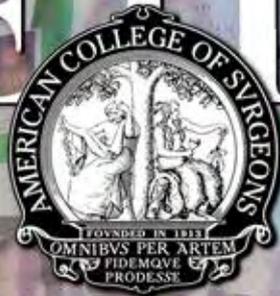
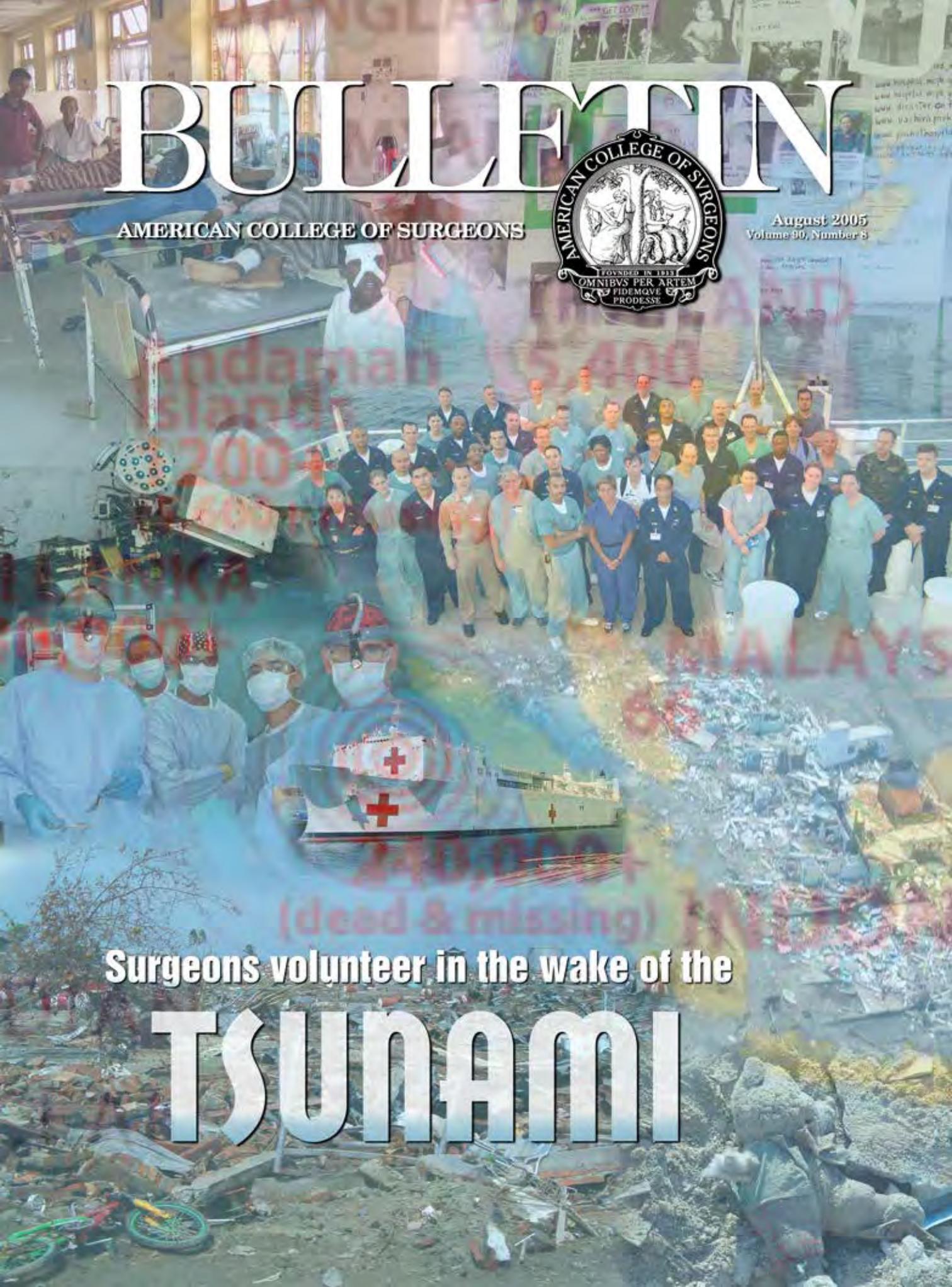


# BULLETIN

AMERICAN COLLEGE OF SURGEONS



August 2005  
Volume 90, Number 8



Surgeons volunteer in the wake of the

# TSUNAMI

# BULLETIN

AMERICAN COLLEGE OF SURGEONS



AUGUST 2005  
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**On the cover:** Many surgeons volunteered to help in the wake of last year's devastating tsunami (see story, page 19). (Photos courtesy of the surgical volunteers and members of Project HOPE and the World Surgical Foundation.)

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**Stephen J. Regnier**  
*Editor*

**Linn Meyer**  
*Director of  
Communications*

**Karen Stein**  
*Associate Editor*

**Diane S. Schneidman**  
*Contributing Editor*

**Tina Woelke**  
*Graphic Design Specialist*

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**Jack W. McAninch,  
MD, FACS**  
*Editorial Advisors*

**Tina Woelke**  
*Front cover design*

## Future meetings

### Clinical Congress

- 2005** San Francisco, CA,  
October 16-20  
**2006** Chicago, IL,  
October 8-12  
**2007** New Orleans, LA,  
October 7-11

### Spring meeting

- 2006** Dallas, TX,  
April 30-May 3  
**2007** Las Vegas, NV,  
April 22-25  
**2008** To be announced

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*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



One of the more intriguing and controversial concepts in health care delivery today is the movement toward pay for performance (PFP)—a system under which Medicare and other payors would link how much physicians and other providers are paid to how well they perform. In other words, physicians, hospitals, group practices, and so on, with track records of providing effective and efficient care, would be rewarded by receiving higher pay for the services they perform. The theory behind PFP is that increased pay will be an incentive for physicians and health care institutions to work toward improved outcomes. Parallel concepts that are being developed are pay for participation and value-based purchasing. Under pay for participation, institutions that contribute outcomes data to quality measurement studies would be reimbursed for a large portion of their data-collection costs. Value-based purchasing is centered on employers' and consumers' efforts to determine which providers offer the best care at reasonable prices.

## **PFP's roots**

The PFP movement is the product of the convergence between ongoing efforts to contain skyrocketing health care costs and to improve quality. The federal government and other payors have long sought to rein in rising health care expenditures. Today, the methods for doing so have included the Medicare fee schedule, health maintenance organizations, and other programs that largely offer incentives for physicians and other providers to offer fewer, cheaper services, but limited, if any, incentives to strive for excellence.

Anomalistically, these payment mechanisms have failed to reduce health care expenditures. Furthermore, reports from the Institute of Medicine have clearly demonstrated that while the cost of medical care has continued to rise, the quality of care has not improved. This situation has forced the government, employers, and insurers to seek ways to help consumers get the best value for their health care dollar and the safest and most effective care.

## **PFP experiments**

One way to guarantee that consumers are able to make informed decisions about which physicians and providers offer value-based care was proposed

**“The PFP movement is the product of the convergence between ongoing efforts to contain skyrocketing health care costs and to improve quality.”**

by the Leapfrog Group, a business consortium. The Leapfrog Group conducted a study that showed a connection between volume and quality. More specifically, the coalition claimed that the institutions in which certain procedures were performed more frequently had better outcomes. The College and other organizations asserted that Leapfrog's methodology was flawed because it failed to examine outcomes in a risk-adjusted way.

Several other physician pay-for-performance models do exist. The National Health System in the U.K. has adopted a PFP initiative, under which one-third of a general practitioner's income depends on his or her performance as defined by 130 quality indicators. Here in the U.S., General Electric has been collaborating with Partners HealthCare, Tufts Health Plan, the Lahey Clinic, and other employers in Massachusetts to develop a “Bridges to Excellence” program. This program rewards physician offices with a bonus of up to \$55 per patient annually if they apply certain systems for improving care, such as registries, electronic medical records, and so on.

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### ***Is it inevitable?***

Physician PFP seems to be an inevitability in both the private sector and government-run programs.

The Medicare Payment Advisory Commission has repeatedly recommended that Congress establish a quality incentive payment policy for Medicare-participating physicians, and the Centers for Medicare & Medicaid Services (CMS) has already implemented a PFP demonstration project for hospitals. Early returns from that program show that financial incentives to reward better quality patient care works.

The message from Capitol Hill, CMS, and other payors is clear: a PFP system for physician services will be instituted in the near future. CMS Administrator Mark McClellan, MD, PhD, has repeatedly stated his intention of implementing a physician PFP initiative next year (although that goal may be a bit too ambitious). Similarly, members of Congress with jurisdiction over the Medicare program have stated that any plan to repair the current flawed physician payment methodology will probably be linked to performance measurement and incentives. Laws will be drafted; regulations will be written.

As Dr. McClellan said during the College's recent Leadership Conference in Washington, DC, physician involvement in developing this new payment system "is important—even critical." The College recognizes that we need to participate in the process of crafting a physician PFP system.

I am pleased to report that CMS has been receptive to the College's involvement, acknowledging that surgeons have the experience, knowledge, and tools to make PFP work. We have been working closely with CMS to determine how the ACS National Surgical Quality Improvement Program (NSQIP) measures and findings from the Surgical Care Improvement Project (SCIP) might be incorporated into a Medicare PFP initiative.

We believe NSQIP, as the first nationally validated, risk-adjusted, outcomes-based program that has been demonstrated to measure and improve the quality of surgical care, could serve as a rational quality measurement instrument. The College also is interested in seeing how SCIP's efforts might be used to determine payment for

surgeons. Initiated in 2003 through the CMS and the Centers for Disease Control and Prevention, SCIP is a national partnership of 10 organizations, including the College, dedicated to improving patient safety by reducing postoperative complications. This summer, SCIP will launch a national effort to reduce surgical complications by 25 percent by 2010. In addition, the College's Health Policy Steering Committee is drafting a plan for our continued involvement in the PFP movement.

### ***We must participate***

Some surgeons object to PFP, asserting that it may result in greater loss of physician autonomy and that surgeons will be left out of the development process, just as they were when the Clinton health reform plan was crafted. Their concerns are understandable. However, I believe that we have a real opportunity to play a significant role this time around, and we cannot afford to lose it. If surgeons don't get and stay involved in this process, someone else will decide how PFP will operate, and we may be very dissatisfied with the outcome. We need to be part of the solution—not part of the problem.



*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).

*Announcing the ACS Foundation*

# The future of patient safety just got even brighter.



The new ACS Foundation will underscore the vital role that surgeons play in benefiting society by enhancing and extending life for patients of all nationalities, creeds, and economic levels. It will help surgery continue to advance and make a positive difference in people's lives for many generations to come.

The American College of Surgeons Foundation invites you to take an active and visible role in

continuing to expand research, increasing efforts to enhance patient safety, and doubling scholarship and fellowship funding. We have initiated a program for recognizing significant gifts either publicly or privately. More importantly, there will be no administrative overhead applied to gifts to our Foundation. So, 100% of your donation will actually go to the support of our programs.

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*To learn more about the American College of Surgeons Foundation, programs it supports, and opportunities for recognizing your commitment to the advancement of surgery, please call Fred W. Holzrichter, Chief Development Officer, at 312.202.5376 or visit our Web site at [www.facs.org](http://www.facs.org).*



# Dateline Washington

prepared by the Division of Advocacy and Health Policy

## Medicare physician payment bills introduced

Two bills have been introduced in Congress to forestall Medicare physician payment reductions. Although Congress passed legislation two years ago to prevent payment cuts in 2003, 2004, and 2005, the flawed sustainable growth rate (SGR) methodology used to determine Medicare fee schedule updates was left in place for 2006 and future years. As a result, the Centers for Medicare & Medicaid Services (CMS) estimates that Medicare fee schedule payments will be reduced by approximately 4.3 percent next year and between 4 and 5 percent annually through 2011.

On May 12, Reps. Clay Shaw (R-FL) and Ben Cardin (D-MD) introduced legislation in the House that would broadly reform the method used to determine Medicare payments to physicians. The bill, H.R. 2356, would repeal the SGR methodology entirely and replace it with a mechanism more similar to the one used to determine annual Medicare payment updates for other providers such as hospitals. The bill would base physician updates on the Medicare economic index (MEI), which reflects the annual change in physicians' costs to care for patients. Although the proposal mirrors recommendations from the Medicare Payment Advisory Commission and has been endorsed by medical and surgical organizations, its steep price tag—estimated by the Congressional Budget Office (CBO) at nearly \$155 billion over 10 years—makes passage unlikely.

Sens. Jon Kyl (R-AZ) and Debbie Stanbenow (D-MI) introduced the Preserving Patient Access to Physicians Act, S. 1081, on May 19. This more limited legislation would halt the anticipated reductions and increase Medicare payments to physicians for a two-year period—by 2.7 percent in 2006 and by the MEI, estimated at 2.6 percent, in 2007. Although less costly than H.R. 2356, the CBO estimates that the Senate bill would still increase Medicare spending by nearly \$88 billion over 10 years.

To maintain the visibility of this issue, Fellows are encouraged to contact their members of Congress and ask them to support and cosponsor either S. 1081 or H.R. 2356. To learn more about the legislation and to obtain a sample letter that can be sent to senators and representatives, visit [http://capwiz.com/facs/mail/oneclick\\_compose/?alertid=7672826](http://capwiz.com/facs/mail/oneclick_compose/?alertid=7672826).

## ACS testifies on patient safety and quality initiatives

The House Energy and Commerce Subcommittee on Health held a hearing June 9 on patient safety and quality initiatives. F. Dean Griffen, MD, FACS, Chair of the ACS Patient Safety and Professional Liability Committee, testified on behalf of the College, highlighting the organization's more than 80 years of championing patient safety and high-quality surgical care. Dr. Griffen also emphasized that the College is actively engaged in more recent quality-related initiatives, such as the ACS National Surgical Quality Improvement Program.

The College is renewing calls for a patient safety bill and is negotiating with senators to achieve passage of a compromise bill, using legislation approved in the House last year as a starting point. A copy of Dr. Griffen's testimony can be found at <http://www.facs.org/ahp/testimony/patientsafety.html>.

