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Future meetings

Clinical Congress
2006 Chicago, IL, October 8-12
2007 New Orleans, LA, October 7-11
2008 San Francisco, CA, October 12-16

Spring Meeting
2006 Dallas, TX, April 23-26
2007 Las Vegas, NV, April 21-24
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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The theme of the 91st annual Clinical Congress, which took place October 16-20 in San Francisco, CA, was “Education for the Spectrum of Surgical Practice,” and I believe the program did, in fact, offer attendees a broad range of learning opportunities. Furthermore, the sense of looking toward the future as a diverse yet united surgical force was more obvious and acceptable this year than ever before.

Convocation

As has been the case for the past two years, this Congress began with the Convocation, which, of course, included the induction of new Fellows, the conferral of Honorary Fellowships, and the installation of Officers. Approximately 1,325 surgeons were officially welcomed into Fellowship this year, and three world leaders in the profession were accorded Honorary Fellowship. You will find the citations delivered for each of these remarkable individuals on pages 32-35 of the November Bulletin.

First woman president

A real high point of the Convocation and for this organization was the installation of Kathryn D. Anderson, MD, FACS, of San Marino, CA, as the first woman President of the College. This milestone signifies the College’s ongoing commitment to becoming an ever more inclusive organization. (See photo, page 5.)

Dr. Anderson has indicated that she would like her presidential term to be remembered as the year of humanity. In light of the disasters that beset this country and other parts of the world this year, now seems to be a particularly appropriate time to stress the humane practice of surgery. We intend to emphasize the opportunities that Operation Giving Back provides for surgeons to reconnect with what it really means to serve those in need and the ethical delivery of care.

Web portal test

We are excited that many surgeons took part in beta testing for the College’s Web portal, e-FACS.org, and training in the use of the ACS case log system. Surgeons who visited the ACS Web portal and Case Log Training Center were able to experience first-hand e-FACS.org, the College’s robust, interactive information resource. (See photo, page 6.) This secure, single sign-on service will be the entry point of access to organized Web information emanating from the College and other reputable sources. Individuals who participated in the beta test were able to visit online communities for the surgical specialties as well as those centered on specific interests, such as minimally invasive surgery, the history and philosophy of surgery, transplant surgery, rural surgery, and so on. They also had a chance to learn about the electronic tools that will be available through e-FACS.org, including discussion forums, news feeds, and a system for calculating and tracking continuing education credits.

Meanwhile, surgeons learned how the ACS case log system will help surgeons monitor their outcomes and benchmark this information with risk-adjusted outcomes data and best available evidence to identify gaps in performance and areas for improvement.

Programming

As always, individuals who attended this year’s Clinical Congress had the opportunity to participate in named lectures, skills-oriented and didactic postgraduate courses, general session panels, specialty and multidisciplinary sessions, the Surgical
Forum, and video-based education programs. In this era of changing expectations regarding maintenance of certification, the College recognizes the necessity of providing surgeons with accredited educational programs, and attendees at this year’s meeting were able to amass up to 48.5 Category 1 continuing medical education credits.

As always, we were fortunate to have some of the foremost surgical leaders of the time deliver named lectures. We were particularly pleased to have Michael D. Maves, MD, FACS, executive vice-president and chief executive officer of the American Medical Association (AMA), present the American Urological Association Lecture. (See photo, this page.) Dr. Maves spoke on Branding Medicine, an issue of growing interest to the medical community, and his participation demonstrates the College’s continuing success in building bridges with the AMA.

The meeting included sessions on cutting-edge clinical and scientific issues, such as stage modalities for lung cancer, stem cell applications, and treatment options for gastroesophageal reflux disease. A number of general sessions also examined nonclinical issues of relevance to surgeons, such as professionalism, teamwork, leadership, the safe use of new technology, the surgical workforce, medical liability, and quality improvement.

We presented 17 didactic and 22 skills-oriented postgraduate courses this year. We also presented “classic” videos from previous Clinical Congresses, which clearly showed the amazing achievements of some of the giants in surgery from the last century.

**Special programs**

We once again presented special programming for medical students and residents during the Clinical Congress. The Medical Student Program featured outstanding surgeon speakers who addressed such topics as surgical career options, the next generation of surgery, the path toward residency, the future of surgical training, and ACS resources for medical students. The Surgery Resident Program focused on “essential skills for surgical practice.” Among other topics, this program showed residents how to manage stress, decrease liability exposure, negotiate a job, and get out of debt. (See photo, page 6.)

In addition, the Resident and Associate Society continued its tradition of sponsoring a symposium during the Clinical Congress. This year’s presentation, Truncated Training for the Surgical Resident—The Future or Fallacy?, examined how abbreviated surgical training might affect residents, training programs, and patient care.
The College offered beta testing for the Web portal and the case log system in the convention hall.

Medical Student Program participants gathered outside the Moscone Center for a photo during the Congress.
Happy Birthday JACS!

This year marked the 100th anniversary of the publication now known as the *Journal of the American College of Surgeons* and originally called *Surgery, Gynecology & Obstetrics*. In observance of this notable occasion, this year’s Clinical Congress presented Centennial Symposium: Cherishing the Past, Shaping the Future. During this program, we honored the role of Franklin Martin, MD, FACS, who developed the journal and founded the American College of Surgeons. Seymour I. Schwartz, MD, FACS, Emeritus Editor of *JACS*, moderated the symposium, which included prominent members of the medical publishing field. (See photo, this page.)

What do you think?

I believe this year’s Clinical Congress offered practicing surgeons in all specialties a range of educational opportunities that will help them to meet the challenges they face today and prepare for a future focusing on the core competencies that have been adopted by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. In addition, the Clinical Congress provides an excellent opportunity for many committees of the College to meet, for groups allied to the College to hold meetings, and for many auxiliary groups to hold receptions and other functions. If you attended this year’s Congress, let us know if you agree with this assessment as well as what you think we could be doing differently. If you didn’t attend, we’d appreciate your input regarding what we could do to guarantee your participation in the future. It is only through your identification of contemporary surgeons’ needs that we can sustain our forward momentum.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
Congressional hearing on P4P and Medicare cuts

At press time, Congress was continuing to debate legislation that would implement pay for performance (P4P) for physician services provided under Medicare. For example, the House Ways and Means Subcommittee on Health held a hearing September 29 on H.R. 3617, the Medicare Value-Based Purchasing for Physicians’ Services Act of 2005. During the meeting, Mark McClellan, MD, PhD, Administrator of the Centers for Medicare & Medicaid Services (CMS), stated that the agency is moving forward with efforts to implement quality reporting measurements for physicians, beginning as early as January 1, 2006. These measures would serve as a basis for P4P for physicians. In response to questions about averting the projected 4.4 percent in cuts to Medicare physician payments between 2006 and 2011, Dr. McClellan expressed uncertainty about CMS’ authority to make regulatory changes that would remove Part B drug expenditures from the sustainable growth rate (SGR) component of the formula used to calculate physician payments. Although removing Part B drugs from the SGR would not stop a payment cut in 2006, it would allow Congress to avert reductions in subsequent years. Rep. Nancy Johnson (R-CT), Subcommittee Chair and lead sponsor of H.R. 3617, and Rep. Mike Thompson (D-CA) voiced concerns about the potential effect of the cut in physician payments on access to care.

H.R. 3617 would avert the reimbursement cuts in 2006 and beyond by repealing the SGR and implementing P4P based on quality improvement efforts such as the Surgical Care Improvement Project (SCIP) and the National Surgical Quality Improvement Program. The College supports this sort of legislation.

ACS comments on 2006 fee schedule proposal

The College submitted comments to CMS September 30, addressing a proposed rule regarding the Medicare physician fee schedule for 2006. In its letter to Dr. McClellan, the College expressed disappointment with the agency’s continued failure to propose any steps to alleviate the projected –4.4 percent update to the conversion factor used to calculate payment under the physician fee schedule. The College believes that the agency does, in fact, have some discretion in determining the update factors and strongly recommends that CMS consider changes in the way it estimates spending increases under the fee schedule.

In addition, the College recommends delaying implementation of CMS’ proposed practice expense relative value units for 2006 until enough data and information are available to allow the public to adequately review and assess the validity of the new methodology. The College also questions some of the agency’s proposals related to liability relative value units and voices its support for CMS’ proposal for a new multiple-procedure reduction for the technical component of certain radiology services. The ACS, however, opposes continuation of an oncology demonstration project on the grounds that this effort is inconsistent with current attempts to develop evidence-based medicine. The College’s comments are posted at http://www.facs.org/ahp/views/medicare2006.html#1.
CMS continues development of quality efforts

CMS and the Hospital Quality Alliance have added two measures for preventing postoperative infections, as well as a value for treatment of pneumonia, to the Hospital Compare Web site. The first two measures are part of a larger set of patient safety measures that will be collected as part of SCIP. SCIP—developed in collaboration with federal agencies, hospitals, and surgical organizations, including the College—is designed to improve patient safety and reduce by 25 percent the incidence of postoperative complications in U.S. hospitals by 2010. Hospital Compare is intended to serve as a tool for patients to use in assessing the quality of care provided at their local hospitals. The Hospital Compare Web site is located at http://www.hospitalcompare.hhs.gov.

In addition, CMS is soliciting proposals for the Medicare Health Care Quality Demonstration, a five-year study to discover means for identifying, developing, testing, and disseminating health care system improvements at the local or regional level. The goal is to provide support for health care organizations and their communities to adopt and use decision-support tools, such as evidence-based guidelines, to reduce practice variations, measure outcomes, improve quality, and reduce costs. Physician groups, integrated delivery systems, and regional coalitions of such groups or systems are invited to apply to participate by submitting a proposal by January 30, 2006. For further information, visit http://www.cms.gov/researchers/demos/mma646/.

Health information commissioners selected

U.S. Department of Health and Human Services (HHS) Secretary Mike Leavitt has selected 16 individuals to serve on a federally chartered commission to advise him on creating digital and interoperable health information. The American Health Information Community has been established to help achieve President Bush’s goal of having most Americans using interoperable electronic health records within 10 years. The HHS Secretary will chair the commission, composed of ranking members of related federal agencies as well as businesses and associations that represent the interests of health care and the information technology industry. For more information, visit www.hhs.gov/healthit.

