Both the state senate and the governor appointed special panels to study the problem and make recommendations in the fall.

Throughout 2004, Medical Mutual Liability Company and the three remaining medical liability insurers in the state paid out on record verdicts and settlements. Another round of premium rate increases was imminent. Med Mutual requested an additional increase for January 1, 2005. This hike, on top of the prior year’s increase and
the loss of a premium rebate, amounted to a sub-
stantial increase for surgeons in a two-year period.
GE Medical Protective, the country’s oldest medi-
cal liability carrier, requested an even larger in-
crease in rates so that it would be on par with Med
Mutual. Clearly, the lack of reform during the 2004
session caused the crisis to escalate.

SURGEONS MOBILIZE

In August, a number of surgeons approached the
Maryland Chapter Council Members for advice and
help. As a result of these requests, an emergency
meeting of surgeons from throughout the state
took place September 18, 2004, at a conference cen-
ter in Ellicott City, MD.

Approximately 100 surgeons of all disciplines
from across the state attended. Also present were
the only physician in the state senate and two law-
yers—one an expert on antitrust law and the other
in health care business law. During the four-hour
session, we outlined immediate ways to stabilize
the situation, as well as the elements of reform
needed to address the liability crisis. Importantly,
the antitrust lawyer tempered calls for a “strike.”

Although the meeting concluded without plans
for a strike, surgeons left with a clear understand-
ing of which reforms were effective, necessary, and
achievable. We formed a network for rapid com-
munication across the state and were determined
to become much more active. Significantly, two
separate groups of surgeons from western Mary-
land resolved to do much more.

PRESSING THE ISSUE

Because January 1, 2005, was the date the addi-
tional rate hikes were due to take effect, time was
short for definitive action. Two surgical group
practices—one in Hagerstown and the other in
Frederick—decided to close their doors. These
multispecialty surgical groups provided 65 percent
to nearly 100 percent of the surgical care to the
patients who live in those western Maryland com-

communities, both with populations of more than
50,000. On November 15, 2004, the Hagerstown
group would stop seeing elective patients for at
least a week and, perhaps, all patients thereafter
if significant reform did not materialize. The group
in Frederick said it would stop caring for patients
entirely on January 1, 2005.

Each group’s intentions quickly became known,
and statewide publicity resulted. The Hagerstown
group enlisted media consultants to assist in get-
ting the message out. A very effective Web site was
established to keep all informed. The issues caus-
ing the imminent loss of access to care were dis-
cussed almost daily in the media. The impact of
the medical liability crisis upon many of the state’s
physicians and hospitals became increasingly ap-
parent. A survey commissioned by the Maryland
Hospital Association highlighted the economic im-

A SPECIAL SESSION

In Annapolis, lawmakers were reviewing recom-

defendations from special panels convened during
the summer. Lawmakers who felt they had put the
issue of tort reform to rest during the previous
general session now were compelled to address it
again. Editorials began to appear in national news-
papers and interviews were shown on national tele-
vision programs. Because the medical community
had pressed the issue and prevented it from being
ignored or postponed until the next general ses-

sion, legislators knew it was time to act. Behind
the scenes, the governor and key lawmakers met.
Provisions of a compromise bill to address essen-
tial reforms were reportedly agreed upon. The gov-
ernor called for a special session of the general
assembly to be held between Christmas and New
Year’s Day. It was the first special session to be
held in Annapolis in 12 years.

The special session convened December 27, 2004.
The entire day was devoted to testimony in the
house of delegates and the senate. I testified be-
fore both bodies on behalf of the College’s Mary-
land Chapter and noted that the impending loss
of surgeons due to increased malpractice premi-
ums would put all Marylanders at risk. The crisis
in access to care affected not only the 67,000
women who deliver babies each year in Maryland,
but all of the more than half-million citizens who
undergo operations each year throughout the
state. The testimony also emphasized the impact
the liability crisis was having on staffing the emer-
gency rooms and wait times to find a surgeon.

Instead of the anticipated single bill to be dis-
cussed and voted on, lawmakers found themselves
confronted with two additional pieces of legisla-
tion. Along with the governor’s so-called compro-
mise bill, each legislative branch drafted its own proposal. After more than 20 hours of testimony in both chambers, the bill that ultimately emerged from the joint conference committee contained very few tort reform measures that the governor had advocated.

Editorials in the national press deemed this bill a “gift to the trial lawyers.” It was referred to as “tort reform lite” during debates on the senate floor. The only substantive measures it contained related to the insurance industry. Measures to tighten requirements for expert witnesses similar to those proposed by the American College of Surgeons were included in the bill, as was a measure for an enhanced certificate of merit. “Good Samaritan” provisions did not survive. To stabilize liability premiums, the bill sought to establish a $40 million fund supported through the elimination of a 2 percent premium tax exemption the health maintenance organizations had enjoyed in Maryland for more than 20 years. The fund’s necessity and adequacy were questioned.

Although the impact the legislation will have on Maryland’s medical liability crisis is still uncertain, our struggle offers some important lessons.

The Bill’s Fate

Nonetheless, the Maryland Patients’ Access to Quality Health Care Act of 2004 (H.B. 2), passed both houses of the general assembly at 3:00 am Thursday, December 30, 2004. It passed despite the governor’s pledge to veto it because of the “new HMO tax” that would be passed on to working families and much to the overwhelming disappointment of everyone but the trial lawyers. Essentially, all important tort reform measures had been diluted or eliminated. The historic special session adjourned and the bill went onto the governor’s desk, where it languished until January 10, 2005. That day, at a well-publicized press conference, the governor carried out his threatened veto. The following day, the general assembly session overrode his veto as its first order of business, with members voting essentially along party lines. The Maryland Patients’ Access to Quality Health Care Act of 2004 became law.

Lessons Learned

Although the impact the legislation will have on Maryland’s medical liability crisis is still uncertain, our struggle offers some important lessons.

Undoubtedly, the courageous actions of two surgical group practices in western Maryland were pivotal in transforming a politically dead issue at the end of the 2004 legislative session into a topic drawing national attention. By setting dates for ceasing practice and, in the case of the Hagerstown group, actually doing it, it became apparent not only to patients and lawmakers, but to the entire state, the media, and the country, that liability abuse was a serious problem in Maryland and tort reform was urgently needed. Because these communities are geographically isolated, their actions did more than just inconvenience a few patients; they brought pressure to bear at the state level to avert a real health care crisis for tens of thousands of patients. This tactic would have been ineffective in Baltimore or in other large metropolitan areas because patients could have obtained care from different physicians or hospitals a few miles—or even a few blocks—away.

It also was apparent that when the debate was revived an important opportunity emerged to reframe the impact of the crisis. Skyrocketing liability premiums affect not just physicians and obstetrical care. By stressing the fact that everyone was at risk, lawmakers had to address the prob-
lem. Additionally, it demonstrated that not only physicians, but hospitals, clinics, and nursing homes throughout the state, as well, spend more on liability premiums and defensive care than on staffing, equipment, and maintenance.

By uniting with other stakeholders in the renewed battle for tort reform, such as hospital associations, medical societies, and business organizations, physicians were able to more widely and effectively broadcast their message. Even though what actually ended up in print or on the television was never truly under the control of tort reform advocates, this experience shows that these tools must be used as often and as effectively as possible if the message is ever to reach lawmakers and their constituents—our patients.

Finally, this case proves that physicians are likely to find the political process arduous and frustrating. We are trained to believe that when a problem is identified it should be analyzed and all possible solutions considered. When the solution is chosen, the time for action has arrived. Our only thought is to correct the problem as quickly and safely as possible. Confrontation and manipulation of colleagues or public opinion is outside of our daily modus operandi. When it comes to bringing about change in the political environment, we must keep our eye on our objective, return again to the fray as often as necessary, work hard, and persevere despite the obstacles.

**Epilogue**

Despite the inadequacies of H.B. 2, the Maryland Chapter of the American College of Surgeons, the state medical society, and the Maryland Hospital Association supported the bill’s signing. From the pragmatic point of view, its adoption will allow many physicians in Maryland to continue to practice for another year or two, assuming the rate stabilization fund is effective. Unfortunately, within days of H.B. 2 becoming law, it was apparent that additional supporting legislation would have to be enacted to entice private liability insurers into accepting the concept of rate stabilization. Those negotiations are ongoing, and it appears they will be successful.

As for the absent tort reform measures, many have been reintroduced as separate bills in the 2005 general session. Without meaningful tort reform, Maryland’s crisis unquestionably will re-emerge. We are concerned that lawmakers’ interest in tackling this subject has been exhausted and that nothing significant will result in the current session. Even so, all participants in last year’s actions are being urged to redouble their efforts. Again, all surgeons and other physicians, in concert with patients, hospitals, and so on, must be at the forefront of the tort reform battle. Our profession and our patients require this effort.

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**Dr. Maizel** is a breast surgeon in private practice in Baltimore, MD. He is President of the College’s Maryland Chapter and a member of the College’s Committee on Patient Safety and Professional Liability.
With the active participation of the Food and Drug Administration (FDA), a national standard for materials used in surgical gowns and drapes has been developed. Entitled Liquid Barrier Performance and Classification of Protective Apparel and Drapes Intended for Use in Health Care Facilities, it allows manufacturers to identify their product’s level of resistance to penetration by viruses, blood, and/or water. Unfortunately, the tests used to define the various levels do not conform to the stresses actually occurring during “usual conditions of use.” Therefore, under the provisions of the FDA’s Medical Device Reporting regulations, it is imperative that surgeons report any “strikethrough” (a term first used by Laufman in 1975) they experience so that a better standard may be developed.

How it all began

From the time that an operating room gown first became part of the surgeon’s armamentarium, its primary purpose was to protect the patient from members of the surgical team. In that capacity, the garment was made of a relatively loosely woven, readily permeable, all carded cotton Type 140 (thread count) material, generically known as “muslin.”

In 1952, William C. Beck, MD, FACS, published his renowned paper, “False faith in the surgeon’s gown.” This article alerted the surgical community to the fact that although the “muslin” material may have been an effective barrier when dry, it lost its protective capabilities once it became wet, even when multiple layers were used.

Dr. Beck’s disclosure triggered the textile industry’s efforts to develop more satisfactory materials for this unique application. In responding to the challenge, makers of both the non-woven disposable and woven reusable gowns introduced a new generation of fabrics. Whereas manufacturers of both types of gowns made claims about their products’ performance, there was no similarity in the facts upon which those claims were predicated.

“False faith in the surgeon’s gown” revisited

by Nathan L. Belkin, PhD, Clearwater, FL
In the interim, under the leadership of Harvey R. Bernard, MD, FACS, and Dr. Beck, the American College of Surgeons Board of Governors’ Committee on the Operating Room Environment (CORE) charged the entire textile industry with the responsibility of creating a test method that would simulate the stresses that they astutely described as “usual conditions of use.”

**Emergence of HIV**

With the emergence of the era of the hazards associated with the transmission of blood-borne pathogens, the primary purpose of the surgical gown suddenly changed from protecting the patient from the surgeon to protecting the surgeon from the patient as well. This meant that whatever degree of strikethrough may have been tolerated in the past no longer was acceptable.

During this early period, two clinical researchers, Drs. Shadduck and Nichols, working independently of one another, reported on the barrier effectiveness of a variety of products that were on the market. What exemplified the need for a standard test method was the fact that some of the materials that Shadduck found to be satisfactory would have failed when subjected to the challenges offered by Nichols. What is particularly noteworthy is that Shadduck, using water for the liquid, reported detecting penetration of the human immunodeficiency virus (HIV) through plastic-reinforced materials in which strikethrough was invisible.