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## **EMTALA panel examines on-call requirements**

The technical advisory group (TAG) that advises CMS on regulations related to the Emergency Medical Treatment and Active Labor Act (EMTALA) and their application to hospitals and physicians met June 15-17. The meeting focused on the physician on-call requirement in EMTALA, also known as the "patient anti-dumping statute."

In its comments to the TAG, the College urged the panel to reject any legislative or regulatory efforts that would require surgeons to take emergency call as a condition of Medicare participation or as a stipulation for obtaining hospital privileges. Several hospital associations prompted the TAG to consider linking on-call requirements to Medicare physician participation and hospital privileges. Most of the panel members believed such a proposal would lead to a dramatic reduction in physician participation in the Medicare program and, as a result, an access to care problem for seniors and the disabled. Hence, they voted to recommend that CMS *not* require physicians to serve on-call as a condition of Medicare participation.

During its next meeting, scheduled to take place in the fall, the EMTALA TAG will consider additional proposals to address the shortage of on-call specialists. The panel also will continue to examine other related EMTALA issues, such as the problem of inappropriate transfers and the impact of specialty hospitals on EMTALA-mandated care.

The EMTALA TAG is composed of 19 members, including four ACS Fellows: general surgeon Richard Perry, MD, FACS (Phoenix, AZ); pediatric surgeon David Tuggle, MD, FACS (Oklahoma City, OK); orthopaedic trauma surgeon James Nepola, MD, FACS (Iowa City, IA); and neurosurgeon John Kusske, MD, FACS (Orange, CA).

## **Medicare drug benefit education campaign launched**

At a press event on June 16, President George W. Bush, Health and Human Services Secretary Mike Leavitt, and CMS Administrator Mark McClellan, MD, PhD, kicked off the "Medicare Covers America" campaign to educate beneficiaries about the prescription drug benefit that will take effect January 1, 2006.

Enrollment in the voluntary prescription drug coverage plan begins November 15, and all beneficiaries, regardless of whether they have existing drug coverage, will be eligible to participate. All beneficiaries will have a choice of plans, and those plans will: (1) be available in all parts of the country; (2) cover both brand-name and generic drugs; and (3) allow purchase at community pharmacies or through the mail. Low-income beneficiaries will qualify for subsidized coverage.

Surgeons may direct patients to the following resources for further information: the CMS Web site <http://www.cms.hhs.gov/partnerships/>, a special White House educational Web page at <http://www.whitehouse.gov/infocus/medicare/>, or 1-800-MEDICARE.

# LIABILITY REFORM IN 2005:

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## *How individual states are addressing the issues*

by **MINDY BAKER**,  
*State Affairs Associate,*  
*Division of Advocacy and Health Policy*

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**T**he first six months of 2005 defied predictions on passage of state medical liability reforms, with six states passing significant reforms, including caps on noneconomic damages, and other reforms, such as alternative dispute resolution, expert witness qualifications, and “I’m sorry” provisions. Inaction by Congress on a federal solution to the problem helped spur on state legislatures to rise to the challenge, with advocates for reform seeing years of hard work pay off.

By January 2005, 22 states had instituted caps on noneconomic damages, with seven of these laws containing annual inflation adjustments. Georgia, Missouri, and South Carolina each passed reforms that included \$350,000 caps on noneconomic damages, and a last-minute compromise between Illinois legislative leaders and Gov. Rod Blagojevich (D) allowed passage of S.B. 475, which caps noneconomic damages at \$500,000 for physicians and \$1 million for hospitals. Alaska reduced the cap from \$400,000 (which was enacted in 1997) to \$250,000, although the new legislation included a provision that a person who is at least 70 percent disabled may be entitled to \$400,000.

### **Specific state highlights**

Georgia's reforms didn't stop at caps—restrictions on venue shopping, elimination of joint and several liability, expert witness qualifications, and an "I'm sorry" provision were included in S.B. 3, which Gov. Sonny Perdue (R) signed on February 16. Georgia was one of the first states in 2005 to pass liability reform legislation, encouraging the neighboring South Carolina to pass reforms of its own. South Carolina Gov. Mark Sanford (R) cited Georgia's bill as a reason to push for the passage of S.B. 83, and he signed the bill into law on April 4. In addition to caps on noneconomic damages, the South Carolina bill enacted expert witness qualifications and allows parties to participate in binding arbitration; furthermore, it mandates mediation for medical liability claims.

For the past three years, Missouri's legislature has passed liability reform only to see it vetoed by then-Gov. Bob Holden (D). Recently elected Gov. Matt Blunt (R) campaigned on the issue of liability reform and on March 29 signed H.B. 393 into law. The Missouri bill contains several significant reforms in addition to the \$350,000 cap: it limits venue shopping, permits joint and several liability when the defendant is more than 51 percent at fault, strengthens the affidavit of merit requirements (including expert witness qualifications), includes an "I'm sorry" provision, modifies the col-

lateral source rule, and creates civil immunity for physicians who volunteer their services at free health centers.

Probably the biggest surprise was passage of medical liability reform in Illinois. Tort reform seemed highly unlikely because of the hold the trial lawyers had on the legislature. However, the recent election of a "pro-tort reform" Illinois Supreme Court Justice and the urging of downstate legislators (on behalf of their constituents) focused the issue and gave reformers the support they needed to pass this legislation. Not only did the bill cap noneconomic damages, but it also included improvements to the affidavit of merit, stronger standards for expert witness qualifications, and an "I'm sorry" provision. However, as part of the compromise necessary to gain Democratic support for the legislation, the bill also included a public access Web site that will contain profiles of physicians' medical liability histories. Furthermore, insurance reforms will permit state insurance regulators to reject steep premium hikes from liability insurers by requiring public hearings.

Montana law had previously enacted several major liability reforms, including a \$250,000 cap on noneconomic damages that was passed in 1995, but that didn't stop Gov. Brian Schweitzer (D) from signing several bills March 24 aimed at adding more protections for Montana's medical professionals. Four separate bills—which included,

## STATES THAT PASSED LIABILITY REFORM IN 2005

<b>State</b>	<b>Caps on noneconomic damages</b>	<b>"I'm sorry" provisions</b>	<b>Expert witness qualifications</b>	<b>Alternative dispute resolution</b>
Alaska	Lowered previous cap to \$250,000			
Arizona	State constitution does not permit caps	✓		
Georgia	\$350,000	✓	✓	
Illinois	\$500,000 for a physician; \$1 million for a hospital	✓	✓	
Missouri	\$350,000	✓	✓	
Montana	\$250,000	✓	✓	
South Carolina	\$350,000		✓	✓

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among other reforms, an “I’m sorry” provision and expert witness qualifications—were signed.

Although Arizona’s constitution prohibits limiting damages, the legislature passed a number of medical liability reforms. In April, Gov. Janet Napolitano (D) signed S.B. 1036, which included expert witness qualifications and an “I’m sorry” provision. To resolve the constitutional issue, S.C.R. 1035, which would give the legislature the authority needed to enact caps, may be brought to the state as a ballot question in November 2006.

During its 2005 session, the Florida legislature passed two bills, S.B. 938 and S.B. 940, in order to clarify constitutional Amendments Seven and Eight, which Florida voters approved in November 2004. It let stand a third amendment, which limits attorney fees.

As passed, Amendment Seven, which allowed for “open [medical] records,” created concerns related about violations of Health Insurance Portability and Accountability Act (HIPAA) regulations. The Florida legislature addressed those concerns by passing S.B. 938, which placed restrictions on who may view the records and what information they may contain in order to comply with HIPAA and still allow for peer review. In addition, the legislature determined that the amendment does not apply to records created or incidents occurring before Amendment Seven was adopted. S.B. 940 addressed physicians’ concerns about Amendment

Eight—a “three strikes” rule for revocation of a Florida medical license after three liability judgments. The first provision of the legislation is that the amendment will not be retroactive; only incidents that occur after November 2, 2004, can be considered a strike. Furthermore, the definition of a “strike” was clarified; settlements may not be considered a strike nor can a single incident count as more than one strike. In addition, disciplinary measures that occur out of state or in another country do not count as strikes unless the burden of proof applied equals or exceeds the burden in Florida. Lastly, before a physician’s license is rescinded, the state medical board will review the three claims for their merit and determine whether the physician’s license should be revoked.

#### **Other liability issues**

Wisconsin has two major challenges to its current \$432,000 cap on noneconomic damages (which adjusts for inflation) pending in the state’s Supreme Court. The first is *Gregory G. Phelps et al. v. Physicians Insurance Co. of Wisconsin Inc. and Matthew Lindemann, MD*. On March 3, the court heard oral arguments in the Phelps case, which is an appeal of a recent appellate court ruling that first-year residents are not included under the state’s cap because the statute requires a health care practitioner to be licensed in order to be covered. As such, this system creates a disadvantage,

### WASHINGTON’S I-330

- Caps noneconomic damages between \$350,000 and \$1,050,000, depending on the number of individuals and institutional defendants
- Permits periodic payment of future damages
- Implements a sliding scale for attorney contingency fees
- Permits voluntary arbitration agreements between patients and physicians
- Eliminates collateral source rule
- Abolishes joint and several liability to hold defendants liable only for their share of damages
- Implements a three-year statute of limitations on medical liability claims

### WASHINGTON’S I-336

- Revokes licenses of physicians who have three jury verdicts for preventable medical injuries against them within 10 years
- Bans secret settlements in medical liability cases
- Before an insurance company could increase liability rates by more than 15 percent, a public hearing would be required and those companies would have to open their financial records to the public
- Establishes a supplemental insurance fund for clinics, hospitals, and health care providers
- Increases from four to six the number of members representing the public on the state’s Medical Quality Assurance Commission

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because *only* first-year residents are not covered.

In addition, on April 26, the court heard arguments in the case of *Matthew Ferdon, et al. v. Wisconsin Patients Compensation Fund, et al.* This case challenges the constitutionality of caps on noneconomic damages in medical liability cases. The state's Supreme Court has previously upheld caps on noneconomic damages in cases of wrongful death. (*Maurin v. Hall*). (Note: Rulings in both the Maurin and Ferdon cases are expected early this summer and were unavailable at press time.)

Not all liability reform centers on capping damages, however. New Hampshire's S.B. 214 established a prescreening panel for medical liability claims. The panel would consist of a "retired judge, (or) persons with judicial experience" who would be named as the chair and then two or three additional members would be chosen by the chair from a list of candidates. At least one member would be an attorney and another a health care practitioner in the same specialty or profession as the accused. If more than one person is accused, a second health care practitioner in the same specialty as the additional defendant may be appointed. In the original language of the bill, if the judgment of the panel is unanimous and the case still goes to trial, the findings of the panel may be admissible in court. (Note: As of press time, the bill had passed both chambers and was awaiting Gov. John Lynch's (D) signature.

In Ohio, State Sen. Kevin Coughlin (R) introduced S.B. 88, a bill to create a pilot program to study the benefits of using arbitration in medical liability disputes. Unlike the bill in New Hampshire, S.B. 88 states that only evidence from the arbitration would be admissible in court (should the claim move forward) and not the final judgment. The bill is facing an uncertain future, and as of press time had not yet been heard in the Senate Insurance, Commerce and Labor Committee where it was assigned in March. Senator Coughlin has stated that he is looking for some form of alternative dispute resolution and is willing to amend his legislation to reflect another option (for example, mediation, a "tort court," and so on).

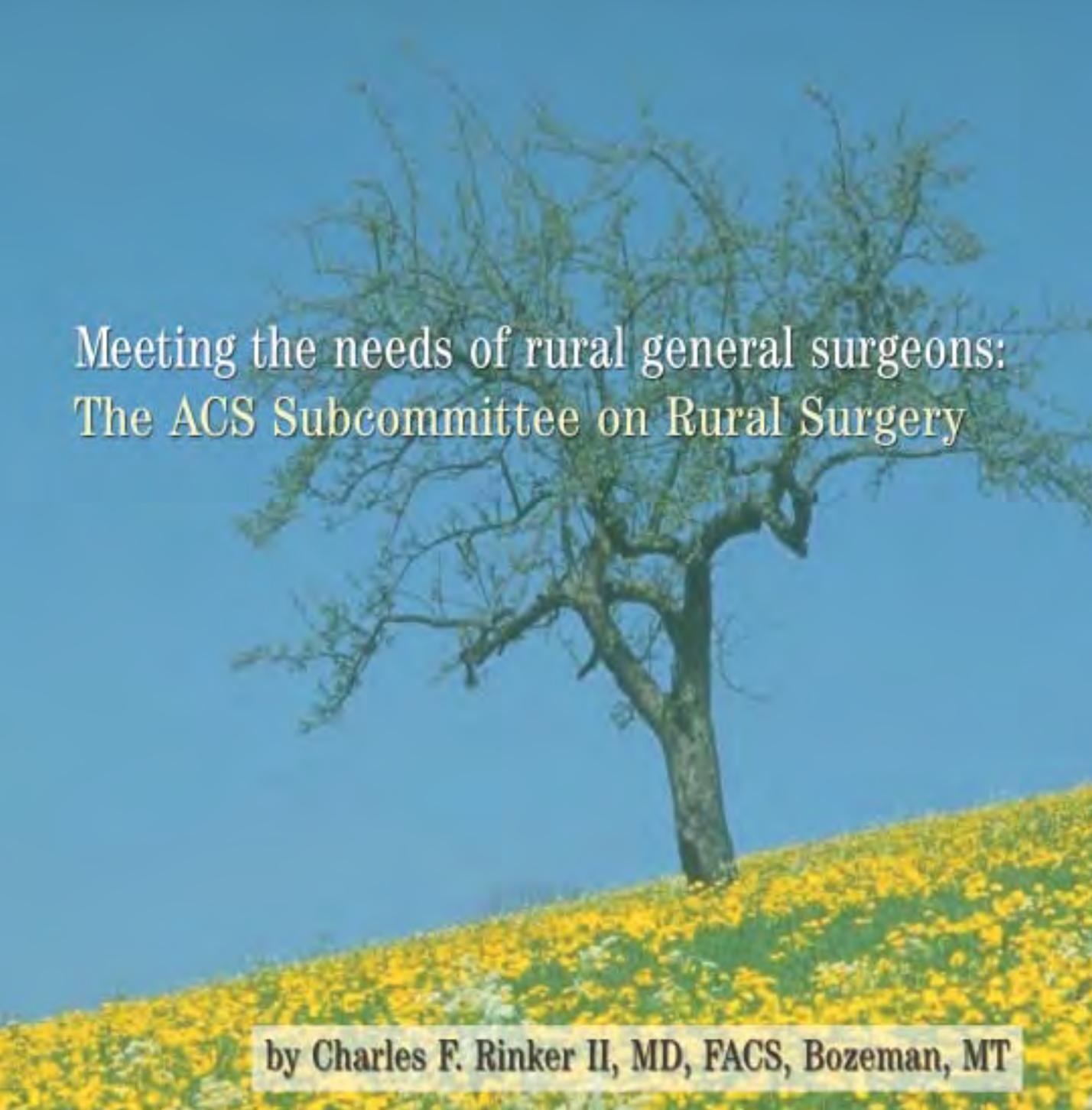
Washington State's medical liability reform initiative, I-330, was certified at the end of 2004 and was heard in the Senate's Health Care Committee in January 2005. No vote was taken, and as the legislature refused to act on the initiative by

the end of the 2005 legislative session, residents will have a chance to vote on it in November of this year. Highlights of the initiative include a cap on noneconomic damages and a limit on attorney contingency fees in medical liability lawsuits.