DMLR launches new education campaign

On October 6, Doctors for Medical Liability Reform (DMLR) launched a new public education initiative. The interactive, grassroots campaign involves an animated e-mail messaging and direct-mail campaign aimed at engaging the public in the issue of liability reform. DMLR is a coalition of nine medical and surgical specialty organizations, including the American College of Surgeons Professional Association. The first animated e-mail message and further information are available through DMLR’s Web site, at www.protectpatientsnow.org.
Presidential Address:

Crises in humanity

by Kathryn D. Anderson, MD, FACS, FRCS,
San Marino, CA
Editor's note: Dr. Anderson delivered this Presidential Address on October 16 at the Convocation in San Francisco, CA.

Some years ago, the leadership of the American College of Surgeons made a conscious decision to become what was termed “gender neutral.” This involved some changes over past practices and the appointment of many women to leadership positions, committee chairs, and the development of a governor position from the Association of Women Surgeons. I believe that the epitome and success of that resolution has resulted in my standing before you tonight as the first woman President of the American College of Surgeons. This is a landmark for the College and the greatest personal honor for me. I look forward to the time when having a woman President will no longer be remarkable.

Each year, the President of the College has chosen a theme for the year. This past year, the theme was “unity among surgeons,” chosen by Edward Laws, MD, FACS. I have chosen “humanity” for this year and for a very specific reason. I believe that medicine today, and especially surgery, is experiencing a crisis in humanity. We do not seem to be any longer in charge of our work, our patients, or even of ourselves. Government intrusion, unfunded mandates, loss of public confidence, and many other factors have combined to separate us from our patients and have made some of us question our own worth and humanity.

You have just been inducted into Fellowship of the largest and most prestigious association of surgeons in the world, and you must be part of the solution to the present crisis in humanity. This is one of the most important days of your lives. Years from now, you will not remember who was President on this day, but you will never forget the day itself. So, before you leave and justly celebrate your great achievement and your “arrival” into the surgical elite, let me guide you briefly through several crises in humanity that surgeons have experienced over the last two centuries and the solutions that were developed. I will finish with what I consider are the present-day crises and suggest some solutions.

Operative pain

Imagine, if you can, what it would be like to have to do an operation, no matter how simple, with four strong men to hold down your patient. Never mind how difficult it would be to work around four assistants, nor how impossible it really would be to keep a patient still enough for you to be able to work well—it would be extremely difficult to ignore the inevitable screams and know that you were provoking those screams. Although surgeons were held to be a callous lot for just these reasons, the types of operations that could be done in these awful circumstances were severely limited, and surgeons must have been emotionally tried each time they had to inflict pain. As a result, the best surgeons were those who could operate quickly, such as amputating a leg in less than 30 seconds. Patients would go to a surgeon only as a very last resort, which meant that diseases would be in a very advanced state. So you can understand that when Dr. John Collins Warren at the Massachusetts General Hospital (MGH) was told about a miracle sleep that rendered the operation pain free, he was willing to try the new technique. This came to be called anesthesia.

In 1772, the English chemist J.B. Priestley discovered nitrous oxide. His assistant noted its ability to mitigate physical pain and commented that, “It may probably be used with advantage during surgical operations.” He never pursued this idea. Seventy years later, both nitrous oxide and ether were being used at parties for the purpose of “getting high” and several observers noted that participants could injure themselves during the frolics without apparently feeling pain. Dr. Crawford Long, in a small village in Georgia, was the first to use this effect for surgical procedures and he had done eight operations before Dr. William Morton, a dentist in Boston, approached the MGH surgeons about using ether on their patients. He knew nothing of Crawford Long’s work, since Dr. Long did not publish his work until later. Dr. Warren agreed to have Dr. Morton demonstrate on one of his patients. He explained to his audience on the morning of October 16, 1846, that he had long wished for something to alleviate his patients’ pain. To the utter astonishment of everyone in the amphitheater, a tuberculous node was removed from the patient’s neck, without a
sound from the patient. Dr. Collins is said to have had tears in his eyes when he said: “Gentlemen, this is no humbug.”

The practice caught on very quickly. In England, that remarkable lady, Queen Victoria, delivered her fourth son while under chloroform anesthesia; thus was anesthesia established in England.

It was unfortunate that the early pioneers of the use of anesthesia were involved in tragic arguments as to whom the credit should go for its invention. But the humanitarian crisis was alleviated nonetheless, not only in terms of allowing operations to be done without pain to the patient and resulting distress to the surgeon and observers, but also from the fact that more and longer operations could be tackled, and patients were more likely to seek help in earlier stages of their disease.

Sepsis

Since death from sepsis is a relative rarity in these modern times of antibiotics and aseptic practices, it is hard to imagine the horror of the mortality from infection that followed open fractures, childbirth, and even clean surgical procedures. But a young Hungarian surgeon named Ignatz Semmelweiss, in his first job as assistant in a delivery ward in Vienna, was distressed by the huge mortality rate of recently postpartum women. In contrast, the adjacent ward, run by nurse midwives, had a very low mortality rate. The difference? There were no medical students to examine the nurses’ patients. Coming directly from the autopsy room, these students, and Dr. Semmelweiss himself, handled infected tissues from women who died of puerperal fever and then examined women in labor without any cleansing of their hands or clothes in between. The more Dr. Semmelweiss sought the answer to this difference by more diligent autopsies, the worse the problem became. He became severely depressed having to watch helplessly as the women died, leaving behind a newly born infant to be cared for by a grieving husband. The senior surgeon felt that his anxiety was affecting his work, and Dr. Semmelweiss was sent on leave to recover his equanimity.

When he returned, he found that his physician friend had cut himself during an autopsy on a dead mother and had died, with findings at autopsy identical to those of puerperal fever. Dr. Semmelweiss guessed that puerperal fever was being transmitted from the septic tissues of the dead to the live women in labor, so he began to do something revolutionary: he washed his hands!

He instituted hand washing in his ward, using chlorine water, and the mortality of puerperal fever dropped precipitously. It rose again briefly when the medical students, contemptuous of their irascible teacher, did not wash in between patients. This sounds horrible—but how many times have you all observed surgical residents on rounds in the morning, examining one patient after another without washing their hands in between, or even been “too busy” yourselves?

The crisis appeared to be solved, but Dr. Semmelweiss was not only ignored by his colleagues but vilified. He went insane and died of puerperal fever—or streptococcal sepsis, as we now recognize it—after cutting his finger, perhaps deliberately.

More than a decade after Dr. Semmelweiss’ death, Koch and Pasteur, a pathologist and a chemist, showed that minute organisms were responsible for infection and demonstrated these organisms in the tissues of women who had died of puerperal fever.

An individual who was aware of both Semmelweiss’ work and that of Koch and Pasteur was Joseph Lister in Edinburgh. He became very distressed by the 45 percent mortality in cases of open fracture. One day in 1865, he discussed this with a friend during a walk that led them past open fields where human waste was used as manure. An absence of the feculent smell jogged his memory that carbolic acid was sometimes used to decrease the obnoxious odor of sewage. He postulated that perhaps carbolic acid would eliminate the purulence that accompanied most cases of open fractures. He embarked on clinical experimentation to test his theory that carbolic acid would kill the bacteria that Koch had described, using dressings soaked in carbolic acid. The mortality of his patients, even with severe open wounds, fell to zero. He then developed an apparatus that could be filled with the antiseptic. The spray was then used in the operating theater, filling the air with a mist of carbolic acid. He was mistaken in thinking that the bacteria came only from the air, but the effect was revolutionary. The method was quite widely adopted in the surgical world and led to a huge surge in the numbers of
operations that could now be done with a successful outcome.

This solution of the crisis of infection eventually led to the practice of asepsis, when it was recognized that bacteria came not just from the air but from the hands, clothes, hair, and breath of surgeons and observers in the operating theaters. And so caps, gowns, and masks began to be used. The story of Dr. William S. Halsted’s invention of rubber gloves to protect his fiancée’s hands from the irritating acid is well known. The advent of steam sterilization extended asepsis to instruments, but even today, antisepsis, according to the tenets of Dr. Lister, is still widely practiced in wound care and in the sterilization of instruments that cannot be heated.

Dr. Lister, unlike Dr. Semmelweiss, who he acknowledged as his forerunner, was recognized for his achievements and became a baron, the first medical man in England to become a peer. It probably did not hurt that he used carbolic acid in the treatment of an abscess he lanced in the axilla of that very progressive English lady whom I have already mentioned, her majesty, Queen Victoria! As Lord Lister said toward the end of his life: “As I esteem the honours which have been conferred on me, I regard that all worldly distinctions are as nothing in comparison with the hope that I may have been the means of reducing in some degree the sum of human misery.”

Trauma: From Antietam to Vietnam

It is almost axiomatic that war represents one of the worst crises of humanity. The horrors were often ignored in the glory of military supremacy, from the ancient Romans to the British triumph at Waterloo over the French. But the Civil War
will rank in American history as one of the worst crises, in which families were divided, brother fought brother, and many more men died of disease than were killed in battle. In addition, the “surgeons,” especially in the southern states, were largely untrained rural practitioners who acquired their surgical skills on the battlefield. At the time of the Civil War, anesthesia for surgical procedures was in pretty general use. The war had ended, however, before Dr. Lister described his antiseptic principles, and so deaths from gangrene and sepsis were distressingly common. The wounded lay around the battlefield for days and because bullets flattened on impact, they carried large amounts of clothing and debris into wounds. This led to gross contamination and almost certain infection. Amputation of limbs was common. In the early war years, operations were carried out in makeshift tents and there were no hospitals to take care of patients.

During and immediately after the war, there were several responses to these appalling conditions, with the establishment of a U.S. Sanitary Commission. Surgical qualifications were defined, hygiene and chains of supplies were improved, and an ambulance service was developed. The building of field hospitals was begun by Jonathan Letterman in 1862. Medical records were kept of the wounded, and after the war was ended, Samuel Gross developed military surgical manuals.