These studies clearly confirmed the need for a meaningful test method that both the surgical community and industry could adopt for use in assessing a material’s barrier effectiveness “under usual conditions of use.” It was also reasonable to believe that whatever test method would be developed would measure a material’s ability to resist liquid penetration at various levels. Rating the materials in this manner would be in accord with the in vitro study reported by Drs. E.J. Quebbeman and G.L. Telford. It would also facilitate the selection process mandated by the Occupational Safety and Health Administration’s (OSHA’s) final rule that the garments be appropriate for the “task and degree of exposure anticipated.”

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**Classification of barrier performance of surgical gowns, other protective apparel, surgical drapes, and drape accessories**

<table>
<thead>
<tr>
<th>Level</th>
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<th>Liquid challenge</th>
<th>Result*</th>
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<tbody>
<tr>
<td>1</td>
<td>AATCC 42-2000</td>
<td>Water</td>
<td>&lt;= 4.5 g</td>
</tr>
<tr>
<td></td>
<td>AATCC 127-1998</td>
<td>Water</td>
<td>&lt;= 1.0 g</td>
</tr>
<tr>
<td>2</td>
<td>AATCC 42-2000</td>
<td>Water</td>
<td>&gt;= 20 cm</td>
</tr>
<tr>
<td></td>
<td>AATCC 127-1998</td>
<td>Water</td>
<td>&gt;= 50 cm</td>
</tr>
<tr>
<td>3</td>
<td>ASTM F1671:2003</td>
<td>Bacteriophage</td>
<td>Pass</td>
</tr>
<tr>
<td></td>
<td>For surgical gowns and other protective apparel</td>
<td>Phi-X174</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>ASTM F1670:2003</td>
<td>Surrogate</td>
<td>Pass</td>
</tr>
<tr>
<td></td>
<td>For surgical drapes and other drape accessories</td>
<td>blood</td>
<td></td>
</tr>
</tbody>
</table>

*All have an Acceptance Quality Level (AQL) of 4 percent.

Adapted from the AANSI/AAMA American National Standard: Liquid Barrier Performance and Classification of Protective Apparel and Drapes Intended for Use in Health Care Facilities.

**New tests**

With the pressing need for a test method, an industry-driven committee of the American Society for Testing Materials (ASTM) modified one of its existing complex mechanical devices developed to determine the effectiveness of protective clothing worn by chemical workers. The group incorporated the methodology into two tests—one for liquid penetration and one for viral penetration. Both methods were first adopted as “emergency standards” and subsequently adopted as formal guidelines in 1995.

However, rather than the results of either test being reported on a comparative basis, each was rated on a pass/fail basis, with a “pass” predicated on the material’s ability to resist penetration at a
level of two pounds per square inch (psi).

It should be noted that prior to the ASTM’s adoption of the test methods, several reports had been published in the clinical literature indicating that the pressure exerted on surgical gowns in both in vivo and in vitro circumstances had been found to be far in excess of 2 psi.11-13

The new “standard”

The American National Standards Institute (ANSI) and the Association for the Advancement of Medical Instrumentation (AAMI) have recently published a “standard” that is said to provide a solution to this half-century need.1 Entitled Liquid Barrier Performance and Classification of Protective Apparel and Drapes Intended for Use in Health Care Facilities, it has been adopted by the FDA, which maintains that the guidelines satisfy their need for performance requirements for these Class II medical devices. It establishes the use of four different test methods and two different liquids to classify the differences in the levels of the materials’ “barrier performance.”

To accommodate the need for determining a material’s suitability for the “level of anticipated exposure,” AAMI’s Protective Barrier Committee selected two of the American Association of Textile Colorists and Chemists’ (AATCC’s) tests—their #42 water impact penetration test and the #127 hydrostatic head test. (It should be noted that this same AAMI group had several years earlier maintained that neither of the two tests were suitable for this purpose.)14

Thus the new standard establishes four levels of barrier effectiveness (see table, page 20).

- For Level 1, the lowest of the four, the AATCC’s 42 water impact penetration test is used (see Figure 1, this page). The material’s capability to resist penetration is determined by being challenged by a fixed amount of water sprayed on it while being held over an absorbent blotter (that has been weighed while dry) at a 45-degree angle. The blotter is again weighed to ascertain any increase. According to the standard, the blotter should not have gained more than 4.5 grams to be considered a Level 1 fabric.
- For Level 2, two tests can be used. One is the same AATCC test used for Level 1. An alternate test is the AATCC 127 hydrostatic head test (see Figure 2, page 22). In this test, a sample of the fabric is clamped horizontally on the bottom of a metered glass cylinder. The hydrostatic pressure is steadily increased as the height of the water in the cylinder is raised. To be acceptable for a Level 2 barrier, it must resist penetration of water when it reaches a height of 20 centimeters. When the impact penetration test is used, the weight of the blotter cannot be more than 1.0 gram.
- For Level 3, both of the AATCC tests are again used but with higher levels of resistance. However, for the impact penetration test, the weight gain of the blotter is again 1.0 gram. For the hydrostatic head test, the water level in the cylinder must be at least 50 centimeters.
- For Level 4 (see Figure 3, page 22), the ASTM’s mechanical device is used for both the viral penetration (F1671 for surgical gowns) and penetration of surrogate blood (F1670 for surgical drapes). The test sample is mounted in a vertical position onto a cell that separates the challenge and a viewing port. The time and pressure protocols specify atmospheric pressure for
five minutes, followed by 2.0 psi for one minute and atmospheric pressure again for 54 minutes. The test is terminated if penetration occurs before or after 60 minutes. (It should be noted that the standard makes no mention of the level of protection that a “pass” provides.)

**Interpreting the results**

For Levels 1, 2, and 3, the results of the water impact penetration tests must stand on their merit because there is no known way of correlating them to a level of protection.

For the hydrostatic head test used for Levels 2 and 3, difference in the level of pressure is known. For Level 2, the equivalent in the psi is 0.20; for Level 3, the equivalent in psi is 0.73.

The question that logically follows is how can the barrier effectiveness of a material that is awarded a pass (at 2 psi) when tested with the ASTM’s device reasonably be compared to the psi of the Levels 2 and 3? Unfortunately, they cannot.

**Surface tension**

Surface tension is defined in the document as the “intermolecular forces acting on the molecules at the free surface of a liquid. Surface tension affects the degree to which a liquid can wet a material (that is to say, the lower the surface tension, the more easily the liquid wets a material’s surface).”

Surface tension is measured by a unit of dynes per centimeter. Whereas water used in both of the AATCC tests measures around 72 dynes/cm, blood is around 42 dynes/cm. (It is viscosity that makes blood thicker than water.) This means that liquids, such as blood, that have a low surface tension can
penetrate fabrics more readily than those with a higher surface tension, such as water.

Thus, in terms of interpreting the results of the tests for Levels 1, 2, and 3, they do not mean that under “usual conditions of use,” they would protect against penetration of blood.

The “critical zone”

The ANSI/AAMI standard defines the “critical zone” as an “area of protective apparel or surgical drape where direct contact with blood, body fluids and otherwise potentially infectious material is most likely to occur.”

One of those areas of the surgical gown in which “leakage” is known to have occurred is at the gown/glove interface. It was first reported by Laufman in 1975 and more recently by Drs. Meyer and Beck. Nevertheless, it is in the list of exclusions as one of the items that the standard does not cover.

In response to an inquiry of the FDA about the exclusion, the agency said that AAMI’s Barrier Committee “excluded this subject because the ‘Standard’ is for the barrier properties of the gown and drapes, especially in the critical zone, and it is not possible to determine how an individual would select a gown that assured him that there would not be a potential problem with this interface.”

What is particularly noteworthy is that both researchers proposed solutions to this problem area, none of which have been pursued commercially to this day.

Another omission

It should be noted that the standard classifies the patient drape as an item of protective clothing. In so doing, it specifies the inclusion of a barrier-quality material in the critical zone. However, the committee failed to consider the widespread use of plastic incise drapes and the advent of minimally invasive surgical procedures that preclude the need of a costly barrier material.

Conclusion

Webster’s New World Dictionary (Second College Edition, 1988) defines a standard as “something established for use as a rule or basis for comparison....” What the ANSI/AAMI standard does is assess a barrier material’s effectiveness using four different tests for liquid resistance for four different levels, three different challenges, and then expresses the results in three totally unrelated ways, including a meaningless pass/fail.

As succinctly stated in the document, the standard was developed with the intent of satisfying the “Food and Drug Administration’s requirements for premarket notification (Section 510(k)) and medical device reporting” and to be “used mainly by device manufacturers in qualifying, classifying, and labeling the barrier performance of their products.”

The new standard is only a beginning. Until the design and construction of the gown/glove interface area is changed, the barrier effectiveness of the surgeon’s gown will be compromised, even if the material has been awarded a “pass.” Change will come only if you and your operating room staff report (as per regulations) every observed strikethrough. Until then, don’t put “false faith” in your gown’s protective capability.

References


Dr. Belkin retired in 1991 after 40 years in research and development of surgical textiles.
The American College of Surgeons Professional Association’s (ACSPA’s) political action committee, ACSPA-SurgeonsPAC, ended its first full cycle of activity in December 2004. In its first two years, the ACSPA-SurgeonsPAC successfully began to educate members of the ACSPA about the importance of political activism and surgery’s increased exposure on Capitol Hill.

Legislation that affects surgical practice was often at the forefront of the 108th Congress’ agenda, and ACSPA-SurgeonsPAC offered support to candidates who are in sync with surgeons’ policy positions. Indeed, the PAC assisted in the election of three members of ACSPA to the U.S. House of Representatives (see related article in the March 2005 Bulletin, page 15).

**Purposes and structure**

ACSPA-SurgeonsPAC was created in October 2002. Its goals are to contribute to the election campaigns of individuals running for national office who support the ACSPA’s legislative agenda, to improve surgery’s access to high-profile legislators, and to build the profession’s grassroots and fundraising potential.

A bipartisan, 18-member Board of Directors representing all surgical specialties and geographic areas of the country governs the PAC (see sidebar on page 25). These individuals consult with the Board of Directors of ACSPA and the College’s Health Policy Steering Committee to receive input on policy decisions. The PAC board, in turn, determines which candidates for Congress are most re-
responsive to ACSPA’s policy objectives. From there, contributions are made to the campaigns of representatives, and senators who have voting records that indicate strong support for surgery’s positions.

Fundraising
To raise funds, members of the ACSPA-SurgeonsPAC’s board and staff have been present at various surgical meetings for the last two years, hosting receptions and communicating with surgeons in convention center exhibit booths. Additionally, the PAC has initiated mail and telephone campaigns, allowing it to reach out to all active members of ACSPA.

In its first election cycle (2003-2004), ACSPA-SurgeonsPAC raised $596,000—$175,000 in 2003 and $421,000 in 2004. A total of 2,293 individuals have contributed to the PAC, for an average donation of $260 each. Among physician PACs, ACSPA-SurgeonsPAC ranks first in terms of membership and eighth in terms of dollars collected. The charts on page 26 illustrate funds raised by a sample of other physician PACs and their membership levels. As these figures demonstrate, the ACSPA-SurgeonsPAC has the capacity to become one the largest physician PACs in Washington, DC.

Recipients of funds
During the 108th Congress, ACSPA-SurgeonsPAC donated to the campaigns of 112 congressional candidates, leadership PACs, and political parties. The total amount of political disbursements during the two years was $386,000. In the 2004 elections, ACSPA-SurgeonsPAC helped five surgeons win congressional seats (two incumbents and three freshmen) in Georgia, Michigan, Texas, and Louisiana. The PAC donated more than $40,000 to the surgeons’ campaigns. The surgeon members of the 109th Congress are:

- Charles Boustany, MD, FACS, Louisiana’s 7th District, thoracic surgery.
- Michael Burgess, MD, Texas’s 26th District, ob-gyn.