The Washington State Trial Lawyers Association proposed its own initiative, I-336. Opposed by physicians and other supporters of reforms similar to those in California's Medical Injury Compensation Reform Act (MICRA), I-336 would revoke licenses of physicians who have multiple jury verdicts against them and would require public hearings before insurance companies could increase liability insurance premium rates. I-336 will also be on the November ballot and because the two initiatives do not conflict, it is possible that both could pass. A coalition, Doctors, Nurses and Patients for a Healthy Washington, has been created to support I-330 and oppose I-336. This group has established a Web site for more information: <http://www.yesoni330.org/>. (More information on I-330 and I-336 is provided in the sidebars on page 11.)

### **The future of reform**

Most state legislatures have adjourned for 2005, so further state medical liability reform is unlikely until 2006. States without caps on noneconomic damages or other MICRA reforms will probably see reform legislation introduced in 2006, and focused grassroots advocacy will be essential if reform legislation is to pass. The College's State Affairs staff is available to assist chapters in their state advocacy efforts and physicians are encouraged to contact Jon Sutton, Manager of State Affairs ([jsutton@facs.org](mailto:jsutton@facs.org)), or Mindy Baker, State Affairs Associate ([mbaker@facs.org](mailto:mbaker@facs.org)). 



# Meeting the needs of rural general surgeons: The ACS Subcommittee on Rural Surgery

by Charles F. Rinker II, MD, FACS, Bozeman, MT

**G**eneral surgeons today are beset by many problems, among them professional liability, constriction of their scope of practice, and a trend toward referring all but the most common procedures to subspecialist surgeons and academic medical centers. At the heart of all these issues is education: in an era of rapidly changing technology, how does a practicing general surgeon remain current and, in particular, gain the skills necessary to safely provide modern surgical care to patients? The problem is particularly challenging for rural general surgeons, who may have dif-

ficulty taking leave of their practice for educational offerings. An attempt to define the problem and to seek possible solutions to this dilemma has been the principal task of the Subcommittee on Rural Surgery.

### ***The Subcommittee on Rural Surgery***

The first Rural Surgery Forum, organized by Paul Collicott, MD, FACS, was held at the October 2003 Clinical Congress in Chicago, IL. This open-microphone meeting was attended by approximately 75 surgeons from around the U.S. and

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led to identification of numerous issues of concern to rural surgeons. Following the meeting, at the direction of Mark Malangoni, MD, FACS, Chair of the Advisory Council for General Surgery, the subcommittee was established (see roster on page 17). Our initial step was to adopt the following mission statement: "The subcommittee seeks to improve patient access to quality surgical care in the rural setting by identifying and addressing the needs of surgeons in this unique environment."

The Rural Subcommittee of the Advisory Council for General Surgery is attempting to address the challenge of meeting the educational needs of rural surgeons. In doing so, two categories of education must be considered: residency training for the rural environment and postgraduate training of practicing surgeons.

The subcommittee has attempted to define "rural," acknowledging that it is an elusive concept. The most useful suggestion for criteria for defining this term came from one of our consultants, D.C. Lynge, MD, FACS. On the basis of his extensive studies of surgical practices, he finds considerable differences in scope of practice, resource availability, and surgeon case volume among the following categories:<sup>1</sup>

- Urban                      Population > 50,000
- Large rural                Population 10,000-50,000
- Small rural                Population < 10,000

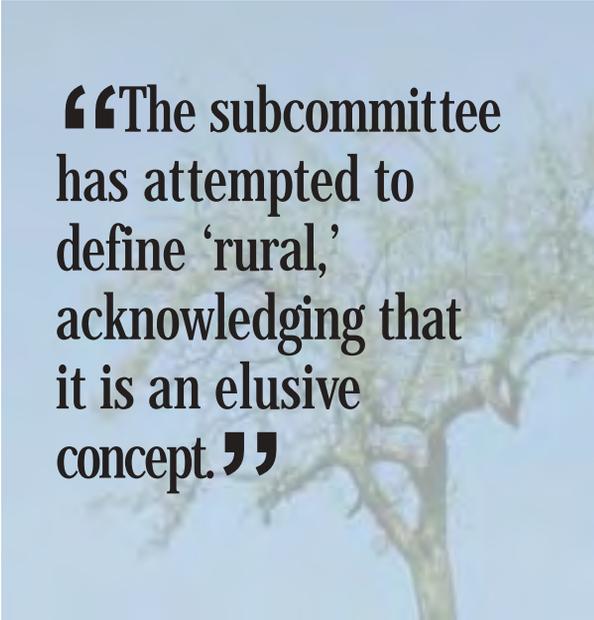
Of the approximately 17,000 general surgeons in the U.S., 80 percent live in or near a major metropolitan area, whereas 11 percent practice in large rural towns. The remaining 9 percent may be found in small rural communities. Most rural surgeons enjoy the small-town practice, despite the drawbacks of limited resources and a degree of professional isolation. Their scope of practice is dominated by hernia repairs; cholecystectomies; appendectomies; colon, anorectal, and breast surgeries; and endoscopies. Depending on locale and available subspecialists, they may perform cesarean sections; gynecologic operations; and, in some circumstances, otolaryngologic, thoracic, vascular, and orthopaedic procedures. Traditional surgical residencies prepare them for the much more complex procedures typically associated with general surgery, and most rural surgeons have a steady diet of emergency operations more demanding

than their more common cases. Typically, however, they perform a relatively small number of any particular, specific, complex procedures in a given year (for example, operations for ruptured aneurysm, blunt or penetrating abdominal trauma, perforated viscus, intestinal hemorrhagic conditions, and so on).

Keeping up with current practice for this broad range of challenging cases is difficult. Liability concerns increase annually, particularly when experts and plaintiff attorneys cite articles from academic medical centers that argue for minimum numbers of cases necessary to maintain competence. When new equipment or an entirely new approach to an old problem (for example, sentinel node biopsy or laparoscopic cholecystectomy) is introduced and accepted as the standard of care, small-town surgeons face a difficult choice: learn the new technique, or cease doing that type of surgery and refer the case to someone else. It is unreasonable and unrealistic to expect skilled and experienced professionals to discontinue treating conditions that comprise the core of their scope of practice because of advances in technology and surgical knowledge. Most surgeons will find some way to learn the new skills. The subcommittee strongly believes that, in the interest of patient safety, it is a responsibility of academic surgery and national surgical organizations to assist in devising methods to facilitate surgeons' acquisition of these skills under validated and supervised circumstances. Thus, it must be asked: How should residents be trained for small-town careers? How do associations and institutions help practicing surgeons to remain current? What can the leaders of surgery in the U.S. do to assist surgeons in maintaining competence?

### ***Training surgeons for rural practice***

There is a school of thought that the traditional surgical residency prepares the resident for all practice environments—the "compleat" surgeon. In a bygone era, this idealistic concept may have been tenable. However, in today's climate of liability, the fact is that no surgeon in his or her right mind is going to undertake a procedure of any complexity without adequate training and experience. Furthermore, a recent spate of directives from academic medical centers and consumer groups recommending minimum annual performance vol-



“The subcommittee has attempted to define ‘rural,’ acknowledging that it is an elusive concept.”

umes for an increasing number of operations traditionally considered part of general surgery has had a chilling effect on rural practitioners. It is no longer sufficient to be busy and active over a broad range but low volume of challenging surgical procedures.

So, if specific training is indicated, what should be taught? Most surgeons agree that a rich experience with endoscopy is helpful and that there may be a need for more emphasis on gynecology. Most other areas are so variable that it is difficult to define a curriculum that will satisfy all circumstances. Under the leadership of Joseph Cofer, MD, FACS, current chair of the Association of Program Directors in Surgery, a survey of program directors is being conducted to assess attitudes regarding the need for specific rural training and to catalogue what models are being used to teach the necessary skills. We hope to discuss the findings of this survey in a panel session at the 2005 Clinical Congress in San Francisco, CA. Future efforts should be directed at identifying the appropriate skills that should be mastered by surgeons planning on rural practice.

John Hunter, MD, FACS, and Karen Deveney, MD, FACS, at the Oregon Health Sciences University in Portland, have reported on a one-year

residency rotation in Grants Pass, OR, designed to expose interested residents to rural general surgery.<sup>2</sup> We are aware of several training programs that regularly arrange one- to three-month electives in rural practices for selected residents. However, it is very difficult for program directors to find time in the curriculum for such electives, particularly in view of work-hour restrictions. In addition, the medical center may forfeit Medicare funding of residency positions when trainees are off campus. One of the goals of our committee is to establish at College headquarters a database of rural training opportunities that could be accessed through the College Web site by interested medical students and residents.

An additional topic worth considering is that most of the Rural Forum participants have expressed concern about who will replace them when they retire. The average age of rural surgeons is more than 50 years, compared with the average age (early 40s) of surgeons in more populous locations.

Workforce studies predict not only a shortage of general surgeons in the coming generation, but in particular a continued dearth of practitioners of all disciplines in sparsely populated regions of the country. According to Thompson and colleagues, “General surgeons form a crucial component of the medical workforce in rural areas of the United States. Any decline in their numbers could have profound effects on access to adequate health care in such areas.”<sup>2</sup>

The majority of medical schools and residency programs are located in urban centers. Students and residents receive most of their education at big medical centers in big cities, staffed by role models and mentors who have no experience in the rural practice of surgery. Unless students have had some exposure to small-town practice or encounter teachers who encourage them to explore the possibilities, they are very unlikely to venture out to the hinterlands to consider it for themselves. Indeed, anecdotal reports suggest that faculty or senior residents discourage students when they express an interest in practicing in a small town. The Advisory Council for General Surgery has had ongoing discussions about the possibility of matching medical students with surgical mentors in small-town community hospitals, although so far nothing substantive has been accomplished. If it

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is agreed that expert surgical care apart from the major population centers is desirable, then attitudes and methods will need to change or future surgeons will not go there.

### ***Postresidency surgical education***

Residents may decide on rural practice after the completion of a traditional training program. Occasionally, surgeons leave academic or urban private practice after several years to seek a small-town location. In both cases, these surgeons very quickly realize that they will be expected to perform procedures for which they have received insufficient or no training. Traditionally, such learning was accomplished by on-the-job training with the hope that no misadventures would occur while the surgeon gained the necessary experience. In the past, such an approach was tolerated, if not exactly condoned. But as previously mentioned, in the current climate of liability, this approach is unthinkable. Michael Gold, MD, FACS, and colleagues have reported in these pages on a rural surgery fellowship they developed at Bassett Hospital in Cooperstown, NY, intended to provide the necessary proctored experience, tailored to the individual needs of surgeons/fellows.<sup>3</sup> Our committee has followed their efforts with great interest, and one of our members participated in the fellowship. If the program is successful, it is hoped that it can be duplicated in similar centers around the country. In any event, it represents a creative and responsible attempt to solve a very real problem.

A much more common problem is related to new technology or new approaches to old problems. Educators describe two kinds of learning needs for surgeons: those items that fall into the cognitive domain and those that are psychomotor skills. Cognitive information can be taught in person (for example, in lectures, seminars, or surgical meetings) or through distance learning (with journals, tapes and compact discs, textbooks, Web-based courses, and the Surgical Education and Self-Assessment Program). These methods are well established. However, the teaching of manipulative skills is far more difficult.

The most dramatic example was the revolution in biliary tract surgery precipitated by the introduction of laparoscopic cholecystectomy in the late 1980s. Once the public and profession realized what a tremendous advance had occurred, there

was no stopping the rush of patients seeking to benefit from the new operation, and the practicing surgeons seeking to be able to provide it. The entire training paradigm was turned on its head. Academia was unprepared to provide the necessary tutelage, so surgeons turned to proprietary and entrepreneurial sources. Those physicians who discounted the importance of minimal access surgery were left in the dust; some of those who charged ahead with minimal supervision may have caused harm. Fortunately, the majority attempted to acquire the needed expertise in the most responsible way they could, and in balance this revolutionary change was accomplished with due regard for patient safety and yielded good results. Eventually, academic surgery was able to regain the initiative, and residents are now properly trained in minimal access surgery. But other advances are bound to occur. In the absence of methods for teaching new technology to practicing rural surgeons, how the present generation of surgeons will be prepared for the next revolution is anybody's guess.