By the First World War, the germ theory was widely known and asepsis was established as perhaps more important than antisepsis. The “golden hour” of dealing with injuries had been elucidated and so field stations for immediate treatment of casualties were developed inside the trenches. Hospitals were often makeshift but were established away from the front. Many amputations were still carried out but it was recognized that infection was more likely in wounds that had damaged tissue left in place. Debridement of devitalized tissue was stressed, especially since the bullets and shrapnel had much more destructive power. The trenches of World War I were dug in the highly manured, long-cultivated fields of Flanders, so that asepsis was almost impossible. Antisepsis was carried out with much less toxic irrigating solutions such as Dakin’s solution. The responses to the crisis included trench first aid stations, hospitals to the rear of the action, motorized ambulances, and debridement and irrigation of tissues.

World War II produced a whole new series of crises. The character of war had changed. Missiles were of much higher velocity; airplanes were in constant use and were shot down with high-powered ammunition, resulting in frequent fires fueled by gasoline. This meant that survivors of a crash would not only have extensive shrapnel damage but were often also badly burned. Skin grafting and reconstructive procedures for disfiguring burns and facial and hand wounds were developed.

Soldiers did not go on forced marches over long distances as in previous wars, but were carried to battle sites in cars, tanks, and airplanes. This meant that they were in better physical shape if they were wounded. The “front” was also mobile, so hospitals had to be mobile also. Efficient ambulance services were developed and rear hospitals were much more highly organized with qualified surgeons and hierarchies. For example, Dr. Edward Churchill from the MGH was the chief consultant in the European theater, and there were senior consultants in various specialties such as neurosurgery. Fixed wing air transport was used to evacuate the wounded after initial treatment and surgery.

Penicillin was beginning to be manufactured, so anesthetic and antiseptic practices were supplemented with the administration of this drug. In short supply at the beginning, it was adequately supplied by the end of the war.

It may surprise some of you to learn that abdominal surgery had never been performed in previous wars. It became routine during World War II and the principle of using diverting colotomy after suture of colonic wounds also became established. Amputation became a last resort although rates of 49 percent were recorded if blood vessels were damaged.

One of the most significant advances in surgery was the recognition of the phenomenon of shock and its treatment by fluid and blood administration. There is no doubt that the war accelerated the use of blood and the establishment of blood banks by such luminaries as Charles Drew, MD, FACS.

Advances during the Korean War were numerous. With helicopter evacuation a new phenomenon
emerged, and in sophisticated mobile army surgical hospitals (so-called MASH units), soldiers received definitive treatment within four to six hours of being wounded. Frank Spencer, MD, FACS, a Past-President of this College, responded to the military order left over from World War II—that injured vessels must be ligated—by simply ignoring the order. He explained to me, “I risked a court martial if repairing injured arteries didn’t work and accolades if it did.” He got the accolades and his techniques “spread like wildfire” across Korea. The amputation rate fell to 13 percent. The amount of fluid and blood for resuscitation was recognized to be far greater than the actual amount lost and blood was available in unlimited amounts. Renal failure was treated by dialysis. The treatment of burns, by the efforts of Curtis P. Artz, MD, FACS; John A. Moncrief, MD, FACS; and Basil A. Pruitt, Jr., MD, FACS, advanced to very sophisticated levels.

In the 1960s, the war in Vietnam began. This was a very unpopular war and had no glory to it. This led to another kind of crisis for surgeons who were posted to Vietnam to take care of the wounded. Perhaps the futility and horror of war were exemplified much more clearly than at any time before. The responses of surgeons to these crises, however, led to spectacular advances in the treatment of trauma—among them were things we take for granted today: the establishment of trauma centers in military and then also in civilian life; the description and treatment of “shock lung,” aka adult respiratory distress syndrome; and the use of Ringer’s lactate in high volumes for resuscitation and the concomitant use of large bore catheters. The wounded reached definitive care within 90 minutes of injury 85 percent of the time, and they could expect repair not only of injured arteries but also veins with only 5 percent mortality and further reduction of the amputation rate.

In order to establish the efficacy of repairing arterial and venous injuries, a vascular registry was developed by Norman Rich, MD, FACS, of the Uniformed Services University of Health Sciences. One thousand repaired vascular injuries have been followed long term, a monumental study of outcomes.

The industrialization of medicine

So what does all this have to do with the present-day practice of surgery? What are the crises that beset us now, and what can we do to avoid succumbing to disappointment in our chosen profession? What do I mean by the industrialization of medicine?

Our senses may be dulled by the trivialization of murder and mayhem as exemplified by television and movies. Are we coming full circle with the first surgeons who had to ignore their patients’ cries in order to be able to treat them with painful procedures?

Today there is less and less “hands-on” care. We can make sophisticated diagnoses and difficult decisions without touching our patients, let alone caring for them as individuals. We have become so superspecialized of necessity that we view patients as multiple compartments and keep strictly to our own small area of expertise. There is a concomitant
perception by society that an adverse outcome is a “mistake”; this makes us justifiably concerned about litigation and we practice preventive medicine as a result, adding to the separation from our patients and to the cost of medicine. The public also demands the ultimate in diagnostic technology and the very latest in treatment modalities without being willing to pay for these. We ourselves are unwilling to consider rationing medical care. So we have decreasing reimbursement, more unfunded mandates, and falling incomes, yet we are working harder than ever. In spite of this, there is still the public belief that doctors are all rich and that it is somehow immoral to be adequately compensated for our work. In the words of the late Alexander J. Walt, MD, FACS, a Past-President of the College: “we have a public greatly impressed by our technical achievements but disgruntled by what they regard as our careless, callous, thoughtless, or even absent psychosocial sensitivities.”

But let’s stop for a minute and define the real problem. I believe it is this: there is less and less of an outlet for the charitable desire to truly serve our patients. We need to work harder and more efficiently in order to make ends meet and therefore spend less time with each patient. We must deal with more and more bureaucratic mandates, which we don’t necessarily believe enhance patient care. And this is frustrating.

So what are my suggested solutions for this present-day crisis in humanity?

Never forget why you went into medicine in the first place. You can’t always be clever, but you can always be kind. Remember the Fellows Pledge you just recited with John Gage, MD, FACS, ACS Secretary: “...I will place the welfare and rights of my patients above all else. I promise to deal with each patient as I would wish to be dealt with if I was in his position.” There are no unimportant acts of kindness and we, as well as our patients, will be the beneficiaries.

Be a joiner. You are now fully fledged Fellows of the College. Follow some of the initiatives in which the ACS is involved, and actively contribute to these activities. Believe me, you can make a significant contribution.

• Participate in ethics seminars, both at the Clinical Congress and in your local communities.
• Be active at state and federal levels with patient advocacy and safety; the College is active in these areas both through the Washington Office and in Chicago. Join your local chapter and be active in its programs.
• Work for medical liability reform; again, the ACS plays a leadership role in this, but we need Fellows to be locally involved in their chapters and in their state and local governments.
• Take the new “Surgeons As Effective Communicators” course, which was launched in May this year. Participants receive extensive training in communication techniques. They are expected to be leaders in their communities to help improve communications with patients, their colleagues, and the public.
• Learn about Operation Giving Back. This is a College initiative spearheaded by Andrew Warshaw, MD, FACS, outgoing Vice-President, which is now run full-time by Kathleen Casey, MD, FACS. Operation Giving Back coordinates many different ways in which surgeons can donate their time to those in need, both nationally and internationally, as exemplified by the Fellows’ response to the recent hurricanes in Louisiana, Alabama, Mississippi, and Texas. You can reach the Operation Giving Back Web site from the ACS Web site at www.facs.org.

Just as the response of past surgeons to humanitarian crises of their day led to advances in the care of patients, by giving of your time and your heart, you will not only help to advance the humane practice of surgery, but you will also reap the rewards of belonging to the greatest humanitarian profession in the world.

Dr. Anderson is professor emeritus, Keck School of Medicine, University of Southern California, Los Angeles, and President of the College.

[Portrait of Dr. Anderson]
Medical liability litigation as a disruptive life event

by Sara Charles, MD, Chicago, IL

Litigation is predictably stressful for surgeons. Our natural responses often compromise all aspects of our lives as well as our performance in the litigation process. To assist us in avoiding these consequences, Sara Charles, MD, professor of psychiatry (emerita) at the University of Illinois at Chicago College of Medicine, and Paul R. Frisch, JD, general counsel for the Oregon Medical Association, provide us with insight and direction for dealing with these complex emotions in a recent publication, Adverse Events, Stress, and Litigation: A Physician’s Guide. The article by Dr. Charles that follows is a glimpse into the content of this important book. For comprehensive information on this subject, surgeons may also access the Physician Litigation Stress Resource Center at http://physicianlitigationstress.org.

—F. Dean Griffen, MD, FACS, Chair, ACS Patient Safety and Professional Liability Committee
“This was the most disruptive experience of my life. I feel I am better after it but only because I decided I could be bitter or better, and I chose the latter…” —Anonymous surgeon

Disruptive:
to upset the order of; throw into confusion or disorder; from the German rupja, meaning “to rip” or “to snatch.”

The disruption physicians feel under the impact of an adverse event or being sued motivates us to unearth the roots of these feelings so that we may examine them carefully. What we learn tells us what we can and cannot control to clear our heads and restore order in our lives. The experienced surgeon quoted at left had tried unsuccessfully to save a six-year-old boy who had sustained head trauma after an automobile accident. He was subsequently sued, along with the driver of the automobile, and charged with “wrongful death.” This surgeon offers a model for responding to an event that he not only experienced as traumatic but which he transformed, by his decision to be “better” rather than “bitter,” into a life-changing opportunity.

Adverse Events, Stress and Litigation: A Physician’s Guide (Oxford University Press, 2005. ISBN 0195171489) advocates this approach by exploring the human reactions to serious adverse medical events and the lawsuits that may result from them. Through a series of interviews with physicians and patients, this book tracks the emotional and legal impact of these experiences and offers practical and supportive advice to those similarly affected.

Paralleling these goals of the surgeon, the book encourages physicians to take an active role in their defense and supports their efforts to become informed and to avail themselves of the support of family members and colleagues during the lengthy litigation process. Its guidelines help physicians cooperate more fully with their legal and insurance counsel in order to become more effective and, hopefully, more successful defendants.