**2005 ACSPA-SurgeonsPAC Board of Directors**

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<td>L.D. Britt, MD, FACS</td>
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<td>(The orthopaedic position is currently vacant.)</td>
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Joseph McLaughlin, MD, FACS
Thoracic surgery
Baltimore, MD
Farouck Obeid, MD, FACS
General surgery
Detroit, MI
Richard Perry, MD, FACS
General surgery
Phoenix, AZ
Carl Sweatman, MD, FACS
General surgery
Columbia, SC
Paul Weiss, MD, FACS
Plastic surgery
New York, NY
Thomas Whalen, MD, FACS
Pediatric surgery
New Brunswick, NJ
Mitchell Willens, MD, FACS
Ob-gyn
Tyler, TX
Paul Wills, MD, FACS
Otolaryngology
Fort Smith, AK

Andrew Warshaw, MD, FACS
Chair
General surgery
Boston, MA
Jean Hausheer, MD, FACS
Vice-Chair
Ophthalmology
Independence, MO
L.D. Britt, MD, FACS
General surgery
Norfolk, VA
James Elsey, MD, FACS
Vascular surgery
Atlanta, GA
Josef Fischer, MD, FACS
General surgery
Boston, MA
Sara Hartsaw, MD, FACS
General surgery
Gillette, WY
Benjamin LeCompte III, MD, FACS
Neurosurgery
Chicago, IL
Charles Logan, MD, FACS
Urology
Little Rock, AR
Stephen McBride, MD, FACS
General surgery
Las Vegas, NV
- Phil Gingrey, MD, Georgia’s 11th District, ob-gyn.
- Tom Price, MD, FACS, Georgia’s 6th District, orthopaedic surgery.
- Joe Schwarz, MD, FACS, Michigan’s 7th District, otolaryngology.

**Political convention attendance**

In its first two years, ACSPA-SurgeonsPAC had the opportunity to present itself on the national stage. For example, in 2004, the national political parties held their conventions to nominate their candidates for President. The ACSPA-SurgeonsPAC participated in both the Democratic National Convention in Boston, MA, and the Republican National Convention in New York, NY. Politically active surgeons were invited to attend these events and represent ACSPA. ACSPA members and staff had the opportunity to speak with scores of legislators including such congressional leaders as House Speaker Dennis Hastert (R-IL) and Senate Majority Leader Bill Frist, MD, FACS (R-TN).

**Looking ahead**

In 2005, ACSPA-SurgeonsPAC plans to have another active year of fundraising and political activity. The PAC will once again visit numerous chapters, have a presence at the 2005 Clinical Congress, and continue to educate members of the ACSPA through mail and telephone campaigns. The PAC will continue its focus on representatives and senators who support surgery on such issues as medical liability reform, Medicare payment, patient safety, trauma systems funding, pay for performance, specialty hospitals, physician profiling, and the uninsured.

Members of the ACSPA who would like further information on how they can get involved in ACSPA-SurgeonsPAC are encouraged to contact Erin LaFlair, Manager of ACSPA-SurgeonsPAC, by phone at 202/337-2701 or via e-mail at elaflair@facs.org. They also may visit the PAC’s Web site at www.facs.org/acspa by clicking on the ACSPA-SurgeonsPAC logo. An ACSPA user id and password are necessary to enter the Web site.

**Physician PACs**

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*Due to federal election law, ACOG’s restricted class is significantly smaller than its 45,000 members.
Ten specialty boards report accomplishments and plans:

Part II

Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the Bulletin to keep Fellows and other interested readers abreast of any changes in the procedures of the various boards.

The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the Bulletin contains reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Orthopaedic Surgery, the American Board of Surgery, and the American Board of Thoracic Surgery.

The March issue of the Bulletin featured the reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Plastic Surgery, and the American Board of Urology.
The American Board of Colon and Rectal Surgery

by Herand Abcarian, MD, FACS, Chicago, IL

The American Board of Colon and Rectal Surgery (ABCRS) held its most recent annual meeting October 3, 2004, and its most recent interim meeting March 21, 2004, both at the Omni Hotel in Chicago, IL. Future meetings will be held at the Omni Hotel through 2007. The schedule is as follows:


Officers/members of the board
The board is composed of 14 members. Nominations to fill vacancies come from the board and five other sponsoring organizations. The ABCRS nominates four members; the American Society of Colon & Rectal Surgeons (ASCRS) nominates four; the American College of Surgeons nominates two; the American Medical Association nominates one; the Association of Program Directors for Colon and Rectal Surgery nominates two; and the American Board of Surgery nominates one. Board members normally serve two four-year terms—a total of eight years.

The board’s current officers are: Alan G. Thorson, MD, FACS, president; Vendie H. Hooks, MD, FACS, vice-president; and Herand Abcarian, MD, FACS, executive director (at pleasure of the board). Current members of the board are: Richard P. Billingham, MD, FACS; Terry C. Hicks, MD, FACS; James W. Flesman, MD, FACS; Martin A. Luchtefeld, MD, FACS; Robert D. Madoff, MD, FACS; Patricia L. Roberts, MD, FACS; John P. Roe, MD, FACS; Marshall M. Urist, MD, FACS; Steven D. Wexner, MD, FACS; Bruce G. Wolff, MD, FACS; and W. Douglas Wong, MD, FACS.

Examination committee activities
Dr. Fleshman chairs the board’s examination committee. It is divided into three working groups consisting of the written, oral, and maintenance of certification subcommittees; each is directed by a separate chairperson. At the March 2004 board meeting, new committee members were chosen. Dr. Wolff was selected to serve as the new examination committee chairman with Dr. Roberts as the written examination committee chair. Because Dr. Fleshman’s term will expire following the September 2005 board meeting, the subcommittee chairs will serve concurrently with the current chairs to ensure a smooth and uninterrupted transition. A summary of the committee’s activities follows.

Oral examination. The ABCRS oral examination committee, under the direction of Dr. Hicks, continues to focus its attention on standardizing the oral examination process. Ultimately, the goal is to change the oral examination from one that merely tests candidates’ recall ability, to one that tests their cognitive knowledge. It is predicted that these changes will make the process more objective and provide a mechanism that better identifies candidates’ shortcomings. Following the October 3, 2004, annual board meeting, the following changes or refinements were made to the oral examination process:

- Written summaries will replace oral critiques. The new procedure will provide failing candidates with a more comprehensive summary and relieves the evaluator of a difficult task. The written summaries will include information advising candidates to address any additional questions within 30 days after receipt of the original performance summary, in writing, to the board office. If a decision is made to grant the request, candidates will be assigned to the appropriate individual for follow-up.
- Candidate surveys conducted. Beginning with the October 2, 2004, oral exam, all candidates were asked to complete a questionnaire regarding the oral examination process. The board is tallying the responses and looks forward to receiving some constructive comments and useful information regarding its exam process. In 2005, the survey will be expanded to obtain additional details about examiners’ performance. The information...
### Table 1: ABCRS recertification performance - 1991-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Participants</th>
<th>Passed</th>
<th>Percent</th>
<th>Failed</th>
<th>Percent</th>
<th>Maximum</th>
<th>Minimum</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>46</td>
<td>33</td>
<td>72%</td>
<td>13</td>
<td>28%</td>
<td>94%</td>
<td>59%</td>
<td>75%</td>
</tr>
<tr>
<td>2003</td>
<td>48</td>
<td>46</td>
<td>96%</td>
<td>2</td>
<td>4%</td>
<td>92%</td>
<td>66%</td>
<td>82%</td>
</tr>
<tr>
<td>2002</td>
<td>43</td>
<td>42</td>
<td>98%</td>
<td>1</td>
<td>2%</td>
<td>94%</td>
<td>59%</td>
<td>82%</td>
</tr>
<tr>
<td>2001</td>
<td>24</td>
<td>23</td>
<td>96%</td>
<td>1</td>
<td>4%</td>
<td>90%</td>
<td>69%</td>
<td>81%</td>
</tr>
<tr>
<td>2000</td>
<td>16</td>
<td>13</td>
<td>81%</td>
<td>3</td>
<td>19%</td>
<td>90%</td>
<td>59%</td>
<td>80%</td>
</tr>
<tr>
<td>1999</td>
<td>68</td>
<td>62</td>
<td>91%</td>
<td>6</td>
<td>9%</td>
<td>94%</td>
<td>61%</td>
<td>82%</td>
</tr>
<tr>
<td>1998</td>
<td>46</td>
<td>44</td>
<td>96%</td>
<td>2</td>
<td>4%</td>
<td>93%</td>
<td>57%</td>
<td>81%</td>
</tr>
<tr>
<td>1997</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>97%</td>
<td>72%</td>
<td>87%</td>
</tr>
<tr>
<td>1996</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>94%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>1995</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>88%</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>1994</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>98%</td>
<td>79%</td>
<td>90%</td>
</tr>
<tr>
<td>1993</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>97%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>1992</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>96%</td>
<td>78%</td>
<td>90%</td>
</tr>
<tr>
<td>1991</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>97%</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td>Totals</td>
<td>351</td>
<td>323</td>
<td>92%</td>
<td>28</td>
<td>8%</td>
<td>98%</td>
<td>57%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Passing score: 70 percent

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### Table 2: Examination results: Pass/fail rates

<table>
<thead>
<tr>
<th></th>
<th>Written exam - March 20, 2004 (71 candidates)</th>
<th>Oral exam - October 2, 2004 (71 candidates)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fail rates</td>
<td>Pass rates</td>
</tr>
<tr>
<td>Total candidates</td>
<td>71</td>
<td>10/71</td>
</tr>
<tr>
<td>First-time takers</td>
<td>60</td>
<td>8/60</td>
</tr>
<tr>
<td>Repeat candidates</td>
<td>11</td>
<td>2/11</td>
</tr>
</tbody>
</table>

---

### Table 3: Geographic/gender distribution

<table>
<thead>
<tr>
<th>Total current diplomates = 1,504</th>
<th>Male</th>
<th>%</th>
<th>Female</th>
<th>%</th>
<th>All</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active U.S.</td>
<td>1,091</td>
<td>72.54%</td>
<td>129</td>
<td>8.58%</td>
<td>1,220</td>
<td>81.12%</td>
</tr>
<tr>
<td>Active international</td>
<td>64</td>
<td>4.25%</td>
<td>5</td>
<td>0.33%</td>
<td>69</td>
<td>4.58%</td>
</tr>
<tr>
<td>Retired U.S.</td>
<td>193</td>
<td>12.83%</td>
<td>4</td>
<td>0.27%</td>
<td>197</td>
<td>13.10%</td>
</tr>
<tr>
<td>Retired international</td>
<td>5</td>
<td>0.33%</td>
<td>0</td>
<td>0.00%</td>
<td>5</td>
<td>0.33%</td>
</tr>
<tr>
<td>Status/address unknown</td>
<td>6</td>
<td>0.40%</td>
<td>0</td>
<td>0.00%</td>
<td>6</td>
<td>0.40%</td>
</tr>
<tr>
<td>Expired certificate holders</td>
<td>7</td>
<td>0.47%</td>
<td>0</td>
<td>0.00%</td>
<td>7</td>
<td>0.47%</td>
</tr>
<tr>
<td>Total</td>
<td>1,366</td>
<td>90.82%</td>
<td>138</td>
<td>9.18%</td>
<td>1,504</td>
<td>100%</td>
</tr>
</tbody>
</table>

*This figure excludes diplomates who are deceased.
will not be used to determine examiner eligibility, but rather, to make improvements to the exam.

- E-mail notification of oral examination results. The October 2, 2004, oral examination results were e-mailed to all candidates the first Tuesday following the exam. The information was transmitted to all candidates who provided accurate e-mail information.

Written examination. Dr. Wolff, chairman of the written examination committee, reorganized the radiology and pathology sections of the written examination into one visual diagnostic examination (VDE), which was offered for the first time during the March 2004 written examination. The VDE combined elements of radiology and pathology into 40 questions incorporating gross and endoscopic photos, various diagnostic studies, and histology. Overall, it covered the gamut of colon and rectal surgery ailments, and the board felt it was very successful.