Meanwhile, subsequent advances have produced similar concerns. An informal poll of Rural Surgery Forum attendees, conducted by our committee, revealed that the majority of respondents would welcome participation in a structured training experience for such skills as office ultrasound, lymphatic mapping and sentinel node biopsy, stapled hemorrhoidectomy, endovascular ablation of varicose veins, new techniques in hernia repair, and a variety of advanced laparoscopic procedures. Many surgical organizations, including the American College of Surgeons, have developed courses to meet these needs. The courses have been well conceived and well attended. However, not all surgeons can afford the time or the expense to travel to a distant site for such courses, and in any event, registration is often limited because so much hands-on, one-on-one participation is involved.

Many new skills are now being taught to surgeons in quasi-academic settings involving a paid consultant (often with an academic title) who has developed or learned the device and/or procedure being touted. All the necessary disclaimers are duly posted. Equipment manufacturers and entrepreneurs often pick up the tab for travel, meals, and lodging. In some circumstances, the purveyors of a particular device will

come to the surgeon, and train him or her in the office or operating room. While it is easy to disparage such methods, it begs the question: Why are such methods necessary? Why can't we construct a safe and effective infrastructure to provide for properly qualified surgeon-educators to teach new technology to practicing surgeons,

## ACS committees working toward meeting the needs of rural surgeons

### Subcommittee on Rural Surgery

Charles Rinker, MD, FACS, *Bozeman, MT*  
Debbie Aaron, MD, FACS, *Ketchikan, AK*  
Richard Field, MD, FACS, *Centerville, MS*  
Peter Hedberg, MD, FACS, *Durant, OK*  
Brad Jimmo, MD, FACS, *Rutland, VT*  
Steven Olson, MD, FACS, *Burns, OR*

#### ACS LIAISON:

Paul Collicott, MD, FACS, Director,  
Member Services, *Chicago, IL*  
Mark Peterson, Administrative Associate,  
Member Services, *Chicago, IL*

### Consultants to the Subcommittee on Rural Surgery

Michael Gold, MD, FACS, *Cooperstown, NY*  
Steven Heneghan, MD, FACS, *Cooperstown, NY*  
Dana Lynge, MD, FACS, *Seattle, WA*  
Sam Finlayson, MD, FACS, *Hanover, NH*  
John Hunter, MD, FACS, *Portland, OR*  
Karen Deveney, MD, FACS, *Portland, OR*

### Advisory Council on General Surgery

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Kenneth Chandler, MD, FACS, *Decatur, AL*

particularly rural surgeons lacking ready access to an academic medical center?

The Subcommittee on Rural Surgery wishes to pursue these and other questions pertaining to postgraduate surgical education, in conjunction with other College committees with similar concerns. The American Academy of Orthopaedic Surgeons has established a learning center with cadaver labs in Chicago, IL, where members can gain hands-on, supervised experience with new instruments and procedures. The College should be able to do something similar. Surgeons fortunate enough to have ties with colleagues in high-volume medical centers can sometimes arrange observation sessions of live surgery, thereby gaining some insight into new technology and approaches. Occasionally, it is possible to import a preceptor to a community hospital to supervise maiden voyages in new procedures. It should be possible, then, to devise a more structured program, available nationally, to which Fellows could apply to meet their specific needs. The College's Education Committee is currently exploring the development of learning centers, and our subcommittee enthusiastically supports the effort. We hope committee members will give consideration to the special circumstances of rural, solo practitioners as the learning centers are established. A radical thought, but one that deserves consideration, is to explore joint ventures between the College and the medical device industry to bring new technology to practicing surgeons in a responsible manner, with appropriate peer review and reassessment. There is probably much that these groups could learn from each other.

### Additional issues

Rural Surgery Forum participants identified many other issues of concern. Not surprisingly, these include professional liability and declining reimbursements. We have chosen to leave these issues to College committees and the Washington, DC, office, which are already dealing with them. Fellows who have concerns specific to rural surgery should contact the appropriate committees or officers for assistance. One issue repeatedly identified by our rural colleagues is that of peer review. Meaningful peer review is extremely difficult to achieve in a small hospital served by only one or a few surgeons. In the informal survey

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mentioned previously, a majority identified self-assessment and personal outcomes tracking as a high priority. All would willingly travel, at their own expense, to a distant site to gain information about how to incorporate these principles into their practices. Most surgeons want to learn and to improve. The American College of Surgeons should try to help them in their quest. At the 2005 Spring Meeting in Hollywood, FL, surgeons had the opportunity to learn how to use personal digital assistants to track their cases and outcomes. This is an excellent example of how the College is attempting to address such issues, and such efforts should be expanded.

### **Conclusion**

Practicing surgeons without immediate access to an academic or large-volume medical center have difficulty keeping pace with the explosion of technology. We need help from our colleagues in surgical education if we are to be able to continue to serve the needs of our patients. Several principles worth considering include the following:

- The education/training of surgeons is time-consuming, expensive, and demanding. It is not sensible to make this investment if the product could be outdated within a few years of commencing practice.

- The public wishes to have sophisticated surgical care available in all communities, large and small. Regionalization of care may be the goal of health-planning agencies, but it is far from being a reality. Unless or until regionalization and the necessary infrastructure exist, a finite number of surgeons must be trained to provide care to our rural population.

- Numerous models exist for the successful teaching of cognitive skills, but teaching of psychomotor skills is labor-intensive and expensive. Interaction between student and teacher and hands-on experience are essential. Development of effective and efficient methods for rapidly upgrading skills of practicing surgeons in all geographic areas is the principal educational challenge for the near future.

- Reputable surgeons and/or surgical organizations have developed a variety of models for teaching psychomotor skills. Nevertheless, many private practitioners obtain information and hands-on experience from entrepreneurial orga-

nizations—medical device manufacturers in particular. The surgical leadership might have something to learn from their successes. Partnerships could be considered. Bringing teacher to student, instead of vice versa for rural practitioners, may be a novel means of accomplishing this goal. 

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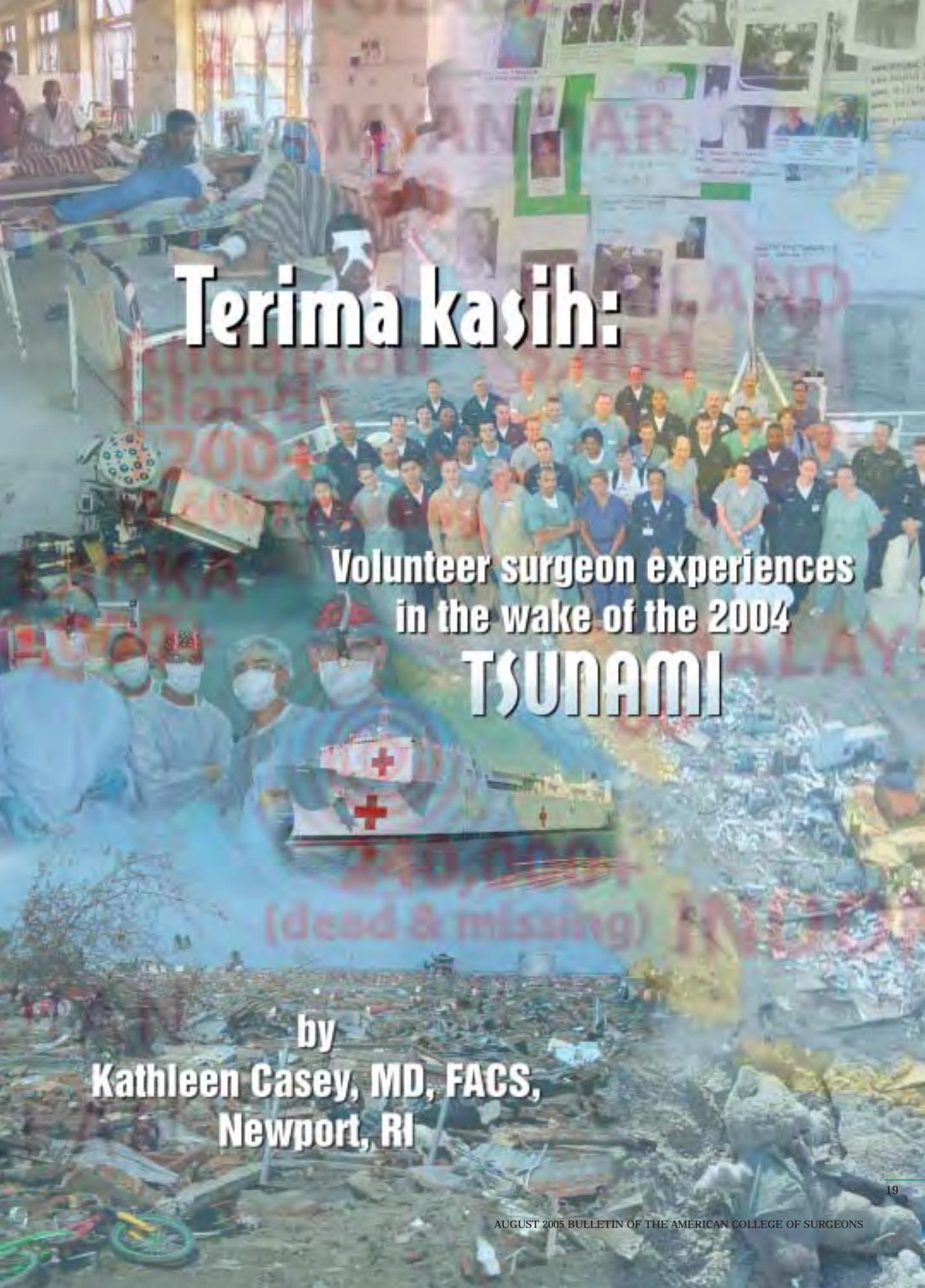
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**Dr. Rinker** is in private general surgery practice in Bozeman, MT, a member of the Advisory Council for General Surgery, and chair of the council's Rural Surgery Subcommittee.





**Terima kasih:**

**Volunteer surgeon experiences  
in the wake of the 2004**

**TSUNAMI**

**(dead & missing)**

**by  
Kathleen Casey, MD, FACS,  
Newport, RI**



Dr. Lal



Dr. Leckman



Dr. Pezzi



Dr. Vithiananthan



Dr. Yoder

**You have not lived until you have done  
something for someone who can never repay you.**  
— *John Bunyan*

**O**n December 26, 2004, the Indian Ocean was rocked by an earthquake of 9.0 magnitude that generated a tsunami of astronomic proportions. Waves estimated at 60 feet high and moving at speeds up to 500 miles per hour rapidly descended on tens of thousands of oceanfront miles in 11 countries, killing more than 200,000 and injuring tens of thousands more, leaving more than 1 million people homeless.

In addition to being one of the most brutal geologic events in history, the scale, location, and politics of the affected areas made the response to this disaster particularly complex and challenging. Physicians and others who responded to the disaster in Indonesia, Thailand, and Sri Lanka experienced firsthand the intricacies of disaster response as they encountered resistance from local governments, vestiges of ongoing civil unrest, cultural and language gaps, and stark limitations in available resources. And yet, such obstacles did little to diminish the contributions

made by those responding or the profoundness of their encounters.

What follows are recollections—excerpts from diaries and e-mails—of five surgeons who took part in the relief efforts. Kenneth J. Yoder, MD, FACS, and Scott A. Leckman, MD, FACS, two general surgeons who responded to a request issued through Operation Giving Back, took part in the Project HOPE (Health Opportunities for People Everywhere) mission off the coast of the Banda Aceh province of Sumatra, Indonesia. Raj B. Lal, MD, MPA, FACS, a cardiovascular thoracic surgeon native to India, and Siva Vithiananthan, MD, FACS, a general surgeon and Sri Lankan native who had fled the country years ago during its civil war, were both prompted to travel to Sri Lanka by concerns that local politics might have an impact on the distribution of aid in the areas most affected by the tsunami. Christopher M. Pezzi, MD, FACS, a general surgeon, traveled with the World Surgical Foundation, which had previously planned a medical mission to the Philippines and rerouted its itinerary through Thailand to assist with disaster relief efforts.

Photographs courtesy of Drs. Lal, Leckman, Pezzi, Vithiananthan, and Yoder, and members of Project HOPE and the World Surgical Foundation.



Mass graves on Point Pedro Beach in the northeast region of Sri Lanka.



An aerial view of devastation at Banda Aceh, Sumatra, Indonesia, two months after the tsunami.



Abidini Hospital in Banda Aceh, after the tsunami.

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### ***Landscape of the disaster***

With the epicenter of the earthquake nearest to the Indonesian island of Sumatra, the coastal region of Banda Aceh was hit the earliest and the hardest. Dr. Yoder describes the landscape: “The wave that hit Banda Aceh was estimated to be about 50 feet high, leaving three zones of destruction. The area closest to the water was completely destroyed with only an occasional palm tree standing. The next zone had about 50 percent of the houses leveled, with the remaining houses uninhabitable from water damage, debris, and mud. The third zone was farthest inland, where most houses just suffered water damage. The largest hospital in Banda Aceh was in the middle zone. Almost all of the 400 or so patients drowned when the single-story hospital wards were filled with water to the ceiling. Many of the physicians and

nurses also perished before they could escape. All the beds, furniture, and equipment were ruined, and the hospital wards had several feet of mud inside.”

Throughout the Indian Ocean basin, the destruction was so violent that the most appropriate comparison was to the ravages of war. Dr. Leckman observed, “The devastation closest to the beach reminded me of pictures I have seen of Hiroshima after the first atomic bomb.” Dr. Pezzi described the west coast of Thailand: “The physical damage to the country is massive, extensive, and some places will never be the same again, I am afraid.... We drove many hours along the coast, stopping along the way, past maybe 100 kilometers of destruction. I don’t believe a nuclear bomb could level such a long and vast area.”

In Sri Lanka, Dr. Vithiananthan gives this vivid



Inset: the USNS *Mercy*. Large photo: The surgical staff of Project HOPE and the U.S. Navy (including operating room staff, surgeons, and anesthesiologists) on board the *Mercy*.

and poignant description: "...Nothing can quite prepare a person for the sight of a ghost town with every building in ruins. It looked like someone had dropped a big bomb in the middle of this neighborhood. It was eerily quiet except for the sea breeze and the sound of the still-unsettled waves. There was a famous local Hindu temple in which people came to worship from far away. The sanctum sanctorum was remarkably preserved. The floods had caused the drapes to fall over the deities' eyes, as if the gods too were closing their eyes against the death and destruction around the temple."