The roots of disruptive feelings
Two key factors contribute to physicians’ feelings prompted by the litigation experience: the impersonal nature of tort law and the highly personal, obsessive-compulsive personality features most physicians demonstrate. A tort, in contrast to a criminal complaint, is a perceived wrong in which the plaintiff must allege and prove negligence in order to obtain compensation. Obsessive-compulsive personality features include a preoccupation with orderliness, perfectionism, and mental and interpersonal control, along with an excessive devotion to work and productivity. These two factors converge in medical liability
cases when a charge of negligence is made. The interplay between these factors profoundly affects physicians’ thinking and behavior. As stated in *Adverse Events*:

Under the impact of a lawsuit, these characteristics may morph into exaggerated and destructive tendencies: Where we once appropriately considered options, we are now obsessed with immobilizing doubts; where we once felt guilty over falling even slightly short of a standard, we are now morbidly self-critical; where we once exercised an exaggerated but controlled sense of responsibility, we now condemn ourselves for not managing circumstances well beyond our control. By eroding our self-confidence these distortions make us miserable. Such a state of mind on our part is exactly what the plaintiff attorneys hope for and depend on: they want us to doubt our competence and to feel guilty and personally responsible, even if we are not, for whatever happened.

**Understanding the sued physician**

The key to mastering any traumatic experience is readiness to explore the emotions associated with it, to organize it intellectually to deepen understanding of it, and to correct any possible distortions about it that may be harbored.

Physicians’ personality characteristics and individual life history strongly influence their reactions to a bad outcome or a lawsuit. Even if a physician has multiple experiences with lawsuits, each one remains unique and demands a different response. Most physicians experience the accusation of fault as an assault on their sense of integrity. When physicians pride themselves on competence and dedication, this painful allegation of failure to meet the standard of care is profoundly disruptive. One cannot begin to address and control these feelings until identifying their roots, naming them correctly, and acknowledging the threat they pose.

Sued for the first time near the end of his career, an internist experienced his first episode of atrial fibrillation the day after the complaint was filed and poignantly describes his feelings in *Adverse Events*:

I had guilt about being involved in a case like this. An individual prides himself on his clinical acumen and his attention to detail. It’s a blow to the image I had of myself, my code of behavior that I tried to live up to. I’m sure I didn’t always do it but I tried to live up to that word (honor) in that the patient who came to me could put his trust in me and I would be his advocate and always try to act in his or her best interest. That was the image that I wanted to convey and also the image that I wanted not only my patients to come away with but also my colleagues that I worked with in the community. It was my impression that I was generally thought of as an honorable person upon whom you could rely and who tried to do a good job.

His lawsuit disrupted his self-concept and prompted him to review objectively his competence and motivations. The lawsuit challenged his healthy narcissism and his self-ideal—that he was a good, caring, and beneficent person who placed the care of patients above his own self-interest. He felt offended and misunderstood. The feelings of guilt, shame, and humiliation with which physicians often react may prompt them to protect themselves by avoiding contact with their colleagues and withdrawing from some of their routine activities. Instead of wallowing in negative feelings and avoiding others, this internist reevaluated his practice, actively rededicated himself to his work, and made changes in his work environment that restored some feelings of control.

Litigation also probes the need for self-preservation. Physicians ordinarily feel devastated both by the patient’s terrible outcome and by the charge of negligence that follows. After being accused of allegedly having made discriminatory remarks, CBS commentator Andy Rooney uttered words with which many physicians can identify: “It is not clear to me whether I have been destroyed or not, but I know that a denial from anyone does not carry anywhere near the same weight as an accusation.” A lawsuit threatens physicians with many potential losses—loss of reputation, time, patient base, affordable liability insurance—and the potential of financial uncertainties that may lead to closing one’s practice or retiring prematurely.

“The loss of trust in others” is identified by psychiatrist Jonathan Shay, MD, PhD, as the “deepest danger” associated with any traumatic event. An
adverse event or lawsuit may disrupt relationships with formerly trustworthy patients along with those colleagues, staff, and even family members who do not understand one’s reaction. A formerly satisfied patient may become accusatory; once trustworthy colleagues may become mildly suspicious and distance themselves; and the system that accepted the physician and in which he or she fit well may become blaming and withdraw support. Physicians who experience this outcome must recognize and acknowledge these feelings of isolation and loneliness if they are to mend these relationships so central to productive work.

**Putting the experience into perspective**

Bad outcomes regularly occur in the human condition and often in medical practice in particular. Physicians recognize that, despite their best efforts, unexpected complications and even errors can occur, and it is normal to react emotionally to them. Their transformation into lawsuits, in the words of an obstetrician-gynecologist quoted in *Adverse Events*, “just prolongs the agony.”

How many of these adverse events actually precipitate a lawsuit? Sometimes those that seem to bristle with the threat do not; sometimes those events that seem minimally dangerous become major lawsuits. Localio and his group estimate that there are 7.6 adverse events caused by negligence to every liability claim. Matching medical records and medical liability claims, however, revealed that the number of adverse events caused by negligence that actually led to claims was 1.53 percent. This difference is explained by the fact that most events for which claims were made in this study did not meet the researchers’ criteria for negligence. The work of Brennan and the earlier work of Danzon suggest that the severity of injury, rather than any suggestion of negligence, is a central factor in filing a liability claim. This explains why specialty looms large in the claims vulnerability of physicians: surgeons and obstetrician-gynecologists are far more likely to work with patients who sustain serious permanent injuries and death than are pathologists and psychiatrists.

The popular culture readily assumes that physicians involved in catastrophic medical events and/or those sued for medical liability are bad or negligent doctors. Two data sources put the results of this perception into perspective. According to an American College of Obstetrician Gynecologists 2003 survey, 76.3 percent of its members had been sued at least once and can expect an average 2.64 medical liability claims during their careers. The Physicians Insurers Association of America’s national claims database of more than 40 member physician-owned insurance companies—which closed 184,950 claims between 1985 and 2003—found that 69.9 percent were closed in the defendant’s favor (63.3% were closed without payment; 5.4%, in a defendant’s verdict at trial; and 0.2%, a defendant’s favor at mediation).

The primary goals of the medical liability system are compensation for those injured in the health care system and the deterrence of poor medical care. Few critics of the tort system believe that these goals are currently being achieved. As noted above, the vast majority of claims are closed without any payment to the injured patient—and often it is not the worst but the best physicians who are sued in liability claims. Lawyers, patients, insurers, health policy makers, patient safety experts, and medical experts all have varying interests in and views on the system and its usefulness to society. As a result, change in the system is slow and subject to widely divergent interests. Because emotions among the participants run high, compromise and resolution are not easy to achieve. Despite the fact that physicians are only one of many participants in the medical liability system, they remain the primary focus of the litigation that engenders emotional disruption that is sometimes life-changing for them.

**Disclosure of adverse events**

Many physicians believe that straightforward honesty about their role in a bad outcome increases their chances of being sued. They are also wary that, if a claim is made against them, any expression of regret or sympathy may be translated into a legally binding admission of fault. Furthermore, disclosure means different things to different people. For many physicians, disclosure carries the connotation of an acknowledgment that implies the disclosure of something that has been or might be concealed.
Will acknowledging that a mistake has occurred and that the physician is truly sorry this has happened imply something physicians do not intend—that is, are physicians actually stating responsibility for the event? Can empathy be expressed without a possibly ambiguous apology?

Increasingly, state legislatures are writing laws that protect physicians’ statements of sympathy from being admitted as evidence in a medical liability case. But the devil is found, as usual, in the details. In California, for example, apologies are protected but specific admissions of fault are not.14

Although most physicians believe in full disclosure, they also know the realities of medical liability litigation and the law that governs it. Most institutions and liability insurers support the disclosure of mistakes while cautioning physicians about how candid this disclosure should be. Most companies suggest that physicians should never speculate about fault and that they contact the insurer before assuming any culpability for the outcome. The insurability of the physician who fails to do so may be questioned. But, whereas some insurers caution physicians, others allow them to use the word “sorry” to express regret for an incident. Physicians are responsible for becoming familiar with the specific disclosure policy of their insurers and health care institutions as well as the parameters of any disclosure law applicable within their jurisdiction.

**Mastering the experience**

Three major strategies are used buffer the impact of any stressful life event: restoring feelings of control, social support, and changing the meaning of the event (see box on this page). Because litigation disrupts the usual order of life, measures aimed at restoring feelings of control are useful; and because litigation leaves a physician feeling isolated and in the spotlight as negligent, he or she may feel alone when facing the charges, shunned by colleagues or abandoned by the institution. Support from those who respect and cherish a personrestores feelings of equilibrium. The charge of negligence brands a physician as a “bad doctor” or negligent or incompetent. To repair the sense of self as a “good” physician in a bad situation, such perceptions must be reviewed objectively and revised accordingly.

**Reestablishing control**

The need to be in control is a prime professional and personal characteristic of physicians. This dynamic, which is both a strength and a need, must be understood if physicians are to monitor their reactions and responses to the pressure of litigation. In the service of both their personal comfort and their professional competence, they must experience a degree of mastery over and certainty about the decisions they make and know that these decisions may alter quickly when the unexpected happens. This professional freedom depends on their observing and managing the ever-present tension of fallibility and vulnerability, being human and so capable of making mistakes and incapable of knowing everything.

The pressure associated with clinical decision-

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**Useful strategies for coping with litigation**

**Obtaining social support**
- Discuss feelings about the case with a trusted confidant

**Regaining control**
- Become informed about the legal process
- During periods of increased stress, rearrange office and surgery schedules
- Avoid situations that generate anxiety and increase risk
- Reevaluate time commitments
- Seek consultation on financial and estate planning
- Participate in leisure time activities such as active sports and exercise
- Schedule the necessary time to participate in the defense of the case

**Changing the meaning of the event**
- Nourish the conviction of being a “good” physician rather than “bad doctor,” as portrayed in the complaint

Adapted from Adverse Events, Stress, and Litigation: A Physician’s Guide, Table 8-1, page 127.
making is also a function of patients’ expectations and demands that physicians be both infallible and omnipotent, that they be gods instead of mortals. If physicians cannot make a healthy distinction between the reality in which they are immersed and the impossible ideal in which they are draped, they may lose their balance and become anxious and indecisive, almost certainly increasing their risk of making an error.

Physicians’ long training period teaches what they must do, even below the level of consciousness, to maintain sufficiently good control in their daily work. Despite their training and experience, this tension, according to medical sociologist Renee Fox, may be a lifelong companion for doctors because the “basic human-associated stresses and dilemma...cannot be eliminated.”