The board believes these changes make the examination more specialty-relevant. The images and corresponding cases more closely resemble “real life” scenarios and authentic practice settings germane to colon and rectal surgery. The examination was projected using contemporary digital equipment, which facilitated the interpretation of material.

Recertification examination. The last recertification examination was given May 8, 2004, in Dallas, TX. Forty-six diplomates participated; 33 passed and 13 failed.

The results and statistical summaries for 2004 as well as the prior 13 years are provided in Table 1 on page 29.

Transition to MOC

At the board’s March 2003 interim meeting, the recertification committee was officially renamed the maintenance of certification committee (MOC), and it is chaired by Dr. Hooks. Under his direction, the ABCRS is transitioning from recertification to maintenance of certification.

The American Board of Medical Specialties (ABMS) developed the concept of maintenance of certification. This action requires the ABCRS and other boards to approach the entire recertification process with a fundamentally different philosophy. Recertification must be viewed as a continuous process over a period of time, rather than as a one-time procedure. Beyond changing the focus of recertification, today, there is a growing need to document physician competency for licensure, membership in various health plans, and reimbursement.

The ABCRS MOC plan requires a 10-year interval between the initial certification and completion of requirements to maintain certification for the first time and for each subsequent 10-year interval. The MOC approach evaluates four basic components: professional standing, lifelong learning and self-assessment, cognitive expertise, and practice performance.

The ABMS approved our application for the first three components, and we are now dealing with how to assess the more difficult fourth component, practice performance. It will require the development of a concise, step-by-step plan for assessing physician practice performance. The board has partnered with the American Society of Colon and Rectal Surgeons (ASCRS) to develop this assessment methodology.

The real purpose of moving from recertification to maintenance of certification is to improve patient care, and the ABCRS is focusing on this goal.

Electronic operative log

The ACGME has been attempting to develop an electronic operative reporting system and has requested that the ABCRS participate in the process to make Accreditation Council on Graduate Medical Education and board data more compatible. In September 2003, the residency review committee (RRC) submitted a request for consideration to the board. The document set forth the advantages of the system and provided details for the establishment of procedures. Subsequently, an ad hoc committee, chaired by Dr. Madoff and including Dr. Thorson and Dr. Luchtefeld, was appointed to explore the feasibility of the proposal and to investigate whether a joint ABCRS/ACGME electronic operative log would be compatible with the needs of both groups. The committee has had several discussions and, as of February 2004, it was agreed that a Web- or palm-based system would simplify data collection and that, provided both diagnosis codes and procedure codes were recorded, data could be manipulated into any format that meets the information needs of the board, RRC, and personal digital assistant. In general, the committee indicated that the proposal would
be feasible. A meeting to work out details of this process took place in April 2004 at the ACGME office in Chicago. The tentative goal is to make the transition to an electronic operative transmittal process by July 2006.

Examination results
The most recent written examination (Part I) was given March 20, 2004; 71 candidates were examined. The most recent oral examination (Part II) was given October 2, 2004; 71 candidates were examined. The pass/fail rates are shown in Table 2 on page 29.

Geographic/gender distribution
As of March 2004, the board has a total of 1,504 diplomates; 1,289 in active practice and 215 retired/inactive, seven of which have expired certificates. Table 3 on page 29 provides the male/female and international distributions.

The American Board of Obstetrics and Gynecology

by Norman F. Gant, MD, Dallas, TX

Exam results
The principal written examination for the American Board of Obstetrics and Gynecology (ABOG) was administered June 30, 2003, at multiple sites.

A total of 1,602 candidates applied for the exam. Of them, 1,165 were new applicants, 1,043 were U.S. medical school graduates (USMGs), 122 were international medical school graduates (IMGs), and 437 were reapplying. Of those individuals reapplying, 327 were USMGs and 110 were IMGs. Pass/fail results are listed in Table 1 on page 32.

The principal oral examination was administered November and December 2003 and January 2004 in Dallas, TX. A total of 1,644 candidates applied for the oral exam: 16 were disapproved ad hoc; 39 were disapproved based on their case lists; 82 turned in incomplete/no-fee applications; two were no-shows; 57 withdrew from the exam; and 1,448 took the exam. Pass/fail rates are listed in Table 2 on page 32.

The number of active diplomates is approximately 33,700.

Exam trends.
For U.S. graduates of American medical schools taking the written examination for the first time, the pass rate has ranged from 87 percent to 95 percent. For the entire examination, the pass rate has ranged from 66 percent to 76 percent. The number of applicants for the written examination peaked in the mid-1990s. Since 1997, however, the number of applicants has declined through the year 2003. The major decrease has occurred in reapplicants.

The pass rates for all candidates for the principal oral examination in obstetrics and gynecology have ranged from 83 to 87 percent in the past decade. The number of applicants for the principal oral examination remained constant between 1996 and 1999 (range, 1,650-1,686). The number dropped abruptly by more than 100 to 1,543 in the year 2000, 1,469 in 2001, and to 1,433 in 2002.

Subspecialty exams
The written examinations in reproductive endocrinology/infertility (REI) and maternal-fetal medicine (MFM) were administered June 30, 2003, at multiple sites. Of the 75 people who took the REI exam, 64 passed and 11 failed. Of the 130 people who took the MFM exam, 110 passed and 20 failed.

Subspecialty oral examinations were administered April 7-9, 2003. In the subspecialty of REI, 42 individuals took the oral exam and 28 (67%) passed. A total of 914 physicians currently are board certified in REI to date. In the subspecialty of MFM, 50 individuals took the oral exam and 44 (88%) passed. In the subspecialty of gynecologic
oncology (GO), 48 individuals took the oral exam and 46 (96%) passed. A total of 771 physicians presently are board certified in GO.

**Trends/subspecialty written examinations.** The number of applicants, those approved to take the examinations and the actual number who took the subspecialty written examinations, in MFM and REI declined in 2001 and 2003. This trend likely reflects the marked decrease in applicants for these fellowship positions first noted three years ago and thought to be due to adding a year to training. The pass rate for the written examination in GO has remained stable since the mid-1990s, between 70 and 82 percent.

A total of 3,186 diplomates have been issued subspecialty certificates (GO, MFM, REI), of whom approximately 2,340 are currently in practice. This number represents approximately 6.9 percent of the total of 33,700 actively practicing diplomates.

**Maintenance of certification**

Certificate renewal/voluntary recertification written exams were administered June 30, 2003, at multiple sites. Of those physicians seeking to renew their certificates in obstetrics and gynecology (ob-gyn), 116 (97%) passed and three (3%) failed. Of those physicians seeking to renew their certificates in ob-gyn and REI, three passed and one failed.

A total of 7,281 individuals applied for annual board certificate (ABC) renewal and voluntary recertification for 2003 in the areas of ob-gyn, oncology, REI, and MFM. A total of 7,271 were approved, five were disapproved, five withdrew, and 247 were incomplete. Pass/fail numbers and percentages of diplomates who started the ABC process are listed in Table 3 on this page.

**Analysis of ABC.** For the obstetrics and gynecology portion of the ABC process, several points are noteworthy. The number of applications in 2003 was 6,354. This number has continued to increase yearly since 1999, and almost certainly represents the influx of diplomates with time-limited certificates choosing this method of certification maintenance.

The percentage of diplomates who failed or did not complete the process decreased from 30 percent in 1998 to 11 percent in 1999. In 2000, this number had decreased to 8 percent, and in 2001 this number was 5 percent. In 2002, the number

### Table 1

**Pass/fail results/written examination**

<table>
<thead>
<tr>
<th>Passed</th>
<th>Failed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Took exam</td>
<td>1,075 (72)</td>
</tr>
<tr>
<td>USMGs</td>
<td>990 (76)</td>
</tr>
<tr>
<td>IMGs</td>
<td>85 (44)</td>
</tr>
<tr>
<td>First-time takers</td>
<td>989 (84)</td>
</tr>
<tr>
<td>USMG first-time takers</td>
<td>909 (86)</td>
</tr>
<tr>
<td>Reapplications</td>
<td>86 (27)</td>
</tr>
</tbody>
</table>

### Table 2

**Pass/fail results/oral examination**

<table>
<thead>
<tr>
<th>Passed</th>
<th>Failed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Took exam</td>
<td>1,225 (85)</td>
</tr>
<tr>
<td>U.S. graduates</td>
<td>1,165 (85)</td>
</tr>
<tr>
<td>International graduates</td>
<td>60 (72)</td>
</tr>
<tr>
<td>U.S. graduates—first-time takers</td>
<td>1,065 (87)</td>
</tr>
</tbody>
</table>

### Table 3

**Pass-fail numbers and percentages of approved diplomates who started the ABC process**

<table>
<thead>
<tr>
<th>Approved</th>
<th>Passed</th>
<th>Did not complete or failed</th>
</tr>
</thead>
<tbody>
<tr>
<td>ObGyn</td>
<td>6,345</td>
<td>6,130 (97)</td>
</tr>
<tr>
<td>ONC</td>
<td>172</td>
<td>160 (93)</td>
</tr>
<tr>
<td>MFM</td>
<td>502</td>
<td>485 (97)</td>
</tr>
<tr>
<td>REI</td>
<td>252</td>
<td>239 (95)</td>
</tr>
<tr>
<td>Totals</td>
<td>7,271</td>
<td>7,014 (96)</td>
</tr>
</tbody>
</table>
was slightly less than 3 percent and in 2003 the number was 4 percent.

More than 70 percent of diplomates using the ABC process in 1998 and 1999 did so voluntarily. This percentage fell in 2000 to 57 percent, and in 2001 this number was 50 percent. The 2002 value was 38 percent, and 37 percent in 2003. This trend was expected due to the entry of more diplomates with time-limited certificates.

Analysis of the subspecialties after four years reveals several similarities to the ABS process in ob-gyn. Approvals of applications have been 100 percent and 98.5 percent in 1999 and 2000 respectively. Approvals were at 99 percent in 2001, 99.5 percent in 2002, and virtually 100 percent in 2003. Since 1999, those individuals failing and/or not completing the subspecialty ABC process appear to have bottomed out at approximately 4 percent. The subspecialists, using the ABC process in ob-gyn, have changed from voluntary to certificate renewal. The 1999 voluntary rate was 77 percent, the 2000 voluntary rate decreased moderately to 61 percent, and in 2001 this rate was 55 percent. The voluntary rate in 2002 was 30 percent, and in 2003, was 33 percent.

**Officers and directors**

The ABOG officers for the year ending June 30, 2005, are: Philip J. DiSaia, MD, FACS, president; Frank W. Ling, MD, vice-president; Larry C. Gilstrap III, MD, treasurer; Gerson Weiss, MD, chairman of the board; Norman F. Gant, MD, executive director; and William Droegemueller, MD, director of evaluation.

Directors include: Mary C. Ciotti, MD; Larry J. Copeland, MD, FACS; Sherman Elias, MD, FACS; David Gershenson, MD, FACS; Diane M. Hartmann, MD; Nicolette S. Horback, MD; Roy T. Nakayama, MD; Kenneth L. Noller, MD; Valerie M. Parisi, MD; Nanette F. Santoro, MD; Robert S. Schenken, MD; Russell R. Snyder, MD; Michael L. Socol, MD; Ralph K. Tamura, MD; and George D. Wendel, Jr., MD.

In addition, the following individuals serve as the directors and representatives of the subspecialty divisions: Dr. Gershenson, division of GO; Dr. Wendel, division of MFM; Dr. Schenken, division of REI; and Dr. Horbach, director and representative for female pelvic medicine and reconstructive surgery.