### ***Getting to the disaster relief sites***

With such profound damage affecting roads, harbors, beaches, and airstrips, the ensuing logistics of routine disaster response were thwarted. Coop-

eration became the essence of this massive global response. Aboard the U.S. Naval hospital ship (USNS) *Mercy*, surgeons and other volunteers with Project HOPE participated in an unprecedented, historic collaboration of military and civilian resources. Dr. Leckman explained, "This is the first time the *Mercy* has been used for a humanitarian mission in conjunction with civilian volunteers and the first time pediatric patients have been aboard. Lots of folks are looking to see how it goes."

After two days' orientation on the sister ship, USNS *Comfort*, Project HOPE volunteers were flown to Singapore where they boarded the USNS *Mercy*. "By the next day, we were on our way through the Straits of Malacca (famous for frequent pirate raids) to the Indian Ocean," Dr. Yoder recalls. "The ship had almost 1,000 beds, with four intensive care units, full-service radiol-

ogy and pathology departments, and 12 operating rooms. We were staffed to care for 250 patients at most on board and really had no idea what to expect as we headed west from Singapore.”

Dr. Yoder recounts an early setback: “The Navy had enlisted several active and retired officers to scout ahead in Indonesia and India to see which area would be best served by our mission. Banda Aceh was identified as the area with the most need and the best logistics for providing health care for the victims. We arrived off the coast of Banda Aceh in the middle of the night, and by the next morning were notified that we would not be allowed to anchor there. After extended negotiations with the Indonesian officials, it was finally determined that the ship would move back and forth off the coast in international waters, and patients would be transported by helicopter to and from the ship. We understood that this would greatly restrict the number of people we could treat because of the limited space in each helicopter and the limited number of helicopters we could use each day, but it was our only real option.”

Dr. Leckman suggested another aspect of the ship’s mission: “We are here, off the coast of Indonesia, as opposed to Thailand or Sri Lanka, for a variety of reasons. Relations between the two governments had been cut off by Congress about eight years ago. There have been essentially no foreigners allowed in this area of the country for quite awhile. The hope is that this operation will help in the public’s perception of the United States in Indonesia and the Muslim world in general.”

### ***The challenges and successes of relief efforts***

On arrival in each country visited, efforts were underway from local and international relief groups. In Indonesia, Dr. Yoder reported the situation on shore: “By the first week of January, a volunteer group from Germany arrived with a small hospital ship and set up a complete field hospital in the parking lot of the municipal hospital. A group of Australians arrived soon after and began cleaning the mud and debris from the hospital wards so they could set up operations there. By the time we arrived, about February 1, the Germans and Australians each had a single operating room running, and an emergency department had been revived by a small group of American volunteers.”

In Sri Lanka, Dr. Vithiananthan points to simi-



Project HOPE helicopter at the main hospital of Banda Aceh, waiting to transport patients to the USNS *Mercy*.



German field hospital, set up in the parking lot of the main hospital of Banda Aceh.

lar international cooperation: “There were many organizations providing medical care...local groups and international NGOs [nongovernmental organizations] like the Red Cross, UNICEF [United Nations Children’s Fund], and so on. There were also groups from governments such as Canada, Norway, Denmark, England, and Germany in the area. Similarly, armed forces from the U.S. and Canada were at hand helping out with the clean up and some medical care.... The war-ravaged ar-



Temporary camp in Galle, Sri Lanka.



A Sri Lankan classroom converted into a makeshift kitchen.

areas in the north and east of the country had been neglected during the last 20 years.... With medical teams and medicines being rushed to the tsunami-affected areas, some people who had not seen a medical doctor for several years were now able to get adequate treatment or assessment. They appreciated the fact that the rest of the world cared for them.”

Dr. Lal underscored the harshness of the political landscape. “Decades of discrimination have

deepened the hatred between Tamils in the north-east and the Sinhalese majority in the south...this area has not received proportionate aid because of local political circumstances. We found conditions considerably better in the southern regions of the island.” In the town of Galle, Dr. Lal said, “U.S. forces had supplied helicopters, Humvees, and troops to help clear the debris and begun rebuilding. We saw people housed in donated tents within their same community, many on the site of their former homes. We saw large numbers of local residents, now ‘employed’ by USAID, engaged in rebuilding efforts. We saw many homes repaired and occupied. We found businesses reopening and life beginning to bear some sense of normalcy for these people. This is an encouraging start for these people who have lost so much to the tsunami, but shouldn’t the people on the north end of the island have the same hope to resume their now shattered lives?”

Despite multiple obstacles, much was accomplished in a short period by all the surgeons who participated in the relief efforts. In Thailand, Dr. Pezzi encountered a far different political climate, and his group was received with official gestures of gratitude and even military police escorts to facilitate travel to the affected areas. Early in his trip, he reported, “We have been involved in acute surgical care at two local public hospitals. The local surgeons here we met were young, very busy, overworked, and, I suspect, underpaid. At one hospital, while they have an operating room, they did not have any surgeons.”

Dr. Pezzi’s brother, Tim Pezzi, MD, FACS, accompanied him on the mission. “Yesterday Tim and I performed an open cholecystectomy, a modified radical mastectomy for a 4 cm breast cancer, a sigmoidoscopy, and repaired a perforated duodenal ulcer in a man with a belly full of pus.”

Later in the mission, Dr. Pezzi’s caseload had ballooned. He said, “All week long, people were clamoring to be screened by our group and to try to get on our schedules. We, of course, could not take care of all of them in the end, and talking with some veterans of many prior missions, it is always like that. You do as much as you physically can do...no matter how many people I did operate on, I still felt for those I could not. We got up at the same time each morning, made rounds, and went to surgery to start all over again. There would be



Hospital ward aboard USNS *Mercy* before patients arrived.



Walkway between wards at the main hospital of Banda Aceh, after much of the mud had been cleared away.

a row of patients waiting in the hall outside of the operating room, just as there had been every day before that.... In the end, I think we did a total of about 175 operations this week alone. Not an overwhelming number, but for each of those people, we believe we made a difference in their lives.”

As for the routine in Banda Aceh, Dr. Yoder recounted, “Each day a group of several physicians and nurses, along with U.S. Navy personnel for security and logistics, would travel to the municipal hospital by helicopter. Rounds were made with the German and Australian physicians to identify any patients needing care beyond their capabilities. These patients were prioritized according to the severity of their illness and our ability to treat their condition. About five to seven patients each day could then be airlifted to the ship. Initially we took on many patients with tsunami-related problems such as long bone or facial fractures and pneumonia. There was a unique type of pneumonia seen mostly in children from inhaling the soil-contaminated water during the initial tidal wave or in the ensuing days while floating around, holding onto debris. This was marked by multiple abscesses in the lungs, empyemas, and eventually brain and liver abscesses. Because we were fortunate to have a burn specialist, we were able to take on some burn patients with longstanding contractures that had never been treated. One three-year-old boy

who had never walked because of severe leg burn contractures was taking his first steps by the time he left the ship.”

In Sri Lanka, Dr. Vithianathan describes a different scenario: “A wound care clinic was set up under a tree. Surgical patients, in this case mostly with leg wounds, made up about 8 percent to 10 percent of the patients. Half of these [patients] had seen a doctor in the local hospital but a majority had not received tetanus toxoid. We brought nearly 1,000 doses from Colombo for this purpose. Most walked around without footwear, because their belongings had been washed away, and were contaminating the wounds that were mostly on the feet.... Our day typically consisted of visiting two to three camps, and seeing on average more than 300 patients. Communication among the centers was difficult because the land telephone lines were either damaged or nonexistent.... Trying to deal with the ensuing confusion, we had to be flexible and creative. By day two, we were a seasoned team. At the time, there were close to 21,000 refugees housed in these camps and we attended to nearly 1,500 to 1,600 patients in the first five days.”

The conditions in local hospitals made a profound impression. Dr. Leckman describes a day at an Indonesian military hospital that he toured with the chief of surgery, Dr. Taufiq, who wears



Young and old lining up for medical care in Sri Lanka. Each family's space is defined by a floor mat in camp.



Hospital ward with tsunami victims (Sri Lanka).

battle fatigues and carries a gun and knife to do rounds. “Today I got to go ashore to the TNI Hospital. The TNI is the Indonesian military, which has control of Banda Aceh but not the rural areas in this region, which are apparently in control of the rebels. Many of the doctors and nurses (other than the military) are working without pay but I understand they are hopeful of being paid by the government in the future.... The operating room is very basic. I scrub my hands with Lux dishwater soap. The nurses then pour alcohol over my hands. The gowns are thin as rice paper. They have real gloves, masks, and head coverings. Oh, and the expected footwear are flip-flops! The patient being operated on for goiter had the largest thyroid I’ve ever seen. They prepped the skin with an iodine solution and had sterile cloth drapes, a single light, and rudimentary anesthesia equipment. All the instruments at our disposal fit on one Mayo stand. I suspect that everything that can be reused is reused. There were also a few flies and mosquitoes.”

In Sri Lanka, Dr. Vithianathan visited the only tertiary care hospital in the region, in Batticaloa. He said, “The hospital consisted of crumbling buildings, half-completed ones and, within the walls still standing, equipment being used well beyond its intended life. The effects of

war were quite visible. But the staff were enthusiastic and proud of their institution, and kept it spotlessly clean.”

Dr. Lal provided a bit more insight into the Sri Lankan medical infrastructure:

“We saw patients in the surgical clinic of the University of Jaffna Hospital, a teaching institution that services 4 million inhabitants, mostly Tamils. It, too, is woefully undersupplied and staffed...no neurosurgery, cardiology, thoracic, or cardiac surgical services for over 20 years. These unfortunate cardiac patients have no alternative but to succumb to the natural history of their diseases in the long run.”

In Thailand, Dr. Pezzi commented, “Surgically, we are taking care of some of the very poorest people of this island at two public hospitals in Patong and Phuket City. When they come to the hospital, they pay 30 baht, which is about 80 cents, to the hospital no matter what they need done. It doesn’t matter if we sew up a small laceration or perform a major operation and they stay for a week—it is 30 baht. The patients are very appreciative of our care and they never complain about pain or anything else. The hospitals are like a time warp to the 1950s, with huge wards and up to 50 patients in one big room. Most rooms are not air conditioned and mostly very ‘low tech.’ The nurses are excellent, meticulous, and do all of the dress-



A debridement in the operating room of Batticoloa Hospital, Sri Lanka.



In Banda Aceh: A three-year old boy's leg. Burned as an infant, the severe contractures kept him from walking. The child took his first steps after his burn contractures were excised and grafted by Dr. Rob Sheridan of Massachusetts General Hospital.



Incision and drainage of abscessed wound in open-air clinic (Sri Lanka).



A patient with a massive goiter (Thailand).

ing and wound changes. I really see and appreciate the importance of nursing and will always look at nurses and nursing with an even greater respect.”

***The lasting impression of giving back***

The impact of the efforts of these volunteer surgeons will be felt for years to come, with many donated supplies left behind, as reported by Drs. Lal and Vithiananthan, and as described by Dr.

Pezzi as follows: “We brought a ton of stuff, with a total of about 30 bags weighing about 60 pounds each. Most of it is medical supplies, a portable anesthesia machine, sutures, medications, and so on, and the best part is we will leave much of it here.”

But the memories and stories are certain to last even longer. Dr. Leckman recounts one poignant situation: “As we were preparing to leave the hospital to catch the helicopter back to the ship, we faced a crisis of sorts. A baby was born just four



Pharmacy and wound care in camp with doctors in background (Sri Lanka).



Drs. Christopher Pezzi and Tim Pezzi in surgery in Phuket, Thailand.

hours ago [with] aspirated meconium [and] suffered a pneumothorax. A volunteer neonatologist from Singapore placed a chest tube...a feeding tube hooked to a bottle of water.... Our pediatrician did not want to leave because she feared the baby would die. There are no Indonesian pediatricians here at this hospital now. We could not leave for ethical reasons, [but] we are not allowed to stay ashore overnight. Fortunately, an ambulance arrived after arrangements were made to transfer the baby to the “university” hospital. [The pediatrician] accompanied the baby and caught a helicopter leaving from there later in the afternoon.... I couldn’t help but think about the ethics of leaving the baby without appropriate care. But then we are leaving in a few days, [and there is] not just one baby but so many more.”

Dr. Pezzi summarized his trip as follows: “Less than a month after this unique tragedy, we could not push the wave back into the sea or reverse the incredible magnitude of its destruction, but we came to do what part, however big or small, we could do. We witnessed the aftermath up close and helped heal some of the lingering wounds. Years from now, I will never forget coming to this place and especially will remember the people. We leave feeling much better about the

tsunami and how the area is recovering. It is recovering and it will. In just one week, things have improved. Each day a few more tourists come to the hotel and the beaches, and things get a little more cleaned up. Life goes on, as it must. The psychological damage to those directly affected here, the dislocation of so many people, and the physical damage to the coastal region will take a lot more time to heal and is beyond our ability to affect at this moment.... While we went to try to help others, and I think we were successful, we ourselves also benefited greatly. I would love to bring one of our residents next time, as it was a great learning and growing experience for the residents and fellows who came along.”

In an editorial printed in the *New England Journal of Medicine*, February 3, 2005, Sen. William H. Frist, MD, FACS (R-TN), commented on his impressions after visiting the devastation, stating that “individual contributions of medical assistance can rank among the world’s most precious and meaningful currencies.”

Dr. Lal witnessed these contributions firsthand in Sri Lanka and observed, “As physicians, we have no control over the politics; however, we do have means to help the patients irrespective of their locations as global citizens. Our



In the hospital ward of the USNS *Mercy*. The guitarist, the “barber of Banda Aceh,” had a femur fracture with non-union and was flown to the ship and treated—which prevented him from being crippled for life.