Being sued shatters the delicate balance of these factors, forcing physicians to work diligently to preserve it. Determining who in the incident was in control and, therefore, responsible for the “bad outcome” is the subject and object of litigation and its draining protocol of depositions, motions, and trials. This issue of who exercised control preys on physicians’ feelings of fallibility and vulnerability and the demand—partly internal and partly external—that they should be in absolute control over every event. Physicians are suddenly forced to question how much control they actually had over the incident and to wonder about all their past and future choices.

Physicians can deal with feeling a loss of control by taking control of those controllable aspects of their lives. One may not be able to determine how other defendants or experts will testify, which judge is assigned to the case, or the pace at which the case proceeds. One can, however, attend to the spiritual side of his or her life as a physician by rededicating his or her self to the profession and by reaffirming the commitment to patients. The strategies that other physicians have found helpful (see box, page 21) may also be of use to others.

Adverse Events, Stress, and Litigation: A Physician’s Guide helps physicians to prepare for deposition and trial testimony and how to evaluate the ramifications of settlement or going to trial. Feelings of control and self-esteem are restored by taking the case seriously, preparing well, and working closely with attorneys throughout the entire process.

**Obtaining social support**

The single greatest help in any traumatic life event is the availability of other persons who can be understanding and offer support. Bolstered by such support, people regain equilibrium more quickly and are less likely to sustain long-term symptomatic disturbances.

Sued physicians, however, face a dilemma when the need for support is thwarted by the advice of lawyers. After any serious or catastrophic event, it is healthy and human to want to talk about it. Yet, lawyers caution to “not talk to anybody” about the event. They do not want a physician with pending litigation to say anything that might suggest culpability and therefore jeopardize the defense of the case. This book encourages physicians to talk directly about their feelings in a way that respects the concern of the lawyers. One can talk about personal feelings with a trusted confidant while restricting discussions of the technical details of the case to conversations with legal counsel, claims professionals, or other persons whose relationship with a litigant is protected by law. If, like others subjected to major life events, we act humanly and feel understood by others, a better perspective about the experience is gained and physicians become better defendants. Suppressing the need to talk about feelings increases the risk of becoming emotionally isolated and more vulnerable to lingering effects of the experience.

**Controlling thoughts**

A legal charge of negligence profoundly disrupts thinking. Physicians’ obsessive personality traits render them vulnerable to repeated mental reviews of what has happened and ruminations about whether there was negligence, if there were some other approach that might have been taken in caring for the patient, or if some other decision could have been made based on the facts present at the time. People are sometimes their own harshest critics, and only concerted effort controls such thoughts—but they can be mastered in various ways.

Viewing the lawsuit within the totality of a career reinforces the belief, “I am a good
physician.” All physicians have had less than satisfactory outcomes on occasion or have made decisions they later regret or would reconsider. Most physicians experience only one medical liability lawsuit during an entire career. There is a need for realistic comparison of the relative frequency of patients’ good outcomes and the relative infrequency of medical liability suits. One case does not make a physician “bad.” The reality of the situation is this: Good physicians find themselves in a bad situation or in one that is perceived as bad, whether it truly is or not.

Physicians help themselves by realizing that the current medical liability system is widely considered as an inefficient mode of compensation and that it does little to deter negligent medical care. Understanding the system’s function and the role of physicians in it may not be comforting but it puts the charge of negligence into perspective.

**Conclusion**

In *Adverse Events*, Mary Santos, an obstetrician-gynecologist, describes her mindset during a liability suit that spanned nine years and a trial of more than two weeks that led to a defense verdict: “I treated it like an adventure. I would not let it interfere with my love of medicine and my patients. I would be a better doctor. I would meet amazing people. It was a terrific challenge. Not allowing the negative distractions associated with the case to interfere with my focus and taking time away from patient care during the trial were important lessons.”

Like the surgeon who chose to be “better” rather than “bitter,” Dr. Santos viewed her litigation experience as an intensely human and deeply challenging experience. By participating actively and assertively, both physicians mastered the experience that enhanced, rather than diminished, their pride in their work and their good feelings about themselves.

**References**

Getting involved in organized medicine can be a rewarding experience, but often younger surgeons are hampered by a lack of knowledge of just how to best begin. This short overview will provide a listing of several places within the ACS where motivated younger ACS members can make a difference.

Join the RAS-ACS Council of Representatives

Every Resident Member or Associate Fellow of the ACS is automatically a member of the Resident and Associate Society (RAS). The RAS-ACS is intended to allow residents and young surgeons to voice their concerns to the College leadership and to provide an avenue for participation in College affairs. (See http://www.facs.org/ras-acs/index.html for more information.)

The RAS-ACS is governed by a council of representatives that meets every year at the Clinical Congress. Any person interested in becoming more involved with the RAS-ACS should attend the council of representatives meeting.

Becoming a RAS-ACS councilmember is relatively straightforward, as every state needs one general surgeon and two specialty surgeons, and these positions often need to be filled after RAS-ACS members get “promoted out” of the RAS—that is, when full Fellowship in the College is attained. You can be appointed as your state’s member of the council only by your ACS state chair. (To view a list of state chairs, visit http://web.facs.org/chapter/ACSChapter_listing.cfm.) The state chair will then forward your nomination to the RAS-ACS administrative liaison, Peg Haar (e-mail: PHaar@facs.org).

Once on the council of representatives, there are opportunities to serve on numerous committees throughout the ACS, including the Board of Governors committees; RAS-ACS committees; and other meetings at the national, local, and resident level. Becoming your RAS-ACS state representative is an amazing opportunity to work on problems in the surgical community at a national level, networking with the leaders of surgery, and offering input that helps them keep in mind the needs of residents and young surgeons.
**Trauma**

Those surgeons with an interest in trauma have several excellent opportunities. Each state/province has a state/provincial ACS Committee on Trauma (COT). COTs are often looking for young and energetic surgeons to serve. Contact your state COT leader for more information. (The listing of state and provincial chairs is available at [http://www.facs.org/trauma/regional.html](http://www.facs.org/trauma/regional.html).) There are several categories of membership in state committees, including Associate (members with medical degrees who are not yet Fellows of the ACS) and Physician in Training (medical trainees with an interest in trauma-related activities).

**Cancer**

Those surgeons who work in a hospital facility with a cancer program can become the hospital’s Cancer Liaison to the ACS Commission on Cancer (CoC). Physicians who participate as Cancer Liaisons are selected by their respective facility’s cancer committee. They serve a three-year term and may be reelected to additional three-year terms at the discretion of the facility’s cancer committee. Cancer Liaisons are volunteers responsible for providing the leadership and direction to maintain and support their facilities’ cancer programs. They spearhead CoC activities at the facility and community level and are a crucial part of any CoC-approved cancer program. For more information, contact the CoC (e-mail: coc@facs.org).

**Committee on Young Surgeons**

The Committee on Young Surgeons (CYS) is charged with establishing closer relationships between the College and surgical residents, Associate Fellows, and young Fellows of the College, and making College activities meaningful to young surgeons in all specialties. (Visit the CYS Web site at [http://www.facs.org/memberservices/cys/cysabout.html](http://www.facs.org/memberservices/cys/cysabout.html).) Committee membership is limited to Fellows younger than 45 years, with consideration given to fair distribution of geographic location and specialty. Appointments to the CYS last three years, but a committee member can serve two times. Members meet twice yearly at the ACS Leadership Conference and the Clinical Congress. In addition to the national committee, a CYS at the state level has been established in the following areas: Northern California, Connecticut, Metropolitan Washington (DC), South Florida, Hawaii, Idaho, Michigan, Missouri, New Jersey, Brooklyn–Long Island, North Carolina, South Dakota, and Wisconsin. To contact any of the College’s 67 domestic chapters, 30 international chapters, or the national committee, visit [http://www.facs.org/about/chapters/index.html](http://www.facs.org/about/chapters/index.html).

In April of each year, the CYS sponsors the Young Surgeon Representatives Meeting during the College’s Leadership Conference, which is held in Washington, DC. The purpose of the annual meeting is to provide young surgeon leaders with an opportunity to learn more about the College and provide information on socioeconomic and other issues that are of vital interest to today’s practicing surgeons. Young surgeons who would like to attend future Leadership Conferences should contact their chapter for consideration.

The CYS provides an excellent way to get involved in the College. Many chapters invite Young Surgeons to serve on their governing councils and standing committees. Members of the CYS serve as liaisons to the ACS Board of Regents, six standing committees of the Board of Governors, and seven standing College committees.

**Present your papers**

- **National ACS meetings.** The ACS provides a multitude of local, state, and national scientific meetings to promote scientific communication, and many favor research presented by younger surgeons. At the Clinical Congress, the Forum on Fundamental Surgical Problems is open to previously unreported and unpublished scientific submissions by younger surgeons. All accepted abstracts are automatically published in the *Journal of the American College of Surgeons* and are eligible for a variety of awards. The Clinical Congress also has a RAS-ACS symposium with topics of interest to resident surgeons.

The ACS Spring Meeting is designed particularly to cater to the interests and needs of the surgical resident and clinical/research fellow. A “Spectacular Cases” general session, “Surgical Jeopardy” resident competition, presentation of
resident research papers, and a one-day Resident Program provide a forum to present clinical cases, to show off surgical knowledge, and to attend lectures of specific interest. Letters are sent to all program directors soliciting paper submissions, Spectacular Case reports, and two Surgical Jeopardy participants per program.

- **State ACS meetings:** Some state chapters of the ACS have annual meetings in which presenting research papers is an option. A list of the Web sites for many local chapters is available at [http://www.facs.org/about/chapters/chapmenu.html](http://www.facs.org/about/chapters/chapmenu.html). Local chapter meetings are also excellent venues for meeting other young ACS members, networking, and finding out more about how to get more involved locally.

- **Residents Trauma Papers Competition:** Every spring, the COT sponsors a resident–clinical/research fellow Residents Trauma Papers Competition. Every state and region tends to run the competition slightly differently, but in general, a regional or state trauma competition is held to decide the local winners, and 14 regional winners are sent (expenses paid) to the Spring Meeting for a national trauma competition. For information regarding the name of the local state/provincial chair to whom you must provide your abstract, or any other information concerning the Residents Trauma Papers Competition, please contact the Trauma Office at ACS headquarters, 312/202-5380, or e-mail Carol Morris at cmorris@facs.org. Local due dates vary, but in general these submissions are due in the fall. For more information, visit [http://www.facs.org/trauma/papers.html](http://www.facs.org/trauma/papers.html).