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The American Board of Orthopaedic Surgery

**Examinations**

The American Board of Orthopaedic Surgery (ABOS) administered its Part I written certifying examination in July 2003 to 760 candidates. The overall pass rate was 83 percent. The pass rate for U.S. and Canadian medical school graduates taking the exam for the first time was 93.1 percent, and international medical school graduates taking the test for the first time had a pass rate of 66.7 percent. Repeat examinees had a pass rate of 40.3 percent among U.S. and Canadian candidates, and 26.7 percent for international candidates.

The ABOS offers multiple pathways for recertification in an ongoing effort to improve convenience and make allowances for candidate examination format preferences and practice profile specificity. The general written recertification examination was administered in March 2003 at the annual meeting of the American Academy of Orthopaedic Surgeons (AAOS) in San Francisco, CA. This was the last “paper and pencil” recertification examination. Ninety-nine percent of the 101 candidates who took the examination passed it.

Of the computerized recertification exam practice profile pathways, 261 candidates took the general examination, of which 256 passed; 52 candidates took the adult reconstructive examination, and all passed; 93 candidates took the sports medicine examination, and all passed; 55 candidates took the spine surgery examination, and all passed;
The American Board of Surgery (ABS) met June 13-15, 2004, under the chairmanship of Ronald V. Maier, MD, FACS, beginning with a half-day retreat to discuss issues related to the surgical curriculum. A number of ongoing programs and new initiatives were discussed. They are summarized in this report.

**Surgical residency curriculum**

The board adopted a position at the January 2004 meeting that a new surgical curriculum needed to be developed for the first three years of residency in order to improve the uniformity, effectiveness, and efficiency of surgical training programs. The board anticipates that more focused teaching of procedural skills early in residency will lead to earlier competence and that use of nonclinical teaching aids will accelerate learning of operative skills and improve operating room technical performance. The ideal would be to have a program of competence-based, rather than time-based, advancement.

Richard H. Bell, Jr., MD, FACS, chair of surgery at Northwestern University, Chicago, IL, and several members of his faculty are developing a template for such a curriculum, and explained their efforts at the retreat preceding the regular meeting. In addition, the curriculum developed by the thoracic surgery program directors over the last three years appears to be an excellent model for the ABS initiative. Jeffrey P. Gold, MD, FACS, who has spearheaded the thoracic surgery effort, gave a detailed presentation at the retreat.

After extensive discussion, the directors decided that the next step in this effort would be to engage all of the stakeholder organizations in the curricular development, and that the groups should meet to define the scope and timing of the effort. Accordingly, a meeting will be organized to include representatives from the College, the Association of Program Directors in Surgery (APDS), the residency review committee (RRC) for surgery, the Association for Surgical Education (ASE), and the ABS. The board recognizes the College’s intention to develop a first-year curriculum that will be applicable to all surgical specialties, and, therefore, plans to mesh its curriculum development effort fully with that of the College.

**CAQ hand surgery**

The ABOS, in cooperation with the American Board of Surgery (ABS) and the American Board of Plastic Surgery (ABPS) offers a certificate of added qualifications in surgery of the hand. In 2003, a total of 65 candidates took this exam; 50 were ABOS candidates, 13 were ABPS candidates, and two were ABS candidates. This was the first year that all candidates were required to take a computerized examination. A total of 61 examinees passed the examination, and four failed—two from the ABPS and the ABS.

A total of 148 candidates took the CAQSH recertification exam—98 ABOS candidates, 28 ABPS candidates, and 22 ABS candidates. One hundred thirty-three candidates passed the exam, and 15 failed for an overall failure rate of 10 percent.

**MOC program**

A task force composed of representatives of the ABOS and the AAOS is studying the maintenance of certification program. This task force is working diligently to develop a method of assessing performance in practice, which requires a considerable amount of effort by both organizations.

The American Board of Surgery

*by Frank R. Lewis, Jr., MD, FACS, Philadelphia, PA*

The American Board of Surgery (ABS) met June 13-15, 2004, under the chairmanship of Ronald V. Maier, MD, FACS, beginning with a half-day retreat to discuss issues related to the surgical curriculum. A number of ongoing programs and new initiatives were discussed. They are summarized in this report.

The board adopted a position at the January 2004 meeting that a new surgical curriculum needed to be developed for the first three years of residency in order to improve the uniformity, effectiveness, and efficiency of surgical training programs. The board anticipates that more focused teaching of procedural skills early in residency will lead to earlier competence and that use of nonclinical teaching aids will accelerate learning of operative skills and improve operating room technical performance. The ideal would be to have a program of competence-based, rather than time-based, advancement.

Richard H. Bell, Jr., MD, FACS, chair of surgery at Northwestern University, Chicago, IL, and several members of his faculty are developing a template for such a curriculum, and explained their efforts at the retreat preceding the regular meeting. In addition, the curriculum developed by the thoracic surgery program directors over the last three years appears to be an excellent model for the ABS initiative. Jeffrey P. Gold, MD, FACS, who has spearheaded the thoracic surgery effort, gave a detailed presentation at the retreat.

After extensive discussion, the directors decided that the next step in this effort would be to engage all of the stakeholder organizations in the curricular development, and that the groups should meet to define the scope and timing of the effort. Accordingly, a meeting will be organized to include representatives from the College, the Association of Program Directors in Surgery (APDS), the residency review committee (RRC) for surgery, the Association for Surgical Education (ASE), and the ABS. The board recognizes the College’s intention to develop a first-year curriculum that will be applicable to all surgical specialties, and, therefore, plans to mesh its curriculum development effort fully with that of the College.
Postresidency fellowships

The second project that the directors elected to take on in January was the improvement of oversight of postresidency fellowships. Currently, the degree of oversight varies widely, depending upon the fellowship specialty. At one end of the spectrum, the specialties with certificates—such as vascular surgery, pediatric surgery, and surgical critical care—are overseen by the RRC for surgery and accredited by the Accreditation Council on Graduate Medical Education (ACGME), with well-defined program requirements, regular site visits, and relatively stringent oversight. This applies equally to those specialties with independent boards—specifically, thoracic surgery, plastic surgery, and colon and rectal surgery.

Next, there are fellowships that do not have certificates but are accredited by specialty societies with well-defined program requirements or guidelines, such as surgical oncology and transplantation. The remaining fellowships, including trauma, gastrointestinal, laparoscopic, bariatric, endocrine, and others, have limited oversight, guidelines, or program requirements. The board feels that all of these fellowships have the same purpose—to provide further training to general surgeons—and that a greater degree of oversight is needed to ensure the quality of the educational programs and to provide some degree of uniformity in the training provided in a specific discipline. An ad hoc subcommittee of the board has been appointed under the direction of Jeffrey L. Ponsky, MD, FACS, current vice-chair of the board, to begin exploring methods for accomplishing this, principally by working through the various specialty societies.

Maintenance of certification (MOC)

The next major topic of discussion was ongoing development of the MOC program. While many elements of this process will duplicate those of the current recertification program, the review cycle for many of the elements will be shorter than every 10 years, and the need for self-assessment in conjunction with continuing medical education (CME) will be significantly increased. Currently, the board has mandated CME of 50 units yearly, of which 30 units must be Category 1 credits. This requirement will be assessed every three years, and will also require self-assessment, either in association with the CME or in other independent venues yet to be developed. Ongoing validity of a state or provincial medical license will be determined at three-year intervals as well. The written cognitive examination will continue to be given at 10-year intervals.

Part IV of MOC involves assessment of medical practice, and the board is still working on a final plan for this aspect of the process. The ABMS has asked that practice assessment address all six competencies described by the ACGME and the ABMS, but effective and feasible measures for all of these competencies have not yet been developed. This program will, of necessity, be phased in over the next few years. Outcomes measures would be relevant for most surgeons but are available in relatively few hospitals and specialties, so it will also be some time before we see general availability for all practitioners. The College’s current efforts to implement the National Surgical Quality Improvement Program (NSQIP) in university and community hospitals is welcome in this regard, because it may facilitate practice assessment in the future.

Surgeons who recertify in 2005 and thereafter, as well as residents completing surgery residency in June 2005 and thereafter, will be subject to the new MOC requirements, and each year’s recertifying cohort will be successively enrolled, so that inclusion of all surgeons will be a 10-year effort.

Computer-based testing

The board adopted computer-based testing in 2003 for specialty recertification, rather than the traditional pencil and paper examination. We contracted with Pearson Vue, a testing vendor with more than 200 testing sites in the U.S., and the transition has gone smoothly. Computer-based testing allows recertifying diplomates to take the examination during a two-week window, rather than on a single day, and to do so at a testing center that is within 50 miles of their homes. This greatly reduces the travel costs and the need to be away from home for more than the day of the test. Our experience in 2003 showed that 85 percent of the diplomates who participated were enthusiastic about the change.

The principal reservations pertained to the security procedures that are required by Pearson Vue for admission to the examination. Examinees are
prohibited from bringing any material or personal effects into the testing room, and must check all personal items—including wallets, cell phones, and watches—in lockers prior to entering. While the ABS did not mandate these security procedures, Pearson Vue applies them to all test takers at their centers, and other clients of the firm require that the procedures be met, so we are unable to modify them for surgeons.

In September and October 2004, general surgeons made the transition to computer-based recertification examinations, in addition to the surgical specialists who transitioned last year. In 2005, the final change will be made in written examinations, and the qualifying examinations for general surgeons as well as specialists will be given in Pearson Vue centers. At that point the board will be entirely out of the pencil and paper testing mode.

Change in examination dates

A further major change will be made in 2005 in the examination dates of both the qualifying examination (QE) and the recertification examination in surgery. The QE will be advanced by two months to make it more proximate to the conclusion of residency and will be given in early August, rather than the usual October date. This change will reduce the distraction of the QE for residents in fellowship training after general surgery residency, which has been a problem for some time, and will also allow successful residents to move ahead to the oral examinations immediately in the fall, rather than delaying this step until the next year. Therefore, it will be possible for at least half of the graduating residents to complete the certification process before the end of the year in which they graduate from residency.

<table>
<thead>
<tr>
<th>Examination</th>
<th>Number of examinees</th>
<th># pass</th>
<th># fail</th>
<th>Pass rate</th>
<th>Failure rate</th>
<th>Total # diplomats</th>
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<tr>
<td>Qualifying</td>
<td>1,268</td>
<td>993</td>
<td>275</td>
<td>78.3%</td>
<td>21.7%</td>
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<td>147</td>
<td>90.1%</td>
<td>9.9%</td>
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<tr>
<td>Vascular surgery QE</td>
<td>118</td>
<td>91</td>
<td>27</td>
<td>77.1%</td>
<td>22.9%</td>
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<tr>
<td>Vascular surgery recertification</td>
<td>156</td>
<td>148</td>
<td>8</td>
<td>94.9%</td>
<td>5.1%</td>
<td>1,277</td>
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<td>Surgical critical care</td>
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<td>77</td>
<td>10</td>
<td>88.5%</td>
<td>11.5%</td>
<td>2,086</td>
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<td>Surgical critical care recertification</td>
<td>125</td>
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<td>15</td>
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<td>Pediatric surgery QE</td>
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<td>3.5%</td>
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<td>Hand surgery</td>
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<td>100%</td>
<td>0%</td>
<td>226</td>
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<tr>
<td>Hand surgery recertification</td>
<td>22</td>
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<td>5</td>
<td>77.3%</td>
<td>22.7%</td>
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<td>IT/SBSE</td>
<td>7,471</td>
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<td>1,216</td>
<td>1,019</td>
<td>197</td>
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<td>64</td>
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<td>89.1%</td>
<td>10.9%</td>
<td>934</td>
</tr>
<tr>
<td>Total</td>
<td>12,434</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

N/A =Not applicable.
4,891 examinees, excluding the IT/SBSE and PITE.
The other change in 2005 dates is for the recertification examination in surgery, which will be moved back approximately two months to early December. The specialty qualifying examinations, as well as the specialty recertifying examinations, will still be given in October, but general surgery will be two months later.