Missing persons postings in Thailand.

humanitarian efforts should also be looking for opportunities to bridge the political differences and our ‘soft power’ may finally bring the peace in the region. Let the tsunami tragedy heal the wounds of distrust, animosity, and hatred and sow the seeds of reconciliation to rebuild the devastated areas in a collaborative way. This is the best we can hope for.”

Dr. Leckman forwarded an excerpt from a speech made by Tamalia Alisjahban, the Indonesian interpreter to the Project HOPE/USNS *Mercy* crew, that seems to crystallize the experience: “I don’t know if you’re aware of this, but since the tsunami, the aid the Americans have given, starting with the helicopters bringing in the food, the newspapers when I left Jakarta there were saying there was a 70 percent change in Indonesian public opinion toward the Americans. We see these big war machines being used to help people bring aid. You were first greeted with suspicion and then puzzlement and then great fondness.... Nearly all the patients were saying how grateful they were and that we really couldn’t thank you enough and there’s nothing that we could give to repay your kindness and your care, and it will have to be God who repays you.... In Indonesian we say ‘terima kasih,’ which

literally means ‘accept love,’ because what it is to thank someone is to give a bit of love. Please do accept our love.” 

The College would like to acknowledge all of the surgeons and other volunteers who took part in providing aid to the people affected by this tragedy. To learn more about volunteer opportunities for surgeons, please visit [www.operationgivingback.org](http://www.operationgivingback.org), or contact Dr. Casey at [kcasey@facs.org](mailto:kcasey@facs.org), tel. 312/485-9534.

**Dr. Casey** is a general surgeon and Director of Operation Giving Back.



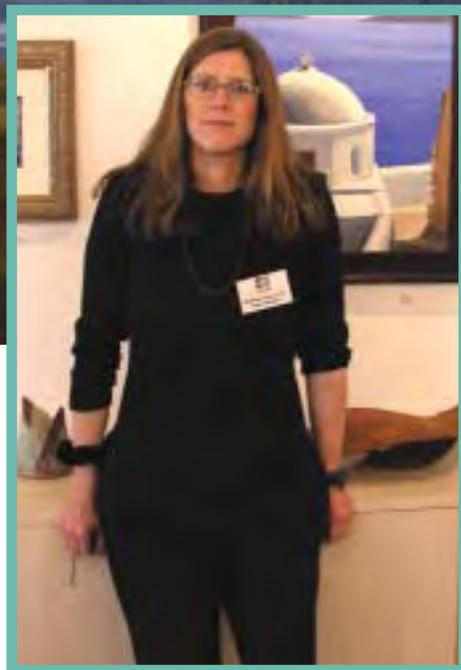
Surgical lifestyles:

# Using a critical eye in surgery and art

by Karen Sandrick, Chicago, IL

**F**ine art painters historically have studied anatomy so they could penetrate the exterior of the skin and find the bony and muscular details that would transform flat, two-dimensional depictions of the human form into visual symphonies of power and movement at the easel.

Already familiar with the underlying structural anatomy that forms the contours of the breast and the forces that end up distorting and distending the abdomen, plastic surgeon and fine artist Katherine Branch Young, MD, FACS, applies the same attention she extends to delving into the surgical subterranean to look for the subtexts lying beneath the surface of objects in nature. She strives to understand the currents that propel undulations in the height and speed of waves, the crevices and outcroppings that cause flickers of shadow and light on rock formations, and the trajectories of sunlight that alter the spectrum and intensity of color in a mass of flowers.



Dr. Young has been a surgeon since 1991, when she interned in general surgery, and a plastic surgeon since 1994, when she completed her residency at Stanford University School of Medicine, Palo Alto, California. For the last 10 years, she has been in private practice as a plastic and reconstructive surgeon in the Pacific Heights area of San Francisco, concentrating primarily on breast reduction;

Inset: Dr. Young. Background: Dr. Young's painting entitled *From Willow Flat*.

breast reconstruction after mastectomy; body contouring after pregnancy; and surgical options after massive weight loss, particularly following gastric bypass surgery. She has lectured on the vertical mammoplasty, immediate breast reconstruction after mastectomy, and safety in large-volume liposuction.

Dr. Young has been a painter longer than she has been a physician. A perennial doodler at a young age, she began training in drawing and painting technique in grade school with a representational painter at the Clifton School of Art in Hampton, VA. She later took art instruction at the Corcoran School of Art in Washington, DC, which has offered accredited fine arts programs since 1977.

Except for a brief hiatus during her general and plastic surgery residencies, when she essentially packed up and stored away her brushes and paints, Dr. Young has continued to pursue her art. But after having only enough time to dabble in art over the last 10 years, a year and a half ago she decided to make more of a commitment to painting. She began taking workshops and art classes at a local community college to reacquaint herself with the painting process. She and her husband, orthopaedic surgeon Christopher Cox, MD, FACS, then converted a spare bedroom in their San Francisco condominium into a formal studio, where Dr. Young now devotes most of her free time on weekends to painting landscapes in oil and watercolor that capture scenes from trips to Arizona, British Columbia, California, and Wyoming, as well as Greece and the Caribbean.

An end-of-residency celebration trip to hike in the Greek Isles produced paintings of Santorini that highlight the stark white, rounded domes of orthodox churches as well as sweeping balustrades and staircases in contrast to the azure sea.

A three-week sailing trip from Virginia to the Bahamas on a 36-foot sailing craft led to a series of works tracing the changeability of the ocean. One of Dr. Young's works depicts gently rolling waves on dappled blue water, while another displays a threatening gray and heaving sea. *Atlantic Sunset* presents a hazy sun on the horizon as it projects a slim trail of yellow dancing across whitecaps.

Dr. Young draws parallels between surgery and painting. To her, a plastic surgery procedure is like an art project because they both involve artistic



*A Small Offering* (top) and *Winter Wave* by Dr. Young.

judgment and a critical eye. “When I’m doing a breast reduction on a woman with large, pendulous breasts, I have to constantly step back in the operating room and look at what I’m doing to see if it’s right for the patient,” she says. The same is true of her painting. She has to stand back and scrutinize an artwork to see if it is true to the subject and her inner vision.

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Both endeavors and their results produce a great deal of satisfaction for Dr. Young. “I get a lot of joy out of completing a painting,” she says. “It’s the same feeling when you complete an operation that you think hits the mark and looks great. It’s a similar sense of accomplishment.” She also enjoys recognition from the Pacific Art League in Palo Alto and an art gallery in Truckee, CA (near Lake Tahoe), which regularly display her works, and the American Physicians Art Association, which awarded her a first prize for a moody oceanscape.

Dr. Young has, on occasion, painted on location, but plain air painting is challenging because light and colors change so quickly. She consequently uses a camera to take scores of photographs of interesting subjects and to find the best composition and lighting. She follows with sketches to carefully map out tonal values, outline areas of shadow and light, and plot the color patterns that form the main shapes; then, finally, she fills in the sketches with paints or watercolors.

Surgery and art involve some of the same sets of skills. Both operating and painting hone eye-hand coordination, and they prime the mind to seek out hidden characteristics and subtle shifts in substance, tone, and texture.

But the paths of plastic surgery and art also diverge. Surgery is unforgiving in its insistence on perfection. “There is no tolerance for mistakes, so as a surgeon, you have a strong sense of discipline and focus,” Dr. Young says. “There is much less pressure on the art, because it’s okay to make a mistake when painting and you can throw a painting away.”

Dr. Young observes, “Surgery is somewhat inventive. Surgeons need to be able to develop new techniques and new ways of looking at procedures to figure out how to close a wound or respond when something unusual pops up. But they don’t want to be too creative.” Surgeons, as a result, perform the same steps over and over within well-defined parameters until their actions are highly practiced. “There is a fine structure and education behind everything we do in the OR,” she notes. Painters can experiment with technique, choosing to make fine or broad brush strokes or add daubs or slivers of paint on a canvas. Painters also can alter perspective.

When painting an actual subject, such as the Grand Tetons, Dr. Young must be true to topogra-

phy. “I have to get the shapes of the mountains right because they are so recognizable,” she says. The same adherence to form can be true for painting figures. In *A Small Offering*, Dr. Young faithfully reproduces a photograph taken by her husband while he was on a mission to Nepal that shows a girl about to enter a Buddhist shrine with a small donation.

But given the artistic license, Dr. Young might choose to show the mountains at different times: in the waning hours of the day, when blues deepen and soften rough edges, or at midday, when yellows and browns bleach and etch them. She might show the heights of the mountain range as it hugs a plain at a distance or the depths of the valley floor as it meanders below.

Surgery is, by necessity, confined to the reality of a patient’s situation, and it can proceed only as far as a patient’s condition will allow. Surgeons do not create as much as refashion existing elements, whereas art creates an image that is completely new. Artists begin with a blank canvas and add colors and embellishments and often change reality. Dr. Young’s seascapes do not represent a single moment in time but take shapes from many different periods to add depth and interest, mood and motion. “With a painting, you can move things around, change things, and make the composition better. Art is more complicated than surgery because there are so many more variables,” Dr. Young says.

Dr. Young is currently working on a painting of a lighthouse located in the San Francisco area and soon will start a work detailing the ice formations she and her husband saw while taking a helicopter ride over a glacier in Canada. She is also preparing research papers on the long-term effects of large-volume liposuction on body weight and metabolism and a review of the 1,200 large-volume liposuction cases at California Pacific Medical Center and St. Mary’s Medical Center in San Francisco and the Plastic Surgery Center in Palo Alto, where she carries a full plastic surgery load.

Dr. Young continues to find that surgery and art feed one another: “Being an artist is making me a better surgeon, and being a surgeon has made me a better artist.” □

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**Karen Sandrick** is a freelance writer in Chicago, IL.

# Statement of principles of palliative care

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*The following statement was developed by the Task Force on Surgical Palliative Care and the Committee on Ethics, and was approved by the Board of Regents at its February 2005 meeting.*

Palliative care aims to relieve physical pain and psychological, social, and spiritual suffering while supporting the patient's treatment goals and respecting the patient's racial, ethnic, religious, and cultural values. Like all good patient care, palliative care is based on the fundamental ethical principles of autonomy, beneficence, nonmaleficence, justice, and duty.

Although palliative care includes hospice care and care near the time of death, it also embraces the management of pain and suffering in medical and surgical conditions throughout life. If palliation is taken to apply solely to care near the time of death, or "comfort measures only," it fails to include the life-affirming quality of active, symptomatic efforts to relieve the pain and suffering of individuals with chronic illness and injury. In this respect, palliative care is required in the management of a broad range of surgical patients and is not restricted to those at the end of life.

The tradition and heritage of surgery emphasize that the control of suffering is of equal importance to the cure of disease. Moreover, by adhering to the standards of professionalism endorsed by the American College of Surgeons, the surgeon is positioned to take a leadership role in advocating for palliative care for all patients.

The Statement of Principles of Palliative Care is an evolutionary step beyond the American College of Surgeons' 1998 Statement of Principles Guiding Care at the End of Life. It describes extending palliative care to a broad range of patients receiving surgical care.

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## Statement of principles of palliative care

1. Respect the dignity and autonomy of patients, patients' surrogates, and caregivers.
2. Honor the right of the competent patient or surrogate to choose among treatments, including those that may or may not prolong life.
3. Communicate effectively and empathically with patients, their families, and caregivers.
4. Identify the primary goals of care from the patient's perspective, and address how the surgeon's care can achieve the patient's objectives.
5. Strive to alleviate pain and other burdensome physical and nonphysical symptoms.
6. Recognize, assess, discuss, and offer access to services for psychological, social, and spiritual issues.
7. Provide access to therapeutic support, encompassing the spectrum from life-prolonging treatments through hospice care, when they can realistically be expected to improve the quality of life as perceived by the patient.
8. Recognize the physician's responsibility to discourage treatments that are unlikely to achieve the patient's goals, and encourage patients and families to consider hospice care when the prognosis for survival is likely to be less than a half-year.
9. Arrange for continuity of care by the patient's primary and/or specialist physician, alleviating the sense of abandonment patients may feel when "curative" therapies are no longer useful.
10. Maintain a collegial and supportive attitude toward others entrusted with care of the patient.

# Socioeconomic tips

## How do you code it?

by the Division of Advocacy and Health Policy

**T**his month's column centers on codes used to report lysis of adhesions and prophylactic mastectomy.

### **Lysis of adhesions**

Performing enterolysis, salpingolysis, or ovariolysis along with other procedures has always been complex to code, in part because the procedure codes have the notation "separate procedure" as part of the terminology. (See the text box on this page for the procedure codes.) There are some instances in which it is appropriate to attach the unusual procedural services modifier (modifier -22) to the code for lysis of adhesions and other instances in which it is appropriate to attach the distinct procedural service modifier (modifier -59). This is true whether the lysis of adhesions is performed as an open procedure (code 44005) or laparoscopically (code 44200 or 58660).

There are instances when a surgeon enters the abdomen to do one operation and, in the course of exploring the abdomen, finds another unrelated problem that requires the performance of lysis of adhesions as another procedure or as part of another procedure. For instance, a surgeon could be removing a gallbladder (diagnosis: chronic cholecystitis) but while exploring the abdomen finds an internal hernia caused by adhesions (diagnosis: hernia of other specified sites). In this scenario, there would be two operations in two different sites in the abdomen and two different diagnoses. It is properly coded using the -59 modifier. The operative report should show that two different sites were involved and it will serve as adequate documentation if requested by the insurance company; no additional documentation is required with the claim.

There are other instances where a surgeon encounters adhesions that he or she must deal with to get to the site of the definitive surgery and/or to free an organ. For example, there may be adhesions extending to the gallbladder. In this case, it is not appropriate to report code 44005 or 44200,

### **Around the corner**

#### **August**

Economedix will hold two teleconferences this month. The first, on August 10, will be on Physician Compensation Formulas of Successful Practices. The second, on August 24, is on Effective Personnel Management...Hiring, Evaluations, and Terminations. For more information and to register, go to <http://yourmedpractice.com/ACS>.

#### **September**

- Economedix will hold two teleconferences this month. The first, on September 14, is on Dealing with Difficult People. The second, on September 28, is on Maximizing Patient Collections. For more information and to register, go to <http://yourmedpractice.com/ACS>.