- **Traveling Fellowships:** ACS Traveling Fellowships are available for Japan, Germany, and Australia/New Zealand and are limited to surgeons younger than 45 years. Although these awards are competitive, they provide an unprecedented opportunity to visit medical centers in another country and attend a surgical congress. For more information, visit [http://www.facs.org/memberservices/research.html](http://www.facs.org/memberservices/research.html).

**Conclusion**

There are countless opportunities for Resident Members, Associate Fellows, and Young Surgeons to get involved in the ACS as it strives forward in its mission to “improve the quality of care for the surgical patient by setting high standards for surgical education and practice.” When members get involved, these positions strengthen, educate, and provide extremely gratifying opportunities for the individual to work on issues that person cares about most.

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The issue of surgeons giving responsible testimony when serving as expert witnesses in medical liability lawsuits has recently received increased attention from the American College of Surgeons and other surgical specialty societies. Although court testimony by one surgeon against another can be a very contentious and polarizing act, the College recognizes that the provision of quality expert testimony is tantamount to the provision of quality patient care. ACS Fellows can play a crucial role within the U.S. judicial system, and the ACS encourages its members to provide expert testimony for both plaintiffs and defendants in cases for which they are qualified.

Recent court decisions have encouraged this effort by concluding that enhanced efforts by medical associations to improve the quality of expert testimony by their members effectively serve the public interest. The College continues to take seriously any complaints and allegations of unethical or unprofessional conduct on the part of its members acting as expert witnesses, and the organization has moved to further clarify the role of the expert witness for its members through the implementation of the ACS Central Judiciary Committee (CJC) review process, an

**Brief history of the CJC**

Formed in 1914, the CJC is one of the College’s oldest committees. The CJC has remained consistently active over the years with strong support from the Board of Regents. Throughout its existence, the CJC has addressed a variety of issues facing the surgical community, beginning most notably with fee splitting, which was prevalent in the Chicago area at the time that the College was formed. Another significant issue the CJC has faced is itinerant surgery, which resulted in the 1981 *Koefoot v. ACS* lawsuit filed in U.S. District Court for the Northern District of Illinois after the College took disciplinary action against a member who was practicing itinerant surgery in direct violation of the *ACS Statements on Principles*. The case went to trial and the court found in favor of the College on both charges of antitrust violations and whether Dr. Koefoot had received a fair hearing by the College.

Today the main issue the CJC manages on behalf of the membership at-large is unethical or irresponsible expert witness testimony. In the fall of 2002, the College began actively encouraging members to report instances of unethical expert witness testimony by other members. As the Regents committee that has responsibility for general supervision and direction of member disciplinary matters, the CJC handles expert witness testimony complaints. Senior staff for the CJC, Paul E. Collicott, MD, FACS, is both a former Regent and former Chair of the CJC. In his current capacity as Director of the Division of Member Services, he reviews all complaints and disciplinary matters before they are referred to the CJC.

**Disciplinary process**

The ACS disciplinary process is set forth in the College *Bylaws* in Article VII, Sections 1 and 2, and specifies that “failure to maintain the standards of conduct set forth in the Fellowship Pledge” or behavior that is “injurious to the good order, peace, reputation, or best interest of the College, or is derogatory to its dignity, [or] inconsistent with its purposes” is grounds for discipline. The College’s Statement 8 (or, ST-8), Statement on the Physician Acting As an Expert Witness, was originally published in the *Bulletin* in August 1989; it was revised in June 2000 and again in March 2004. This statement provides suggested guidelines and qualifications for members giving expert witness testimony in liability lawsuits. The *Bylaws* and ST-8 are used together by the CJC when considering complaints of unethical testimony.

Whenever a Fellow or any member of the public lodges a complaint with the College about a member, the complainant must specify the violation in writing and include a transcript of the testimony in question. Complaints go through several potential levels of review, which include contacting the surgeon who is the subject of the complaint to get his or her account of the event in question. Of course, before any investigation is launched, the College must have confirmation that the lawsuit in question has been fully adjudicated. Simply waiting for the lawsuit to run its course can delay an investigation at the College level by six months to a year. Once this hurdle has been cleared, the College staff reviews the complaint, and if it is deemed to have merit, the matter is referred to the CJC for initial review.

More often than not, the testimony in question involves a standard of care issue for a specific specialty. In those cases, a panel of members from the respective specialty advisory council will review the case for possible ethical violations. The CJC uses these reviews to aid in adjudicating the matter.

If appropriate, the next step in the process is to recommend to the ACS Executive Director that the Fellow be charged with a violation of the *Bylaws*, at which time the Fellow is invited to respond to the charges by submitting additional information and to appear before the CJC at its next meeting. The Board and the CJC meet three times each year to discuss these matters. It is only after this step has been taken that disciplinary action may be recommended to the full Board. Possible disciplinary actions that the Board may take are admonition, censure, probation, suspension, and/or expulsion from the College.

To date, 52 investigations of expert witness testimony have been initiated as a result of complaints lodged with the College. Of those, 19 have been referred to the CJC for review, and 11 respondents have been charged with a violation of the *Bylaws* of the ACS. These violations have resulted in one
admonition, four censures, and one suspension by the Board of Regents. The CJC reviews, on average, two new cases involving questionable expert witness testimony per meeting. These investigations require an average of one year from the time an initial complaint is lodged until possible disciplinary action by the Board. The College is very careful to ensure that due process is provided.

**Expert Witness Affirmation**

To further address the issue, the College has developed the Expert Witness Affirmation, which was prepared by the Ethics Committee and released in April 2004 and published in the September 2004 *Bulletin*. The Expert Witness Affirmation set forth 10 principles for members of the College providing expert witness testimony that include but are not limited to the following pledges: to testify only on matters in which the member has relevant clinical experience and knowledge; to evaluate the care provided in light of generally accepted standards that prevailed at the time of the occurrence; to submit testimony to peer review if requested by a professional organization; and to not accept compensation that is contingent upon the outcome of the litigation. The affirmation is a tool to help guide the membership in the provision of appropriate expert witness testimony in the courtroom. The affirmation and the statement on the expert witness are recent efforts intended to raise the bar for medical expert witnesses in liability litigation.

**Model legislation**

To encourage state action in expert witness testimony, the College adopted model legislation that was distributed to all ACS chapters in February 2004. This prototype outlines the necessary qualifications for expert witness testimony for consideration by state legislatures. Among other provisions, the model state legislation called on the state courts to permit expert witness testimony only by a physician who meets the following qualifications: the physician’s specialty is appropriate for the subject matter of the case and he or she holds current privileges to perform the procedure at an accredited hospital, has qualified experience or demonstrated competence in the subject matter of the case, and is familiar with the standard of care that was applicable at the time and under the circumstances of the alleged occurrence. Advocates of such legislation, including the ACS, have begun to see their work pay off as state legislatures have included expert witness testimony qualifications as integral parts of their medical liability legislative efforts. State legislatures that passed expert witness qualifications in 2005 include Arizona, Georgia, Illinois, Missouri, Montana, and South Carolina.

**Working with the AMA**

The College has played an active role in the American Medical Association (AMA) House of Delegates (HOD) with respect to promoting expert witness qualifications and guidelines. Based on its own statement on the physician expert witness, the College and a group of surgical specialty societies offered a resolution at the December 2003 meeting of the HOD, calling on the AMA to adopt expert witness qualifications and guidelines for behavior. Because of the complex nature of some of the legal issues related to expert witness qualifications and guidelines, the report was referred to the AMA Board of Trustees, which tasked the Council on Ethical and Judicial Affairs (CEJA) with developing a report. Submitted to the June 2004 meeting of the HOD, CEJA Report 12 addressed a majority of the issues that were raised by ACS in the original resolution and was unanimously adopted by the HOD.

At the same meeting, the College, along with other specialty societies, sponsored a resolution calling for the AMA to adopt an expert witness affirmation statement for its members. This statement came before the December 2004 meeting of the HOD and was largely similar to that adopted by the ACS Board of Regents. Again, there was unanimous support in the HOD for adopting this affirmation statement.

**AANS Program**

In the early 1980s, members of the American Association of Neurological Surgeons (AANS) grew concerned about the organization’s lack of a proper procedure for dealing with unethical or unprofessional conduct of its members. AANS found there was neither a mechanism in place to evaluate the seriousness of member complaints, nor a uniform and equitable procedure that could deal with these complaints. In response to this concern, the AANS worked to develop its professional conduct...
program, which has become an influential model for other surgical specialty societies.

In 1983, the AANS adopted expert witness guidelines, intended to establish standards of quality and impartiality in expert witness testimony provided by neurosurgeons on both sides of professional liability cases. At the same time, the AANS adopted procedural guidelines in order to establish a mechanism for reviewing and enforcing ethics complaints and violations of the expert witness guidelines. These guidelines stated that neurosurgeons were expected to comply with certain basic principles when testifying as an expert witness.

The AANS adopted procedural guidelines in order to ensure due process for all parties involved, and tasked its underused professional conduct committee (PCC) to be the arbiter of complaints lodged by members of the association. Violations of expert witness guidelines, if supported by credible evidence, were to be brought before the PCC and, ultimately, their board of directors for appropriate discipline. The neurosurgeon facing charges is given the opportunity to respond in whatever fashion he or she believes appropriate, and hearings are then scheduled during the AANS or CNS annual meetings. Either side may have counsel if wanted, but extensive cross-examination is not permitted.

After both sides make presentations, the PCC determines whether unprofessional behavior has been established and, if so, which of the following penalties is appropriate: censure, suspension of membership, or expulsion from the AANS. A PCC report is then sent to the board of directors and to the claimant and respondent. The respondent then has the opportunity to make a further presentation to the board before final action is taken. The respondent may then further appeal directly to the AANS general membership.

Over the years, approximately one-third of the complaints filed with the PCC have been dismissed during preliminary review, and the remaining two-thirds have received a full hearing. Nearly all of the cases that have received a full hearing have resulted in some disciplinary action, including eight letters of censure, 15 suspensions of membership, and one expulsion from AANS.