Primary vascular surgery certificate

The last major activity of the past year has been the filing of an application with the ABMS for issuance of a primary certificate in vascular surgery by the ABS. This effort was approved by the directors at the January meeting after extensive meetings with the Society for Vascular Surgery and the Association of Program Directors in Vascular Surgery (APDVS). The rapid expansion of endovascular therapies has fundamentally changed the nature of vascular surgery practice, and significantly decreased the amount of intraabdominal surgery that is being done. (Presently, more than 50% of abdominal aortic aneurysms are repaired with endovascular techniques, and, at some institutions, it is up to 80%.) As a result, prior full training in general surgery with certification is no longer felt to be essential, while there is a need for expansion in the amount of vascular training.

Under ABMS bylaws, a subspecialty certificate cannot be issued without the diplomate holding a prior primary certificate. To accommodate a change in the vascular curriculum, the only route available is to create a primary certificate in vascular surgery, parallel to the present certificate in surgery. There is ample precedent for this, as four other boards currently issue multiple primary certificates, so after the approval of the directors in January an application was filed with the ABMS to allow the ABS to issue the new certificate. The approval process is lengthy, and requires a minimum review period of one year. If other boards oppose the new certificate, the process could be lengthened.

Currently the American Board of Radiology has registered its opposition to the primary vascular certificate, and the first hearing on the issues will occur September 22 at the interim ABMS meeting.

ABS/ABTS joint training program

The other action that is going before the ABMS in September is a joint training proposal developed by the American Board of Thoracic Surgery (ABTS) and the ABS, which provides for development of a joint program in a single institution by which a resident could qualify for both certificates in a total of seven years of training. The program will continue to require completion of all the same program requirements currently mandated by each board, but will allow greater degrees of overlap in rotations during the fourth and fifth residency years, and will allow some rotations to count for credit in both specialties. This application will be reviewed by the ABMS in September and, if approved, will go to the RRCs of surgery and thoracic surgery for the development of specific implementation guidelines.

New and retiring directors

New members elected to the American Board of Surgery are: Stanley W. Ashley, MD, FACS, from the Association for Academic Surgery; Jeffrey B. Matthews, MD, FACS, from the Society of University Surgeons; John J. Ricotta, MD, FACS, from the Association of Program Directors in Vascular Surgery; William P. Schecter, MD, FACS, from the Pacific Coast Surgical Association; and Ronald J. Weigel, MD, FACS, from the Society for Surgical Oncology.

Directors who are completing their six-year term and leaving the board after June 30 are: Ronald V. Maier, MD, FACS, chair; Julie A. Freischlag, MD, FACS; Timothy J. Eberlein, MD, FACS; Frank W. LoGerfo, MD, FACS; and Bruce E. Stabile, MD, FACS. All of these individuals have provided outstanding service to the board for the last six years, and all directors expressed their gratitude to them.

New officers

Barbara L. Bass, MD, FACS, assumed the chair of the board at the end of the June meeting for the 2004-2005 year. Vice-chair is Jeffrey L. Ponsky, MD, FACS, of the Cleveland Clinic. Subsequently, the directors have chosen the new vice-chair-elect, and we are pleased to announce that Courtney Townsend, MD, FACS, chair of the department of surgery at the University of Texas, Galveston, has been elected.

Staff member retires

George Cruft, MD, FACS, retired from the staff of the ABS June 30 after serving for 30 years. Dr. Cruft has had two completely independent careers, the first half in multiple positions of senior re-
Inactive status
Diplomates holding a valid certificate from the American Board of Thoracic Surgery (ABTS) who anticipate being clinically inactive for one year or more may apply for inactive status. Applications must be submitted in writing and approved by the board before inactive status will be granted. Activities calling for such status include, but are not limited to, academic sabbaticals, advanced studies, elected/appointed political offices, temporary disability due to illness, or appointment to administrative positions in hospitals, medical schools, or health care-related industries. For more information about the new inactive status policy, visit the board’s Web site at www.abts.org.

Recertification policies
In response to an initiative by the American Board of Medical Specialties, the ABTS, along with the other medical certifying boards, has begun the transition toward implementing a maintenance of certification program. Beginning in 2001, the ABTS changed some of its recertification policies. All diplomates should be aware of the changes in the requirements in anticipation of renewing their own certificates. The board believes that recertification is important to the public and to each physician’s professional career.

A valid ABTS certificate is an absolute requirement for entering the recertification process. The only pathway for renewal of a lapsed certificate will be to take and pass the Part I (written) and the Part II (oral) certifying examinations. The ABTS will no longer publish the names of individuals who have not recertified.

The deadline for submitting recertification applications is now May 10 of each year. This change allows diplomates to include continuing medical education (CME) hours earned at meetings held in the spring. Additionally, diplomates must be in compliance with the annual certification maintenance fee in order to enter the recertification process. Additional information concerning the recertification requirements can be found in the annual Recertification Booklet of Information.

In 2003, 236 diplomates recertified, of which 134 did so for the first time and 102 for the second time. One hundred ninety diplomates used the SESATS computer version, and 46 diplomates used the paper-and-pencil version. (See table on page 39 for more information.)

Background
Diplomates certified after 1975 must recertify within 10 years of the date of the original certification to maintain their certification. Diplomates with time-limited certificates may apply within three years of the expiration of their certificate.

Diplomates of the Board of Thoracic Surgery and the American Board of Thoracic Surgery certified prior to 1976 do not require recertification and are considered to hold unlimited certificates.

The annual certification maintenance fee is required of all active diplomates, age 65 and under. The cumulative fee helps to defray administrative and computer expenses. The board will not re-
spond to inquiries about the diplomate’s certification status until the annual fee is paid.

Examinations

For the first time, the ABTS administered the Part I (written) exam in a computer-based format December 6, 2004, at Pearson Professional Testing Centers, throughout the nation. By offering the exam in a computer-based format, the board anticipates that most candidates will be able to take the exam at a site located near their homes. The ABTS would like to thank the American Board of Surgery, in particular Robert S. Rhodes, MD, FACS, associate executive director, who has facilitated the board’s relationship with Pearson.

On November 23, 2003, the board administered its eleventh criterion-referenced Part I (written) exam to 164 individuals. The pass rate for the examination was 89 percent. The board administered its eighth criterion-referenced Part II (oral) exami-

<table>
<thead>
<tr>
<th>Date of original cert.</th>
<th>Total # of cert.</th>
<th>Total # recert. first time</th>
<th>Percent recert.</th>
<th>Total # recert. second time</th>
<th>Percent recert. second time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 1976</td>
<td>N/A</td>
<td>67</td>
<td>—</td>
<td>4</td>
<td>—</td>
</tr>
<tr>
<td>1976</td>
<td>160</td>
<td>142</td>
<td>89%</td>
<td>128</td>
<td>80%</td>
</tr>
<tr>
<td>1977</td>
<td>146</td>
<td>129</td>
<td>88</td>
<td>108</td>
<td>74</td>
</tr>
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<td>1978</td>
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<td>141</td>
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<td>110</td>
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<td>82</td>
</tr>
<tr>
<td>1981</td>
<td>131</td>
<td>124</td>
<td>95</td>
<td>111</td>
<td>85</td>
</tr>
<tr>
<td>1982</td>
<td>159</td>
<td>147</td>
<td>92</td>
<td>126</td>
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<td>159</td>
<td>47</td>
<td>30</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

nation to 165 individuals June 11-12, 2004. The pass rate for the examination was 91 percent.

New pathways/requirements certification

Certification by the ABTS may be achieved by completing one of the following two pathways and fulfillment of the other requirements outlined in the board’s Booklet of Information:

1. Successful completion of a full general surgery residency approved by the ACGME (five years) or the Royal College of Physicians and Surgeons of Canada, followed by the successful completion of a two- or three-year ACGME-approved thoracic surgery residency. Certification by the American Board of Surgery (ABS) is optional for individuals who started their thoracic surgery residencies in July 2003 or after.

2. Successful completion of a categorical-integrated six-year thoracic surgery residency, to be developed by the Thoracic Surgery Directors...
Association. Residents in these programs will be under the direction of the thoracic surgery program directors. Before this pathway is implemented, the residency review committee for thoracic surgery must first approve institutions to offer such programs. As of this report, no institution has received accreditation for a categorical-integrated thoracic surgery residency.

3. Any individual currently in the ABTS certification process (that is, who is in a thoracic surgery residency or who has already finished a thoracic surgery residency) will be guided by the requirements in force at the time of his or her residency.

The ABTS is committed to working closely with the ABS and other organizations in general surgery toward the development of combined 4/3 programs leading to the possibility of certification by both the ABS and the ABTS.

Applications
The deadline for applying for certification is August 1 each year. The ABTS is no longer able to accept applications pending certification by the ABS. All requirements must be fulfilled at the time the application is submitted. All residents who begin their training in 2001 or after must file their application and operative cases logs electronically through CTSNet.

In-training examination
The 2004 in-training exam was administered online March 27 and April 3 to 354 residents and fellows. The in-training examination consists of general thoracic and cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination.

College representation
Both of the College’s representatives to the Board of Thoracic Surgery will complete their terms of service as directors this year. Gordon N. Olinger, MD, FACS, has been a director since 1994. His original six-year term was extended when he was elected examination chair, a position he has held since 2001. David B. Campbell, MD, FACS, has served as board director since 1996. His term also was extended because of his key role in developing the electronic format for the board’s qualifying examination, which was initiated at multiple computer testing centers in the U.S. for the first time in December 2004.

Drs. Olinger and Campbell both have had important leadership responsibilities with the board and have been instrumental in advancing the board’s efforts at examination revision and modernization. Dr. Olinger, who has been a board representative to the ABMS, where he served as chair of the COCERT, also has led the board’s efforts in initiating a maintenance of certification program.

At the Board of Thoracic Surgeons meeting in Florida October 21-23, 2004, new College representatives were elected to director positions to replace Drs. Olinger and Campbell. The Advisory Council for Cardiothoracic Surgery nominated two slates of candidates for the College seats on the board, and these nominees, who were approved by the Board of Regents, were considered for election at the board meeting October 24. David M. Harpole, Jr., MD, FACS, Durham, NC, and Edward L. Bove, MD, FACS, Ann Arbor, MI, were elected as the new board directors representing the College.
Socioeconomic tips

Frequently asked ACS Coding Hotline questions

by the Division of Advocacy and Health Policy

This column lists some questions recently posed to the ACS Coding Hotline and their responses. Fellows and their office may consult the hotline 10 times annually without charge as a benefit of membership in the College.

Coding the excision of a benign or malignant skin lesion requires measuring the lesion. How is the size of the lesion properly measured?

First of all, the lesion must be measured before excision. The measurement is the greatest clinical diameter of the lesion plus the margin required for the excision. Measurements of three skin lesions are illustrated on page 51 of the professional edition of Current Procedural Terminology (CPT) for 2005.

I am uncertain whether to use the –58 modifier, Staged or related procedure or service by the same physician during the postoperative period, or the –78 modifier, Return to the operating room for a related procedure during the postoperative period. Can you help me?

In general, use the –58 modifier when the second procedure was planned at the time of the first procedure. In fact, it is very useful to indicate on the operative report for the first procedure that a second procedure will take place. The –78 modifier generally is used when an emergency arises during the postoperative period that requires returning to the operating room. For Medicare and some other payors, both modifiers are used to reset the global period.

What code should be used for wound exploration and evacuation of a hematoma following a mastectomy?

The correct code is 35820, Exploration for postoperative hemorrhage, thrombosis or infection; chest. Modifier –78, Return to the operating room for a related procedure during the postoperative period, should be appended to ensure that the claim is accepted. Appending the modifier will also reset the start of the global period to the date of the second procedure. Note that codes 35800-35860 are for postoperative exploration of the neck, abdomen, and extremities, in addition to the chest, so the series of codes may be used in many situations.