- The ACS will sponsor basic and advanced coding workshops for surgeons and their office staff September 15 and 16 in Dallas, TX. To register, visit the ACS coding workshop Web page at <http://www.facs.org/ahp/workshops/index.html>.

### **Three codes for lysis of adhesions**

**44005** *Enterolysis (freeing of intestinal adhesion) (separate procedure)*

**44200** *Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)*

**58660** *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)*

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because both contain the phrase “separate procedure.” In Current Procedural Terminology,\* “separate procedure” indicates that the procedure should not be reported when a procedure of which it is an integral part is also reported; and, of course, exposing the gallbladder is an integral part of any operation on the gallbladder. However, it is appropriate to report the operation on the gallbladder with a -22 modifier if it actually took much more time than usual to complete the surgery.

Unlike the -59 modifier, the -22 modifier requires that additional documentation accompany the claim. The first diagnosis code, of course, should be whatever diagnosis led to removal of the gallbladder. The second diagnosis should be adhesions. Because adhesions are organ-specific, their codes are listed in many places throughout Volume I of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). For the gallbladder, the diagnosis code is 575.8, *Other specified disorders of the gallbladder*. But for additional documentation beyond the claim, be sure the operative note includes a description of where the adhesions were and perhaps some description of them. Then compose a letter to the insurance company that explains that the adhesions caused more work, providing an estimate of how much more work and how much the normal fee has been raised. Send the letter and a copy of the operative report along with the claim.

Only use the -22 modifier if something such as the removal of adhesions or a surgical field altered by radiation therapy or earlier surgery adds a substantial amount of time to the operation. Payors occasionally monitor for frequent use of -22 modifiers and will not reimburse those people for charges related to the -22 modifier.

### ***Prophylactic mastectomy***

The correct ICD-9-CM diagnosis code for prophylactic mastectomy is V50.41, *Prophylactic organ removal, breast*. In this case, however, proper reporting does not guarantee payment. The payor may have a policy of requiring extra documentation before reimbursing for a prophylactic procedure or may even have a policy of deny-

ing any payment for prophylactic procedures. Therefore, the safest approach is to check with the payor before the procedure is performed to determine whether the procedure will be reimbursed.

If the contralateral prophylactic mastectomy is performed on the same day, show that a bilateral procedure was done by providing different diagnosis codes for the two procedures. If the payor uses the two-line convention for showing a bilateral procedure, simply provide the procedure on the first line without a modifier and show the same procedure on the second line with a multiple procedure modifier (modifier -51) and a bilateral modifier (modifier -50). If the payor accepts the right and left modifiers (-RT and -LT), use those as an alternative. Whichever way the procedure is coded, show the diagnosis code of V50.41 for one side of the body and the correct code for the malignant neoplasm for the other side. If the payor uses the one-line method for coding bilateral procedures, check with the payor to see how to display the diagnoses on the claim. □

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\*All specific references to CPT terminology and phraseology are: © 2004 American Medical Association. All rights reserved.

## 2005 Japanese and German Exchange Travelers announced

The International Relations Committee of the College has established an exchange program with the Japan Surgical Society and the ACS Japan Chapter. Earlier this year, David W. Chang, MD, of M.D. Anderson Cancer Center, Houston, TX, attended the Japan Surgical Society annual meeting and went to various Japanese surgical centers. The Japanese exchange traveler, Fumiaki Tanaka, MD, PhD, a surgical oncologist from Kyushu University Hospital, will attend the College's Clinical Congress in October, make a presentation, and then tour several surgical institutions in North America.

More recently, the German Surgical Society and the ACS Germany Chapter have developed a similar exchange program with the College. ACS



Dr. Tanaka



Dr. Lang

Fellow O. Joseph Hines, MD, FACS, of the University of California, Los Angeles, inaugurated this exchange by participating in the German Surgical Society's annual meeting in April 2005, then visiting surgical sites around Germany. His German counterpart, Hauke

Lang, MD, PhD, of Essen University, Essen, Germany, will attend the ACS Clinical Congress and choose several surgical sites to visit with the guidance of his mentors at home and in the U.S. Dr. Lang specializes in transplantation surgery and conducts research in oncology of the liver.

## Spring Meeting sessions now available on ACS E-Learning Web site

The American College of Surgeons continues to focus on efforts to support surgeons in achieving their lifelong learning objectives. The Division of Education of the College has established an electronic-learning program, which allows surgeons to obtain online Category 1 continuing medical education credit with great flexibility and convenience.

The E-Learning Web site provides learners with opportunities to select professional activities that meet their specific educational needs 24 hours a day, seven days a week.

The following sessions from the College's 2005 Spring Meeting have just been added to the site: ACS/SAGES (Society of American Gastrointestinal Endoscopic

Surgeons)/AHPBA (American Hepato-Pancreato-Biliary Association) Welcome and Assembly: Modern Management of Colon Cancer; Excelsior Surgical Society/Edward D. Churchill Lecture: Primary Hyperparathyroidism—The Changing Surgical Paradigm; How to Get Out of Trouble in the OR. For additional information, visit [www.acs-resource.org](http://www.acs-resource.org).

**Space sold by Elsevier**

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## College launches bariatric surgery center program

On February 12, 2005, the Board of Regents of the American College of Surgeons voted unanimously to expand its approvals and verification program to encompass disciplines in addition to cancer and trauma. The Regents specified the development of bariatric surgery cen-

ters as the first priority for this expanded effort. After consulting experts in the field, the College staff developed standards, stipulated necessary resources, defined credentialing criteria, and developed verification procedures for establishing an ACS Bariatric Surgery Center Net-

work. The College began accepting applications for enrollment in the network May 23. Interested individuals can find a description of the program and application information on the ACS Web site at <http://www.facs.org/cqi/bscn/>.

## AAS surgical research/career development courses to be held in October

The Association for Academic Surgery (AAS), an organization devoted to the training and development of young surgical scientists, will present its courses, Fundamentals of Surgical Research and Career Development, in parallel on Friday and Saturday, October 14-15, 2005, just before the American College of Surgeons Clinical Congress in San Francisco, CA.

The 16th annual Fundamentals of Surgical Research course is designed especially for residents in their laboratory year or for any resident or young faculty member interested in surgical research. This course features lectures on topics such as abstract writing, writing a research application, ethics and informed consent, and achieving balance.

The Career Development course is intended to help young surgeons develop the special skills required to balance the demands of research, teaching, and administrative tasks if they are to succeed as new faculty

members. This AAS course was designed in conjunction with the Howard Hughes Medical Institute and the Burroughs Wellcome Fund to provide training in three key areas: (1) job strategy: Obtaining and negotiating a faculty position and planning for tenure; (2) time management: How to successfully manage conflicting demands on your time; and (3) grantsmanship: A

how-to guide for obtaining funding via mentored and investigator-initiated awards.

The registration fee for each course is \$295 for AAS members, \$345 for nonmembers, and \$260 for residents. Registration is due before September 16, 2005. For more information, visit [www.aasurg.org](http://www.aasurg.org), send an e-mail to [registration@aaasurg.org](mailto:registration@aaasurg.org), or call 310/437-1606, ext. 108.

### Trauma meetings calendar

The following continuing medical education courses in trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

- **Advances in Trauma**, December 9-10, 2005, Kansas City, MO.

- **Trauma and Critical Care 2006**, March 20-22, Las Vegas, NV.

- **Trauma and Critical Care 2006—Point/Counterpoint XXV**, June 5-7, Williamsburg, VA.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: <http://www.facs.org/trauma/cme/traumtgs.html>, or contact the Trauma Office at 312/202-5342.

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Now online

## College introduces online highlights from its treasure of archives

In May, the American College of Surgeons introduced a new online feature to provide visitors to the College's Web site with a periodic snapshot of an important piece of College history. The new feature, "Highlights from the Archives of the American College of Surgeons," can now be viewed at <http://www.facs.org/archives/>. Each month a new photo or document exhibiting one of the many treasures from the ACS archives will be displayed, along with narrative text defining the place of each object in the College's history.

The inaugural highlight featured a portrait of Franklin H. Martin, MD, FACS, who is credited with being the person most responsible for founding the American College of Surgeons. Along with a monthly highlight, the section also includes an overview of the archives history and historical links of interest, including a full listing of past ACS Presidents, and dates and locations of all 90 Clinical Congresses.

In addition to its educational value, the move toward establishing a supplemental online archive will also enable the College to begin the process of developing a digital collection of some of its cornerstone photographs and documents. Because of its life span, which encompasses most of the 20th century, the ACS Archives is a unique

repository for the study of the history of medicine in North America.

The Highlights from the Archives of the ACS project was de-

veloped by Susan Rishworth, ACS Archivist, and ACS Communications electronic publishing staff.

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## JACS centennial symposium: Publishing excellence celebrated

In celebration of 100 years of publishing excellence for surgeons, the *Journal of the American College of Surgeons (JACS)* will host a symposium during this year's Clinical Congress in San Francisco, CA, as part of the celebratory events that will take place throughout the week. To be held on Monday, October 17, at 4:00 pm in the Hilton San Francisco, the symposium will honor the role *JACS* played in the formation of the American College of Surgeons in 1913.

First published as *Surgery, Gynecology & Obstetrics* by Franklin H. Martin, MD, in July 1905, the journal was renamed the *Journal of the American College of Surgeons* in 1994. During the symposium, four renowned leaders in publishing will provide perspectives on the importance of scientific publishing for sur-

geon education and patient safety. Seymour I. Schwartz, MD, FACS, Editor Emeritus of *JACS*, will moderate the session. The speakers will be: George Lundberg, MS, MD, ScD, editor-in-chief, *Medscape General Medicine*, and adjunct professor of health policy, Harvard School of Public Health; Michael Sarr, MD, FACS, co-editor, *Surgery*; Jerome Kassirer, MD, former editor, *New England Journal of Medicine*; and Timothy J. Eberlein, MD, FACS, Editor-in-Chief, *Journal of the American College of Surgeons*.

All attendees are invited to a reception immediately following this symposium, which will also be attended by members of the *JACS* editorial board, guest speakers, the members of the College's Board of Regents, *JACS* authors, and ad hoc reviewers. For more information, contact [whusser@facs.org](mailto:whusser@facs.org).

## ACS Surgery keeps pace with changes in the practice of surgery

Given the speed in which the field of surgery changes, keeping up with what is now considered “best practices” can be challenging. That is why the official reference of the College, *ACS Surgery: Principles & Practice*, is continually updated. Every month, *ACS Surgery Online* presents at least three chapters that

are entirely new or revised.

In addition, the most recent edition of the bound volume—*ACS Surgery 2005*—which was published this past February, contains 40 percent new or updated material compared with *ACS Surgery 2004*. Included in both the print and online versions are more than 50 new

recommendations offered by master surgeons to help maximize surgical outcomes and practice efficiency.

For more information, visit [www.acssurgery.com/learnmore.htm](http://www.acssurgery.com/learnmore.htm) or call 800/545-0554. ACS members are eligible for substantial savings on all *ACS Surgery* formats.

## CALL FOR SUBMISSIONS

The Committee for the Forum on Fundamental Surgical Problems  
The American College of Surgeons

For the 2006 61st annual Surgical Forum published in  
the *Journal of the American College of Surgeons*

Accepted abstracts\*  
will be presented at:  
American College of  
Surgeons

- Clinical Congress •  
8-12 October 2006  
Chicago, IL



\* Abstract Supplement  
published in *JACS*  
September 2006 issue.

### Who

- Young surgical investigators (principal investigator is first named author).
- Up to ten (10) co-authors allowed.

### What

- 250 maximum word abstract that presents a concise summary of research done and in progress, but not presented or published previously. Title must be brief; body of abstract must include Introduction, Methods, Results, Conclusions. One-page table may be submitted separately (see Author Instructions on Web site) if absolutely necessary; table does not count toward the 250 maximum word count.

### When

- Abstracts accepted from November 1, 2005, through March 1, 2006.

### Where

- Online submissions ONLY: <http://www.facs.org/sfabstracts>. Abstracts may not be presented in advance of the Surgical Forum program in October or manuscripts published in whole or in part before the abstract submission.

- **Final Decision:** May 2006 (principal author will be contacted).
- **Format:** Follow Author Instructions, Online Submission.
- **Questions:** [kkoenig@facs.org](mailto:kkoenig@facs.org) or: 312.202.5336.

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## NTDB™ data points

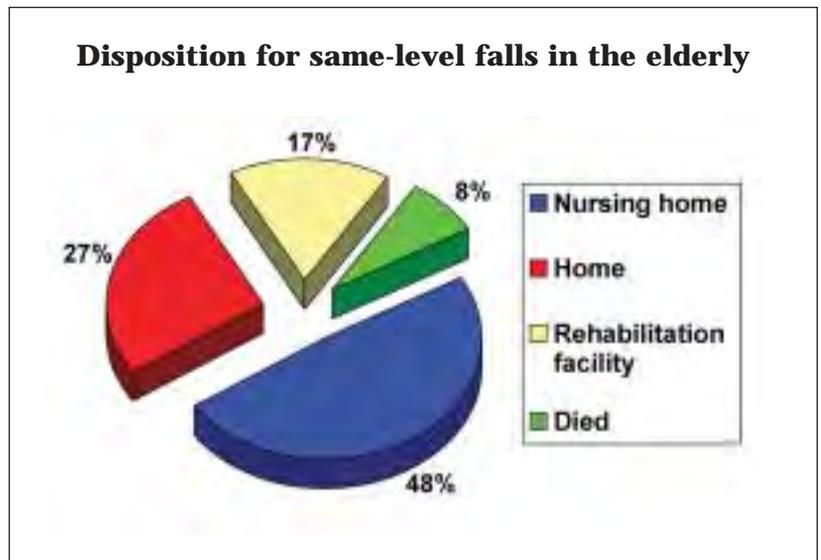
# I've fallen and I can't get up

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

The U.S. population is aging at a considerable rate. In 2003, there were nearly 36 million people aged 65 years and older accounting for 12 percent of the total population. Over the last century, those in the older population grew from 3 million to 35 million. Starting in 2011, the baby boomers will begin turning 65. By the year 2030, those in the older population are projected to be twice as many in number than their counterparts in 2000. They will account for more than 71 million, representing nearly 20 percent of the total U.S. population.