In the early 1990s, the AANS professional conduct program began to draw judicial fire. In 1991, George Jacobs, MD, a New Jersey neurosurgeon, filed a complaint for injunction against the AANS in an attempt to block the charges of unprofessional conduct against him. His complaint asserted that only a trial judge can measure the appropriateness of expert witness testimony and that a medical professional association should be prohibited from attempting to review and possibly criticize such testimony after a trial. The case was appealed up to the state supreme court, which found nothing inherently improper with the AANS professional conduct program procedure and determined that Dr. Jacobs had been granted due process.

The second judicial challenge to the AANS program was the landmark case of Austin v. AANS, which resulted in a federal appeals court decision that stands as the definitive court opinion regarding such programs. Dr. Austin, a neurosurgeon and member of the AANS, had testified that permanent damage to the recurrent laryngeal nerve of a patient during the course of an anterior cervical fusion procedure could only have occurred as a result of negligence on the part of the surgeon and that a majority of neurosurgeons would concur with his opinion. The PCC and the board concluded that Dr. Austin was wrong in both of these statements and suspended his membership for six months.

The ACS, with the AMA and the Illinois State Medical Society, filed an amicus brief supporting the AANS in this case. The brief stated the following: “Because the rendering of expert witness testimony constitutes the practice of medicine, amici believe that the testimony should be subject to the same exacting standards of professionalism expected of a physician in any other sphere of his or her practice. Additionally, expert witness testimony is subject to peer review, and any physician failing to maintain standards set by the profession should be disciplined accordingly.”

The U.S. District Court in Chicago found no merit to Dr. Austin’s argument that the AANS was only sanctioning members who were testifying on behalf of plaintiffs. In writing this opinion in favor of AANS, Chief Judge Richard Posner praised the AANS professional conduct program, stating, “This kind of professional self-regulation furthers, rather than impedes, the cause of justice.”

The court concluded that the AANS’ discipline of Dr. Austin served to further the quality of health care provision by physicians, which is of major

continued on page 41
Surgical technologists are individuals with specialized education who function as members of the surgical team in the role of scrub person. With additional education and training, some surgical technologists function in the role of surgical first assistant.

Surgical technology programs are accredited by the Accreditation Review Committee for Educational Programs in Surgical Technology—a collaborative effort of the Association of Surgical Technologists and the American College of Surgeons, under the auspices of the Commission on Accreditation of Allied Health Education Programs. Accredited programs provide both didactic education and supervised clinical experience based on a core curriculum for surgical technology.

Accredited programs may be offered in community and junior colleges, vocational and technical schools, the military, universities, and structured hospital programs in surgical technology. The accredited programs vary from nine to 15 months for a diploma or certificate to two years for an associate’s degree.

Graduates of accredited surgical technology programs are eligible for certification by the Liaison Council on Certification for the Surgical Technologist, an administratively independent body from the Association of Surgical Technologists, consisting of representative certified surgical technologists, a surgeon, and the public.

The American College of Surgeons strongly supports adequate education and training of all surgical technologists, supports the accreditation of all surgical technology educational programs, and supports examination for certification of all graduates of accredited surgical technology educational programs.

The following statement was developed by the ACS Committee on Perioperative Care and was approved by the Board of Regents at its June 2005 meeting.
The American College of Surgeons recently released a complimentary compact disc (CD) coding “primer” entitled CPT and ICD-9 Coding for Surgical Residents and New Surgeons in Practice to residents of all specialties who are in at least PGY4. Residents have some familiarity with Current Procedural Terminology (CPT) codes because they must use CPT codes to keep track of their cases.* However, this use of CPT is quite different from how it is used to bill in the practice of surgery. The CD was written and reviewed by practicing Fellow volunteers, under the leadership of John Preskitt, MD, FACS, who understands how residents use the CPT coding system and the requirements of a busy surgical practice.

Because they have been using CPT, senior residents preparing to enter private or academic practice frequently underestimate what they need to learn about assigning codes to (and receiving payment for) the patient services they provide. In fact, proper procedure and diagnosis coding is critical not only for obtaining full and fair payment, but also for ensuring proper compliance with the law. Heavy financial penalties may be and have been levied on institutions and individuals who routinely violated some basic rules of coding and documentation.

“For those reasons,” Dr. Preskitt said, “it was important to get a CD out so that residents could read it on their own, when they had time. [Users] also have a ready reference document that they can consult when necessary. Furthermore, we included some other material released by the Centers for Medicare & Medicaid Services [CMS] and the College that we believe they will find valuable.”

The CD contains separate chapters about using CPT to report surgical cases and evaluation and management (E/M) services. The CD explains other topics, including the following:

- Diagnosis coding using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).
- For those who remain in an academic environment, an extensive guide to CMS’ rules on what teaching physicians must do to receive Part B reimbursement.
- An overview of diagnosis-related groups (DRGs), which helps the surgeon see the importance of getting correct diagnosis codes into the hospital medical record so the hospital can report

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are: © 2004 American Medical Association. All rights reserved.
them on its claim.


The material on ICD-9-CM makes the point that the diagnosis code(s) justify the medical necessity of the procedure(s). Because failure to supply the correct code could result in denial of reimbursement, the CD suggests that the surgeon either supply the ICD-9-CM code or get in the habit of dictating progress notes and operative notes using language from the ICD-9-CM. The CD also makes the point that the full ICD-9-CM code needs to be shown on the claim. The chapter contains the essential steps to selecting the correct code and contains many examples of actual general surgery coding, including problems to avoid. The material includes an explanation of the V codes for factors affecting health status and contact with health services, and E codes for causes of injury and poisoning.

According to the discussion of CPT surgical codes in this resource, it is even more important that the surgeon select the procedure code(s) because he or she was present for the delivery of service and knows exactly what happened. There is also discussion of the global surgical package, how to write a good operative report, and an explanation of the modifiers that are attached to the surgical codes. Finally, there are examples of procedure coding that show some of the potential problems in reporting surgeries. This section is very thorough, containing cases from general surgery as well as closely related specialties, such as pediatric and vascular surgery.

The CD also takes new physicians step by step through all phases of E/M coding, including selecting the code family, selecting the correct level, and documenting the E/M service. In explaining how to select the correct code level, the CD presents an important alternative to using the traditional measures of history, physical examination, and medical decision making: selecting the code based on time when counseling or coordination of care take up the majority of time. Use of the E/M documentation guidelines is explained.

If teaching physicians are to receive reimbursement from Part B of Medicare, they must be present for a portion of the service being provided. The CD explains what portion of the service the teaching physician must be present for (it varies by type of service) and what portions of the service the resident may do on his or her own if the teaching physician wishes. It also explains the documentation requirements for various services.

Hospitals receive payment from Medicare, Medicaid, and many other payors on the basis of DRGs. There is a brief overview of DRGs to help the surgeon see the importance of documenting relevant diagnoses so a complete picture of the patient’s condition is apparent to the hospital’s coders. They, in turn, will be able to submit the codes that give the hospital the appropriate reimbursement for the case.

The CD contains several additional documents from CMS and the College that are helpful in other aspects of billing and reimbursement. Perhaps the most complete and useful of these documents is the New Physician’s Guide. In addition to diagnosis and procedure coding, it contains chapters on applying for a billing number, Medicare as a secondary payor, reading remittance advices, and a number of important Part B policies such as performing services “incident to” a physician’s services.

Members of the College who did not receive a copy of the CD can view it on the College’s Web site in the “members only” section, at http://www.facs.org/members/members.html#cpt.

This CD does not tell residents and young surgeons all they need to know about diagnosis and procedural coding, however. Upon completion of this CD and spending some time mastering its contents, they will need the information presented in the College’s basic coding workshop, Introduction to CPT, ICD-9-CM and Evaluation and Management Coding (Basic). The workshop complements this CD by offering an overview of a practice’s business office, an overview of CPT, and more in-depth material on E/M coding. Each fall, the College announces the time and location of four workshops around the country in the following year. In addition, the College offers the workshop at Clinical Congress each year. Coding staff is welcome to attend along with the surgeon.
Being selected as the 2005 American College of Surgeons Japan Traveling Fellow was a great honor for me. I had an incredible two weeks of educational and cultural exchange that was very valuable to me both personally and professionally.

When I arrived in Tokyo, I first visited St. Luke’s International Hospital, where Seigo Nakamura, MD, is the chief of surgery, specializing in breast cancer management (see photo, this page). I arrived during the weekend, and Dr. Nakamura very graciously showed me around Tokyo and invited me to have a dinner with his family. I really appreciated his kindness and very generous hospitality.

The next day just happened to be the opening day of the hospital’s new Breast Center. Dr. Nakamura and his colleagues had planned this center for quite some time to provide multidisciplinary care to their breast cancer patients so that all aspects of breast care management, including diagnosis and surgical and medical management of the disease, could be performed efficiently at one location. I was told that this multidisciplinary center might be the first of its kind in Japan.

I spent Monday at St. Luke’s, visiting patients with Dr. Nakamura in his new clinic and participating in the operating room. In the morning, I scrubbed in on a mastectomy that involved placement of a tissue expander as an initial stage of breast reconstruction. In the evening, there was a suture workshop that had been organized for the surgical residents, fellows, and staff. I gave a lecture on the principles of wound management and demonstrated various suturing techniques by using models provided by a suture company (Ethicon).

The following day, I went to the operating room with Dr. Nakamura and scrubbed in on a case of bilateral lumpectomies (see photo, next page). I was asked to demonstrate how to reconstruct these defects with local advancement flaps. Later that day, I gave a lecture to the staff of the Breast Center on the topic of breast reconstruction.
The next day I went to Nagoya on Shinkansen, “the bullet train.” I was accompanied by Hiroshi Yagata, MD, a faculty member at St. Luke’s. When we arrived in Nagoya, we went to the convention center, where I registered for the 105th Annual Congress of Japan Surgical Society. The following day, I was scheduled to present in the breast session. I gave a talk on the impact of recipient vessels on microvascular breast reconstruction. The presentation was well received, and there was some discussion afterwards. That evening, I was invited to give a lecture at the Nagoya University by Dr. Tsuneo Imai, MD, the chief of breast and endocrine surgery at Nagoya University Hospital; he had organized a breast symposium and wanted me to participate. I gave a lecture on the autologous breast reconstruction. After the symposium, several surgeons expressed great interest in visiting the M.D. Anderson Cancer Center to further their learning regarding breast reconstruction.