I billed Medicare for codes 44005, Enterolysis (freeing of intestinal adhesions) (separate procedure); 43830, Gastrostomy, open; without construction of gastric tube (eg. Stamm procedure) (separate procedure); and 44015, Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure.) I was only paid for code 43839, the g-tube. Is that correct, or should I appeal?

The payment was correct. Two of the procedures are designated “separate procedure,” meaning that the codes cannot be billed with any other code of which it is considered an integral component. Code 44015, the g-tube, has a plus sign in front of it, meaning it is an add-on code. However, it may not be reported with code 43830. The correct coding initiative (CCI) bars payment for codes 44005 and 44015 when reported with code 43830.

Are codes 61210, Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device (separate procedure), and 61312, Cranectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural, considered bundled?

*All specific references to CPT terminology and phraseology are: © 2004 American Medical Association. All rights reserved.
The CCI edits generally consider these two codes to be bundled. However, if code 61210 is performed for a separate purpose, it is possible to append a –59 modifier, _distinct procedural service_, and bill for both. In this case, 61210 was probably performed to place a pressure recording device and a hematoma was evacuated in a separate procedure.

**My physician performed a consultation in the emergency room and later that day admitted the patient to the hospital. What code should I use to report the admission?**

In CPT, the introductory notes to the initial hospital care codes state that all of the evaluation and management (E&M) services performed on the same date as a hospital admission are considered part of the initial hospital admission. Therefore, the code selected for the hospital admission should reflect all of the E&M care given in such places as the office, skilled nursing facility, and emergency room, as well as the initial hospital setting. Incidentally, the same rule applies to a skilled nursing facility admission.

**How do I code for the removal of a g-tube in the office? Another physician placed it.**

Removal of a g-tube in the office is always reported using an E&M code.

**My doctor saw a patient in consultation for a positive mammogram and performed an open breast biopsy. Because the pathological report came back positive for cancer, we called the patient back within the 10-day global period of the breast biopsy to discuss the treatment options, including more surgery. How do I code for each of these encounters?**

The secret is careful use of ICD-9-CM diagnosis code(s) and CPT modifiers. When you perform the consultation and the open breast biopsy, you only know that the patient has an unspecified breast mass, ICD-9-CM code L11.72, so that is the diagnostic code to report with the claims for both the consultation and the breast biopsy. Once the pathology report is in hand, though, you know that the patient has a diagnosis of cancer. When you call the patient back in the global period of the open breast biopsy for an E&M service to counsel on breast cancer, report the appropriate level of an established patient E&M service with a –24 modifier, _Unrelated evaluation and management service by the same physician during a postoperative period_, and report the diagnosis code of breast cancer. Also report the subsequent surgery using the diagnosis code of breast cancer. If it is performed within the global period of the breast biopsy, append a modifier –58, _Staged or related procedure or service during the postoperative period_. The description of modifier –58 indicates that it is appropriate to use it for therapy following a diagnostic surgical procedure.

**I know that when we do a mastectomy for treatment, we use the ICD-9-CM code for cancer in the appropriate part of the breast. What diagnostic code should be used for a prophylactic mastectomy?**

In this case, use a code from the V section of ICD-9-CM. Code V50.41 is the correct one to use.
RAS-ACS symposium at Congress to examine truncated resident training

The Resident and Associate Society of the American College of Surgeons (RAS-ACS) will sponsor a symposium during the Clinical Congress on a topic targeted at surgery residents, fellows, and young surgeons. Truncated Training for the Surgical Resident—The Future or Fallacy? is the topic to be examined during this year’s symposium, which will be held in San Francisco, CA, Sunday, October 16, from 1:00 to 4:00 pm.

The symposium will focus on the issue of truncated training for residents who will go on to surgical specialty training and will provide insight into the future of surgical training and what impact truncated training would have on the trainees, on training programs, and on the needs of society. Attention will be paid to the possible advantages and pitfalls of reducing the number of years of training required for surgical specialists. The discussion will also focus on the role of truncated training in the world of limited work hours, the possible long-term financial benefits, and the impact on family life.

Attendance at the symposium is open to all RAS members as well as all residents, fellows, and medical students. An open-microphone discussion will promote audience participation.

For more information regarding this RAS-ACS program, contact Peg Haar at 312/202-5312 or via e-mail at phaar@facs.org.

Rural, urban physicians have comparable incomes

According to a national study released recently by the Center for Studying Health System Change, average physician incomes in rural and urban areas do not differ significantly. In fact, after adjusting for differences in the cost of living, physician work effort, specialty, and other physician and practice characteristics, rural physicians on average have 13 percent more purchasing power than their urban counterparts, the study found.

Lower incomes are often cited as an obstacle to recruiting physicians to practice in rural areas, which have fewer physicians per capita than urban areas. However, the study found that the difference in average annual income—$204,000 in rural areas versus $218,000 in urban areas—is not statistically significant.

Moreover, the average income of rural physicians adjusted for the cost of living was significantly higher than that of urban physicians’—$225,000 versus $199,000.

The study’s findings are detailed in an Issue Brief, Physician Incomes in Rural and Urban America, which can be accessed online at http://hschange.org/CONTENT/725/.
COC colon cancer practice profile reports to be available online

The Commission on Cancer (COC), a major program of the College’s Division of Research and Optimal Patient Care, recently announced the release of a Web-based Cancer Program Practice Profile Report (CP3R), which will provide the 1,420 approved cancer programs in this country with comparative information to assess local use of adjuvant chemotherapy following the resection of stage III colon cancers. These practice profile reports provide a ranking scale permitting cancer programs to compare local practice with that of aggregated practice measures from similar types of cancer programs nationally, regionally, and at the state level. The rank assigned to each COC-Approved Cancer Program is based on historical patterns of each cancer program’s reported treatment of Stage III colon cancer, using the information submitted by cancer registries to the National Cancer Data Base (NCDB).

The reports will allow COC physician volunteer surveyors to promote standards for quality multidisciplinary cancer care delivered by local providers. In addition, the reports will support the COC’s efforts to develop effective educational interventions to improve cancer care outcomes at the national and local levels. For additional information, contact the NCDB at NCDB@facs.org.

TELESURGERY, from page 13


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

For purchase and pricing information, call ACS Customer Service at 312/202-5474 or visit our E-LEARNING RESOURCE CENTER at www.acs-resource.org
Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings

October 9-10, 14, 2004

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

American College of Surgeons Professional Association (ACSPA)

The ACSPA conducts programs aimed directly at surgeons and their patients and is a member organization of Doctors for Medical Liability Reform (DMLR).

To promote the issue of medical liability reform, the ACSPA distributed patient education brochures and campaign-style buttons to its members, and placed advertisements on behalf of various chapters engaged in state tort reform efforts. More specifically, ACSPA advertisements appeared in newspapers across various states to call attention to television newsmagazines that were airing under the auspices of the DMLR. The ACSPA assisted some College chapters in generating public support for November ballot initiatives on non-economic damage caps and alternative dispute resolution. It printed office posters for distribution to the Fellows in those states, as well as print advertisements that appeared shortly before the election.

The DMLR was formed to conduct an aggressive, state-by-state public education campaign regarding the need for federal medical liability reforms. The campaign began in February 2004 with 30-minute television newsmagazines broadcasting in some states. The newsmagazines highlighted how the medical liability crisis affects physicians and patients in and the economic health of those states. Filming took place in several states in order to develop a video that could be used in a variety of settings.

Print advertisements also were placed in national and local newspapers in an effort to both educate the public and put pressure on senators to support federal tort reform legislation. In the next stage of the effort, DMLR member organizations will dedicate their own political action committee (PAC) funds to more focused print advertisements.

Meanwhile, the ACSPA-SurgeonsPAC raised $455,000 in contributions from Fellows, Associate Fellows, and Resident members during the 2003 to 2004 election cycle. The PAC raises
funds at a variety of venues such as the Clinical Congress and chapter meetings, as well as through telephone calls. The ACSPA-SurgeonsPAC donated to over 100 candidates, party committees, and leadership PACs during last year’s elections. The donations were split between Republicans and Democrats at a ratio of 70 percent to 30 percent, respectively.

The PAC Board of Directors concluded that participation in the 2004 national party conventions would benefit surgery. Six Fellows attended the conventions. The ACSPA-SurgeonsPAC worked with three other medical organizations to plan health care events at both conventions. Additionally, six surgeon candidates sought congressional offices in 2004. Three are Fellows of the American College of Surgeons. (For more information, see the article on page 24).

The ACSPA Board of Directors reappointed ACS Regent L.D. Britt, MD, FACS, and Paul Weiss, MD, FACS, to second terms on the PAC Board. The Board of Directors also appointed Sara Hartsaw, MD, FACS; Benjamin LeCompte III, MD, FACS; and Carl Sweatman, MD, FACS, to initial terms on the PAC Board.

American College of Surgeons (ACS)

At its June meeting, the Board of Regents held a strategic planning session. At its October meeting, the Board reviewed and approved the summary of the June plenary session. The overarching theme of these meetings was patient safety, and all efforts in this arena are expected to tie into the programs and activities offered through the College’s divisions and support services.

New ACS chapter

The Board of Regents approved the formation of an ACS chapter in Turkey. It is the College’s 32nd international chapter.

New statement

The Board of Regents approved a Statement on Restrictive Covenants. The statement appeared in the February 2005 issue of the Bulletin (page 25), and is posted on the College’s Web site.

Finance Committee

The Board of Regents approved the Finance Committee’s request to form a mutual fund company for the benefit of the Fellowship. The Finance Committee will pursue the formation of such a company with an emphasis on retirement funds. The College will also do a market survey of its Fellowship.

The Board also approved:

• Approximately $1.5 million for 2006 scholarship funding.
• A request for additional 2005 health policy scholarships, as well as the necessary funding.

Development Program

The Board of Regents approved a business plan to establish an American College of Surgeons Foundation. The sole purpose of the foundation will be to raise money to support the College’s education, research, and patient safety programs. Bylaws for the foundation and its officer structure were scheduled for presentation to the Regents for their approval in February.

Advocacy and Health Policy

The following is a summary of the activities carried out by the College’s Division of Advocacy.

• The College asked the Centers for Medicare & Medicaid Services (CMS) to model a “dominant specialty” approach to arriving at malpractice RVUs, under which data from only the top specialties necessary to reach 51 percent of a code’s use would be used. The CMS created a model for the dominant specialty approach, but dismissed it out of hand. The College is working with the surgical specialty societies and other organizations representing high-risk physicians to develop comments on this aspect of the regulation.

• The College issued comments on the final Emergency Medical Treatment and Active Labor Act (EMTALA) regulation. Of concern
was a statement in the interpretive guidelines implying that physicians who, for whatever reason, do not accept general call at a particular hospital but do respond to calls regarding their own patients or individuals with whom they otherwise have an established physician-patient relationship, could be in violation of EMTALA. In its letter, the College emphasized that this type of activity is not the equivalent of a physician who is on a hospital’s on-call list and “cherry picks” new emergency room patients based on ability to pay or other factors. The College asked CMS to alter the interpretive guidelines to clearly distinguish between these two situations.