Every day the public is reminded of this trend as an increasing number of television commercials targets this demographic group. There are numerous pharmaceutical commercials for medications relevant to a maturing population, in addition to advertisements for lift chairs and the "I've fallen and I can't get up" advertisement for health monitoring products.

People work hard during most of their adult life and look forward to a time when they can retire and take part in some of the activities they may have put off while they were part of the workforce. However, along with the rewards of reaching retirement age are the realities of change in an individual's physical attributes. For example, reduction in organ reserves and



alterations in physiology put elderly people who experience a traumatic event at greater risk when compared with a younger individual exposed to a similar traumatic event.

A seemingly mild traumatic event mechanism would be a same-level fall, such as a fall from a standing position. There is a series of external cause of injury codes (E codes) for falls that encompasses this group.

The records contained in the National Trauma Data Bank™ *Annual Report 2004* show that there are more than 12,000 records of patients aged 65 and older. These patients spent 8,000

days in the intensive care unit and 3,500 days on the ventilator in 2004. Their hospital charges were close to \$230 million and, according to the National Center for Health Statistics at the Centers for Disease Control and Prevention, by 2020 this will escalate to \$32 billion per year. Nearly half (48%) of the elderly trauma victims in the NTDB who had experienced trauma from a same-level fall were discharged to a nursing home, 17 percent went to a rehabilitation facility, 8 percent died, and 27 percent were discharged home. These data are depicted in the graph on this page.

The reasons for falls in elderly persons are numerous; they include balance dysfunction, reaching for a high shelf, slipping on wet floors or throw rugs, and effects of prescribed medications, though such falls can also occur simply because a room has poor lighting. Many of these are preventable with proper evaluation of the home environment.

For more information on falls

in the home, there are numerous Web sites such as <http://www.nsc.org/issues/fallstop.htm>. It is up to all people with elderly family members to assist them with evaluating their environment and making it as safe as possible. After all, no one wants to hear the phrase, "I've fallen and I can't get up."

Throughout the year, we will be highlighting these data

through brief monthly reports in the *Bulletin*. The full NTDB Annual 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](mailto:mneal@facs.org).

## Child care available at Clinical Congress

Attendees at this year's ACS Clinical Congress in San Francisco, CA (October 16-20), can bring their entire family to the meeting. By popular demand, Camp ACS makes its return to the Congress. ACCENT on

Children's Arrangements, Inc., has planned a children's activity center and youth tours for the children of Clinical Congress attendees. ACCENT is a nationally recognized professional child care company that pro-

vides on-site children's activities in a nurturing, safe, and educational environment. For further information, please visit the Web site at [www.facs.org/clincon2005/social/campacs.html](http://www.facs.org/clincon2005/social/campacs.html).

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□ **ONLINE CME:** Courses from the American College of Surgeons' Clinical Congresses are available online for surgeons. The online courses feature printable written course transcripts, audio of sessions, video of the introduction of each session, post-test and evaluation, and printable CME certificates upon successful completion. Several of the courses are offered **FREE OF CHARGE**. The courses are accessible at: [www.acs-resource.org](http://www.acs-resource.org).

□ **BASIC ULTRASOUND COURSE:** The ACS and the National Ultrasound Faculty have developed this course on CD-ROM to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. It replaces the basic course offered by the ACS and is available for CME credit.

□ **BIARIATRIC SURGERY PRIMER:** Developed by Henry Buchwald, MD, PhD, FACS, and Sayeed Ikramuddin, MD, FACS, the primer addresses the biochemistry and physiology of obesity; identifies appropriate candidates for bariatric surgery; and discusses the perioperative care of the bariatric patient, basic bariatric procedures, comorbidity and outcomes, surgical training, and the bariatric surgical and allied sciences team, along with facilities, aspects of managed care, liability issues, and ethics.

□ **SYLLABI SELECT:** The content of select ACS Clinical Congress postgraduate courses is available on CD-ROM. These CD-ROMs are able to run in the PC and Mac environments and offer you the ability to word-search throughout the CD.

□ **PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons:** The CD uses an interactive/lecture format to arm surgeons with basic financial management skills. The course is designed to educate and equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children) and proper planning for financial stresses related to their surgical practice.

□ **PRACTICE MANAGEMENT for Residents and Young Surgeons:** The CD uses an interactive/lecture format to arm surgeons with basic practice-management skills. The course is designed to educate and equip residents and young surgeons recently in practice with the knowledge to manage their personal surgical future, including: how to select a practice type and location; the mechanics of setting up or running a private practice; the essentials of an academic practice and how to guide your career; and surgical coding basics.

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# Chapter news

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by Rhonda Peebles, Division of Member Services

To report your Chapter's news, please contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at [rpeebles@facs.org](mailto:rpeebles@facs.org).

## Utah Chapter examines surgical technology

The Utah Chapter met in Park City last February. The theme for the education program was "What's new in surgical technology?" The keynote speaker was Ronald B. Hirschl, MD, FACS, Chair of the College's Committee on Informatics. In addition, a paper competition for Residents was conducted (see photo, this page). Winners included the following:

*First place:* Steve Granger, MD,\* Laparoscopic Treatment of Esophageal and Gastric Spindle Cell Tumors.

*Second place:* Peter Brant-Zawadski, MD,\* Split Abdominal Wall Flap Repair of Congenital Diaphragmatic Hernia.

*Third place:* Sarah Vogler, MD,\* Isolated Limb Perfusion for Recurrent Melanoma.

*Fourth place:* Brian T. Miller, MD, Black Thyroid Resulting from Doxycycline Use.

## Manhattan Council established

Last April, the Manhattan Council was formally established. The council will help facilitate the governance activities of the College as well as provide College members in Manhattan with opportunities to participate in advocacy and education programs. The Manhattan Council will be staffed and managed by the New York Chapter.

The newly elected leaders include the following: Chair: Arthur Cooper, MD, FACS; Vice-Chair: John E. Sherman, MD, FACS; Councilors: Mark Reiner, MD, FACS; Anthony Antonacci, MD, FACS; Eugene Nowak, MD, FACS; Victoria Teodorescu, MD, FACS; Soumitra Eachempati, MD, FACS; and Marina Kurian, MD, FACS; Governors: Dennis Fowler, MD, FACS; and Thomas H. Gouge, MD, FACS; Executive Director: Heather Bennett, JD.



Utah Chapter, left to right: Sean Mulvihill, MD, FACS, Chair, Department of Surgery, University of Utah; Courtney L. Scaife, Chair, Cancer Liaison Physicians; Dr. Miller; Dr. Vogler; Rebecka L. Meyers, MD, FACS, Immediate Past-President; Dr. Brant-Zawadski; Dr. Granger; and Leigh Neumeier, MD, FACS, Governor.

For information on or assistance with the Manhattan Council, contact Heather Bennett at 518/433-0397 or [Bennett@bennettfirm.com](mailto:Bennett@bennettfirm.com).

## South Texas Chapter presents resident competition

Last March, the South Texas Chapter conducted its education program, which featured a variety of topics, including 15 resident presentations. Barbara Bass, MD, FACS, a Regent of the College, presented the ethics lecture. The winning residents were as follows:

- *Basic Science:* James Suliburk, MD,\* Ketamine Attenuates Lipopolysaccharide-Induced Liver Injury: Role of COX-2.

- *Clinical Science:* Greg Muehlstedt, MD, Management of Ovarian Torsion in Children: Clinicopathologic Correlation.

## Results of India elections

Elections for new officers for the India Chapter were completed in April. The new officers include the following: Naresh Trehan, MBBS, FACS, President; T. K. Parasarathy, MBBS, FACS, Vice-

\* Denotes Resident Member.



Ohio Chapter: Mark A. Malangoni, MD, FACS (left), receives the chapter's Distinguished Service Award from E. Christopher Ellison, MD, FACS.

President; N. K. Pandey, MBBS, FACS, Secretary; and Rajiv B. Ahuja, MD, BS, FACS, Treasurer.

## General Assembly recognizes Ohio Chapter 50th anniversary

The Ohio Chapter received proclamations from the Ohio Senate and the Ohio House in commemoration of its 50th anniversary. Sen. Kevin Coughlin (R-Cuyahoga Falls) and Rep. Mark Wagoner (R-Toledo) made the presentations during the chapter's Annual Meeting in Columbus. Afterward, chapter members converged on the state capitol to meet with their legislators to discuss legislative proposals related to nonphysicians' scope of practice and mandatory arbitration for medical negligence claims.

During the annual business meeting, new officers were elected, and the chapter awarded its highest honor—the Distinguished Service Award—to Mark A. Malangoni, MD, FACS, current Ohio Chapter Governor and Past-President (see photo, this page). In addition, Thomas R. Russell, MD, FACS, the College's Executive Director, presented the chapter with its 50th anniversary commemorative charter.

Newly elected officers for the Ohio Chapter include John A. Howington, MD, FACS, Secretary; Michael E. Stark, MD, FACS, Immediate Past-



Indiana Chapter, left to right (all MD, FACS): Wayne E. Moore, President-Elect; Ralph W. Stewart, President; Bradford Barrett, Secretary-Treasurer; and David J. Carlson, Immediate Past-President.

President; Linda M. Barney, MD, FACS, Treasurer; Gary B. Williams, MD, FACS, President; and Brad L. Feldman, Executive Director.

## Indiana conducts competition

The Indiana Chapter met May 12-14 in Indianapolis to conduct its annual residents competition. The winners included the following:

*Willis D. Gatch, MD, Award: Carol Sheridan, MD.\**

*Leonard A. Ensminger, MD, Award: Kelly Mattix, MD.\**

*Carl H. McCaskey, MD, Award: Ben Tsai, MD.\**

In addition, new officers were elected (see photo, this page).

## Illinois Chapter honors Philip T. Siegert, MD, FACS

On May 20, the Illinois Chapter honored Philip T. Siegert, MD, FACS, by establishing the Fellows Service Award in his name. Dr. Siegert has been active in the Illinois Chapter for many years, and his father was a founding member. In addition, under Dr. Siegert's leadership, the College updated and published its standards for office-based and ambulatory surgical facilities. The award reads as follows:



Illinois Chapter, left to right (all MD, FACS): Daniel S. Johnson, President; Norman C. Estes, Governor; Max D. Hammer, Governor; Lynne M. Jalovec, Governor; James S. Gregory, Immediate Past-President; Lorin D. Whittaker, Jr.; and Raymond S. Ryan, Jr., Secretary-Treasurer.

*Whereas*, Dr. Philip T. Siegert through tireless and selfless dedication to the art and science of Surgery has exemplified the true spirit of Fellowship in the American College of Surgeons, and

*Whereas*, Dr. Siegert has served as a mentor to younger surgeons and through leadership positions at all levels from program chair for the Chapter meeting to Governor of the ACS has risen to the service of Fellows of the Illinois Chapter and the College at large, and

*Whereas*, Dr. Siegert has fostered collegiality and personal growth in a compassionate and lasting manner to the members of this Chapter, while maintaining a professional record of patient care that best exemplifies what is meant by Board Certification

The Executive Council of the Illinois Chapter of the American College of Surgeons by unanimous decree do establish in perpetuity the: Philip T. Siegert Fellows Service Award

To be awarded by the executive council of the Illinois Chapter on the occasion of a recommendation of a nominating committee comprised of the Current President, Past Presidents, and Governors.

## Chapter meetings

For a complete listing of chapter meetings, please see <http://www.facs.org/about/chapters/index.html>.

**(CS)** following the chapter name indicates a program cosponsored with the College for Category 1 CME credit.

**Lebanon**, Sept. 8-10, St. George's Hospital, Beirut. Contact: Michel Daher, MD, FACS, 961/158-1714.

**New Mexico**, Sept. 9, TBA. ACS representative: R. Scott Jones, MD, FACS, Director, Division of Research and Optimal Patient Care. Contact: J. Ralph Macfarlane, MD, FACS, 505/748-2314.

**Kansas**, Sept. 10-11, Capitol Plaza Hotel, Topeka. ACS representatives: Adrienne Roberts, Division of Health Policy and Advocacy, and Rhonda Peebles, Division of Member Services. Contact: Harold Riehm, 785/234-3319.

**Kentucky**, Sept. 16, Hyatt Regency Louisville. Contact: Cindy Thoene, 10207 Garlanreid Pl., Louisville, KY 40223; 502/629-3538.

**Arkansas**, Sept. 17, Embassy Suites, Little Rock, AR. Contact: Linda Clayton, 505 Waterford Dr., North Little Rock, AR 72116; 501/526-7053.

**Georgia**, Sept. 17-18, The Cloister, Sea Island. Contact: Lois Stell, 912/925-8969.

**Turkey**, Sept. 17-18, Istanbul University. Contact: Cemalettin Topuzlu, MD, FACS, 90-212-347-6300.

**San Diego (CS)**, Oct. 3, TBA. Contact: Jim Cox, Box 33116, San Diego, CA 92163-2116; 619/579-2946.

**Connecticut**, Nov. 2, Sheraton Four Points, Meriden. ACS representative: Bruce Browner, MD, FACS. Contact: Christopher Tasik, 203/674-0747.

**Massachusetts (CS)**, Nov. 19, Dedham Hilton Hotel, Dedham, MA. ACS representative: R. Scott Jones, MD, FACS, Director, Division of Research and Optimal Patient Care. Contact: Aurelie Alger, JD, 900 Cummings Ctr., Ste 221-U, Beverly, MA 01915; 978/927-8330.

## Chapter anniversaries

Month	Chapter	Years
<b>July</b>	Southwest Missouri	53
	New Jersey	54
	Keystone (PA)	53
	West Virginia	55
<b>August</b>	Georgia	55
	Hawaii	54
	Illinois	55
	Brooklyn-Long Island, NY	55
	Northwest Pennsylvania	55
	Rhode Island	53