- CMS requested comments on a proposal regarding payment for emergency services provided to undocumented aliens. The most controversial aspect of the plan would require these individuals to provide an indication of citizenship status. In its comments, the College said it favors using the information that the hospital has traditionally gathered during the financial screening process as an indicator of citizenship status. The College also stated that it favored CMS’s approach of paying for EMTALA care and any related inpatient care, but suggested that CMS withhold payment for unrelated care.
- The College has found that its Surgery State Legislative Action Center is a convenient grassroots advocacy tool. Fellows have sent approximately 2,000 letters and faxes to their respective state legislators and government officials on such issues as trauma, medical liability reform, and scope of practice through this program, which can be accessed at http://www.facs.org/sslac/.
- With respect to the College’s Practice Management and Coding Workshops, plans are under way to boost registration for these popular and important courses by offering one less session of each this year. For more information, go to http://www.facs.org/ahp/workshops.
- The College continues to gain more influence within the American Medical Association (AMA). Most recently, the College accepted management responsibility for the Surgical Caucus of the AMA. With the departure of Zan Lofgren, who had managed the surgical caucus since 1989, the group’s executive committee determined that it was best that surgical association staff continue to serve as its manager. Jon H. Sutton, Manager, State Affairs, ACS Division of Advocacy and Health Policy, has taken on this responsibility.
  - A new task force met to begin identifying fundamental changes needed to insert rationality and stability into Medicare and other physician payment systems. Its charge is to focus on broad-scope issues with systemwide impact, as opposed to past efforts that tended to result in incremental and temporary “fixes” to the current payment crisis.
  - Congress is likely to revisit the issues of health system reform and coverage for the uninsured. The College’s Health Policy Steering Committee intends to participate actively in crafting legislation that is beneficial to surgical patients.

Education

The Division of Education has purview over the following activities:

- A number of new general sessions, didactic and experiential postgraduate courses, and Internet-based education programs, as well as new education products, were launched in 2004. For more detailed information, visit the Web page for the College’s Division of Education at http://www.facs.org/education/index.html.
- A special program for surgical residents was offered at the 2003 and 2004 Clinical Congresses. These sessions focused on nonclinical topics, such as career choices, personal financial management and debt management, and professionalism and communication skills. The program was kept short so that residents could attend other sessions and activities.
  
Likewise, a new one-day program for surgical residents that also centered on nonclinical topics was offered just before the 2004 Spring Meeting. Plans are under way to offer this program again, with minor changes, in conjunction with the 2005 Spring Meeting.
Three special sessions for residents are being planned for the 2005 Spring Meeting in collaboration with the Resident and Associate Society (RAS). These sessions are entitled Spectacular Cases for Residents, Surgical Jeopardy, and a new Clinical Abstract Presentation. Compact scheduling of resident events, including weekend days, should require residents to take only a short time away from their clinical responsibilities.

- An Internet-based resource, the Residency Assist Page, was launched in 2003 to help surgery program directors in designing innovative educational approaches adapted to the 80-hour workweek restriction. The program is now being expanded to address other issues in surgical training as well. For more information, visit http://www.facs.org/education/rap/.
- A special program for medical students was offered at the Clinical Congress for the third consecutive year. The program was further refined to continue meeting the specific needs of medical students. A special panel on Surgical Career Options was added, which included speakers in all surgical specialties.
- Plans for the 2005 Spring Meeting progressed well. The program was developed in collaboration with the Advisory Council for General Surgery. The meeting will begin Saturday, April 16, in Hollywood, FL. For more information, visit the Web at http://www.facs.org/2005springmeeting/index.html.

**Operation Giving Back**

Kathleen M. Casey, MD, FACS, Director, Operation Giving Back (OGB), unveiled a new Web site for the OGB project: http://www.operationgivingback.facs.org. OGB had an exhibit during the Clinical Congress in New Orleans, LA, and Dr. Casey was involved in panel discussions throughout the week.

**Member Services**

The ACS Job Bank has approximately 497 jobs listed and 71 position seekers have posted their resumes. This is the most comprehensive surgical job bank on the Internet, and it can be accessed at http://www.healthecareers.com/site_templates/ACS/index.asp?aff=ACS&SPLD=ACS.

Also, a 10 percent discount on textbooks and journals was negotiated with Elsevier.

**RAS**

The RAS actively seeks individuals to serve as liaison members on all College committees. Their involvement will facilitate communication among all levels of membership and identify the focus of future planning and programs. For more information, visit the Web at http://www.facs.org/ras-acs/about/about.html.
Objectives
At the end of the course, the participants will be able to describe:
• The essentials of personal financial management as they relate to young surgeons in practice and residents and their families.
• The impact of interest rates and time upon loans, compound interest, and the implications for debt management.
• The building blocks necessary for the surgeons to invest successfully.
• The importance of time in reducing the risk of investing.
• The basics of mutual funds, stocks, bonds, and other investment vehicles.
• How to evaluate and choose a financial advisor.

Intended audience:
• Surgical residents and surgeons recently in practice.
NTDB™ data points

The bank’s window

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

Earlier this year we reported that the National Trauma Data Bank™ (NTDB) had eclipsed the one million record mark. Since becoming the largest aggregation of trauma registry data ever assembled, the NTDB has been able to derive the Annual Report for 2004 from a consolidated sliding window of the most recent five full years of data submission. These data are depicted in the graph on this page.

This is compared with a six-year window in the Annual Report for 2003 that was required in order to accumulate the needed number of records. The significance of narrowing this window allows for reporting on trauma care that is less likely to be influenced by the changes in practice, technology, and available diagnostic and therapeutic modalities that are occurring at an ever-increasing pace.

As the number of trauma centers participating in the NTDB increases, we will see a concomitant increase in the number of records submitted yearly. It then may be feasible to continue to narrow this window in future reports.

It is important to keep in mind that the NTDB represents a convenience sample of trauma centers that voluntarily submit their trauma data. With the significant yearly increase in the number of trauma centers that participate comes the potential for looking at a subset of these data as a representative national sample. Such a sample would truly represent a significant contribution to the advancement of trauma care in the U.S.

The NTDB Subcommittee of the American College of Surgeons’ Committee on Trauma continues to actively participate and collaborate with several national consensus groups relating to trauma data reporting and aggregation. The once modest goal of accumulating trauma registry data has blossomed to include the ability to benchmark trauma center care and is on the verge of becoming a national trauma care data sample that will further the research potential of the largest aggregation of trauma registry data ever assembled.

Throughout the year, we will highlight these data through brief reports monthly in the Bulletin. The full National Trauma Data Bank Report Version 4.0 is available on the ACS Web site as a PDF file and a PowerPoint presentation at http://www.ntdb.org. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.
Announcing a new instructional CD-ROM

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

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

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

Bariatric Surgery Primer

Course objectives:

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

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

American College of Surgeons • Division of Education
with the American Society for Bariatric Surgery
Chapter news

by Rhonda Peebles, Division of Member Services

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

Residents’ Competition at Manitoba Chapter

On November 16, 2004, the Manitoba Chapter conducted its Residents’ Competition and annual meeting. The winning residents included:

- Gregory E. J. Harding, MD,* Activation of MMP-2 in Response to Vascular Injury Is Mediated by Phosphatidylinositol 3-Kinase-Dependent Expression of MT-1 MMP (MMP-14).
- Dion L. Davidson, MD,* The Clinical and Anatomic Features of Patients with Abdominal Aortic Aneurysms in Manitoba.
- M. Moon, MD, Perivascular Delivery of Losartan with Surgical Fibrin Glue Prevents Neointimal Hyperplasia after Arterial Injury.

Brooklyn-Long Island hosts Clinic Day

In conjunction with the Nassau Surgical Society (NSS), the Brooklyn-Long Island Chapter (BLIC) hosted the 2004 Clinic Day on December 1, 2004. In addition to separate education sessions for the surgical specialties, Michael D. Maves, MD, MBA, FACS, executive vice-president of the American Medical Association, addressed the group (see photo, this page).

Ohio conducts first election update teleseminar

On December 9, 2004, the Ohio Chapter’s lobbyist, Dan Jones, conducted an update on the 2004 statewide elections via telephone conference call. Mr. Jones reviewed a comprehensive list of elections and changes in the legislature and reported on the status of the state’s professional liability commission. In addition, Mr. Jones noted that the chapter (along with other specialty societies) succeeded in electing new state Supreme Court judges, who will be pivotal in securing tort reform in Ohio.

Hawaii launches Web site

Under the guidance of its Executive Director, Gary Belcher, the Hawaii Chapter has launched a Web site, now available at http://hawaii.facs.org. According to the site, the theme for the chapter’s August 5-6 summer meeting is Technological Advancements in Surgery.

Maine contributes to tort reform efforts

Late last year, the Maine Chapter contributed funds to support the advocacy activities of the Coalition for Health Care Access and Reform, which was established by the Maine Medical Association, the Maine Osteopathic Association, the Maine Hospital Association, and Medical Mutual Insurance of Maine. The coalition is chaired by Lee L. Thibodeau, MD, FACS, and is supported by a number of statewide surgical and

*Denotes Associate Fellow or Resident Member.
medical specialty societies. The coalition supports a limit on noneconomic damages and other tort reform measures.

**Louisiana Chapter meets in New Orleans**

On January 15-16, the Louisiana Chapter conducted its 2005 annual meeting at the Ritz Carlton in New Orleans. In addition to the annual business meeting, the chapter also conducted its yearly Residents’ Competition (see photos, above). The winning residents included:

*First place:* Shawn J. Stafford, MD,* Not All Angiogenic Vessels Are the Same: Effects of Two Somatostatin Analogs in Human Angiogenesis in Vitro.

*Second place:* Kerry Brynes, MD, Eukaryotic Initiation Factor 4E (eIF4E) Targeted Gene Therapy Increase Disease-Free and Overall Survival in a Minimal Residual Rat Breast Cancer Model.

*Third place:* Siddhartha Rath, MD, Insulin Prevents Oxidant-Induced Pulmonary Endothelial Barrier Dysfunction.

**Southern California conducts annual meeting**

The Southern California Chapter (SCCACS) conducted its 2005 annual meeting January 21-23 in Santa Barbara. During the annual business meeting, new officers were elected, and benefits for new members were described, which include waiving the first year’s annual dues and the registration fee for the annual meeting. Also, the SCCACS agreed to discontinue its membership in the area’s Medicare carrier advisory committee.

During the young surgeons’ session, the effects of the 80-hour workweek for residents were discussed. The young surgeons attributed the increase in the number of residents choosing general surgery to the work-hour limit, and they reported that in southern California, it appears that more sur-

**Chapter meetings**

For a complete listing of chapter meetings, please see www.facs.org/about/chapters/index.html.
geons are seeking post-residency/fellowship training opportunities. In addition, in consultation with the Chapter Council, three $3,000 scholarships were awarded to young surgeons to pay for their attendance at a College-sponsored education program (such as the Spring Meeting, Clinical Congress, or Leadership Conference). The three recipients are: Maher Aref Abbas, MD; Amir-Hossein Mehran, MD; and Ali Salim, MD, FACS.

2005 Leadership Conference

The 2005 Leadership Conference will take place June 12-14 at the Washington Court Hotel in Washington, DC. Significant changes are planned for this year’s conference:

• **Attendees:** In addition to Chapter Officers and Young Surgeons, invitations also are being sent to other College members serving in leadership positions, such as individuals on the Board of Governors, the Committee on Trauma, and the Advisory Councils. Announcements also are being sent to the State Cancer Liaisons and the members of the Council on Resident Representatives.

• **Registration fees:** For the first time ever, nominal registration fees will be collected:
  - Fellows and Associate Fellows: $65
  - Affiliate members and chapter executives: $45
  - Residents and medical students: $35

Registration can be completed online at the College’s Web site at www.facs.org.

• **Capitol Hill visits:** On Tuesday, June 14, attendees will have the option of full-day Capitol Hill visits so that they can meet with their entire congressional delegation. **All Capitol Hill visits will be scheduled by the College’s Washington Office staff.**

**Note:** A chapter management education program will be held for those who decline participation in the Capitol Hill visits.

For questions or to obtain a registration form, please call the Chapter Hotline at 888/857-7545. **The registration deadline is June 1, 2005.**

Chapter anniversaries

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THE SURGEON’S GOWN, from page 23