After the meeting, I came back to Tokyo on the Shinkansen train. The following morning, I went to Tokyo University Hospital, where I met Isao Koshima, MD, professor and the chief of plastic and reconstructive surgery (see photo, this page). Dr. Koshima is a world-renowned reconstructive microsurgeon and has developed a subspecialty called “super microsurgery.” When I visited, he had a patient who had developed bilateral lymphedema in the lower extremity after being treated for uterine cancer with pelvic radiation. Treating lymphedema surgically is very challenging and also controversial, and the reported success rate has been generally poor. Dr. Koshima has apparently performed approximately 200 cases of lymphatico-venous bypasses over the past 15 years, with a long-term success rate approaching 50 percent.

In the case I witnessed, he performed nine bypasses in various parts of the two legs by connecting lymphatic channels to adjacent veins. Anastomoses
were less than 0.5 mm and required the use of 12-0 nylon with the 50-micron needle. This was certainly an incredible technical feat. I was impressed by his technical proficiency and his patience, as the procedure was very long and tedious. On one occasion, the lymphatic channels could not be identified, so he transferred a lymphatic gland from the left axillary region as a lymphatic free-tissue transfer. He introduced me to one of his fellows who wanted to come to M. D. Anderson for approximately a year to learn the various aspects of oncologic reconstruction.

The following day, I went to Jikei University where one of the faculty members is Kazumi Kawase, MD. Dr. Kawase had spent some time at M. D. Anderson as a breast fellow and is now an assistant professor in the department of surgery at Jikei University. She had organized a breast symposium, and I was asked to give a lecture on breast reconstruction. The organizers had also invited faculty members from other universities. After the lecture, there was an animated discussion about the various aspects of breast reconstruction and breast cancer.

This was my first visit to Japan and my initial impression was very positive. The people are kind, hospitable, humble, disciplined, and team oriented. The streets are clean, orderly, and safe. The health care delivered is very high in quality. Physicians are knowledgeable, highly skilled, well trained, highly motivated, and very proud of their work. Patients appear to be grateful and have tremendous respect for their doctors.

Overall, the trip was a very productive one. I had an opportunity to see the medical system in Japan, which is quite different from that in the U.S. I also had a chance to interact with the residents and fellows. The Japanese training system in surgical residency is also quite different from ours in the U.S.

I am especially grateful to all the surgeons I met during this trip for their incredible kindness and hospitality. They welcomed me to their hospitals, operating rooms, and clinics and had me examine their patients and discuss with them the various management options available. They invited me to have dinner with their own families and friends. The friendships that I developed during this short time in Japan will continue to blossom and mature at the personal and professional levels. I expect to have at least two breast surgeons come to M. D. Anderson within a year to visit; one fellow in plastic surgery is planning to come to our department for further education and training.

Once again, I’d like to thank the American College of Surgeons and the International Relations Committee for giving me this great honor and opportunity to have had this very valuable experience.

Dr. Chang is an associate professor in the department of plastic surgery of the M.D. Anderson Cancer Center, Houston, TX.

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**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, 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](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312/202-5342.
Space sold by Elsevier
ACS issues call for submissions for 2006 Congress in Chicago

The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at the 92nd Annual Clinical Congress, October 8–12, 2006, in Chicago, IL.

Abstract specifications for each program will be posted on the ACS Web site at www.facs.org. The submission period will begin on November 1, 2005. Submission of a single abstract to more than one program is not permitted

Video-Based Education Session
Program Coordinator: GayLynn Dykman (gdykman@facs.org).
Submission deadline: February 1, 2006.
Presentation type: Video (acceptable formats: Mini-DV, SVHS, Betacam SP, DVCPRO, DVCAM).

Papers Session
Program Coordinator: Molly Clear (mclear@facs.org).
Abstracts are to be submitted online only, via www.facs.org/education/congress/papersession.html.
Submission deadline: 5:00 pm (CST), March 1, 2006. Late submissions not permitted.
Presentation type: Oral.

Posters Session
Program Coordinator: Lisa Richards (lrichards@facs.org).
Abstracts are to be submitted online only, via www.facs.org/clincon2006/sciexhibit.html.
Submission deadline: 5:00 pm (CST), March 1, 2006. Late submissions not permitted.
Presentation type: Poster display.

Surgical Forum
For surgical residents and scientific investigators in-training.
Program Coordinator: Kathryn Koenig-Matousek (kkoenig@facs.org).
Abstracts are to be submitted online only, via www.facs.org/sfabstracts/index.html.
Submission deadline: 5:00 pm (CST), March 1, 2006. Late submissions not permitted.
Presentation type: Oral.

ACS and COT seek general surgeon input on trauma surgery

The American College of Surgeons and its Committee on Trauma (COT) are seeking information that is important to the future of trauma surgery, general surgery, and their relationship.

General surgeons have been invited to participate in a survey regarding this issue through news items that have been published in the College’s weekly e-mail newsletter, ACS NewsScope.

Although many general surgeons have participated in the survey thus far, there are still many more readers whose opinions have not been heard and that are crucial to obtaining accurate findings that can be used to reliably guide the College and the COT leadership.

Your input is essential to the success of this project, so please seriously consider taking a few minutes to respond to the survey at http://www.surveymonkey.com/s.asp?u=78931787372. The members of the COT and the leadership of the College sincerely appreciate your assistance in this survey process.
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.

Leading the Challenge to Meet the Need

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. Holzerichter, Chief Development Officer, at 312.202.5376 or visit our Web site at www.facs.org.
Cooperative group membership: An online three-step process

by R. Scott Jones, MD, FACS, Director, ACS Division of Research and Optimal Patient Care, Chicago, IL

In the last Bulletin, we announced the opening of several new and exciting trials, including Z6041 (Local Excision Neoadjuvant Chemoradiation for Early Rectal Cancer), Z1031 (Neoadjuvant Aromatase Inhibitors in Breast Cancer), and Z4032 (Brachytherapy and Sublobar Resection in Non-Small Cell Lung Cancer). There was great enthusiasm for these trials expressed at the Clinical Congress in San Francisco, CA, in October. We learned, however, that many surgeons have not registered with the National Cancer Institute (NCI) or with the American College of Surgeons Oncology Group (ACOSOG) and therefore cannot participate in NCI-sponsored trials. In response, we have written a short primer on how to join a cooperative group. We hope you find this condensed material useful.

For convenience, links to all of the following information may be found at the ACOSOG membership Web site: https://www.acosog.org/membership/NCI_reg_info.jsp.

**Detailed instructions**

Joining a cooperative group allows practicing surgeons to participate in NCI-sponsored clinical trials. Joining is easy. The following information has been taken from the Web and organized to help guide you through the process.

**Step 1**

National Cancer Institute investigator registration: To contribute to the many surgical trials performed by the NCI, you must first register with the NCI and get a NCI investigator ID number. This is done through the NCI’s Pharmaceutical Management Branch (PMB).

Instructions:

- Click on the link to download each form at http://ctep.cancer.gov/resources/investigator2.html.
- U.S. Food and Drug Administration (FDA) Form 1572—Statement of Investigator. This two-page form outlines the responsibilities that the investigator agrees to assume in order to conduct the study.
- Supplemental Investigator Data Form. This two-page form will document the date that the investigator successfully completed the “Protection of Human Research Subjects” training. If you have not completed this training at your own institution, you can do it online at: http://www.cancer.gov/clinicaltrials/learning/page3 (expect 30-60 minutes to complete).
- Financial Disclosure Form. This one-page form defines the investigator’s financial relation-
ship with any private sector bodies.

• A curriculum vitae must be submitted with the FDA Form 1572.

• Completed registration packets should be mailed directly to PMB at the address noted on the forms. A response may take a few weeks.

Once approved, you will be given a NCI investigator ID number and you can proceed to steps 2 and 3.

**Step 2**

**Cancer Therapy Evaluation Program (CTEP) registration:** Now that you have a NCI ID number, you will need to establish a “user account” with CTEP (CTEP is the division of NCI that performs large cancer trials.) The Web application automatically searches for electronic information from your FDA Form 1572. If you confirm the accuracy of the database information, you will be asked to choose a user name and provide an e-mail address.


• Select “new registration” from the menu.

• Answer “yes” to the question “Are you a physician?”

• Complete the CTEP Investigator New Account application, which asks for a name and NCI investigator ID number.

• Hit “submit” to send the information.

You will receive an e-mail with notice of approval and a user name and temporary password. At this point, you activate the account by entering your user name, temporary password, and a permanent password. You will automatically become part of the CTSU (Clinical Trials Support Unit).

Any questions or problems with the online registration process should be directed to the CTEP Registration Help Desk via e-mail to ctepreghelp@ctep.nci.nih.gov or by telephone at 301/496-9910. Help is available via telephone Monday through Friday, 8:30 am to 4:30 pm, EST.

**Step 3:**

**American College of Surgeons Oncology Group (ACOSOG):** The final step is to complete the membership application for ACOSOG.

• Access ACOSOG registration at: https://www.acosog.org/membership/NCI_reg_info.jsp.

• Complete the Web-based application, which asks for the NCI investigator ID number, demographics, hospital affiliation, disease sites of interest, and research coordinator contact information.

• You will receive an e-mail confirmation containing your ACOSOG ID and password for access to the ACOSOG membership Web site.

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**EXPERT WITNESS, from page 30**

interest in public policy, thus providing powerful support to medical associations that were trying to improve the quality of expert testimony by their members.5

**Conclusion**

Emboldened by the court decisions supporting the legality of the AANS professional conduct program, the College has begun strengthening its program through the implementation of a CJC review process, the expert witness affirmation, ST-8 the development of model state legislation, and working with other membership organizations to build consensus. Through these efforts, the ACS continues to safeguard the standards of surgical care necessary to sustain an optimal and ethical medical practice environment.

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**References**


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

ONLINE CME: Courses from the ACS’ Clinical Congresses are available online for surgeons. Each online course features video of the introduction, audio of session, printable written transcripts, post-test and evaluation, and printable CME certificate upon successful completion. Several courses are offered FREE OF CHARGE. The courses are accessible at: 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.

BARIATRIC SURGERY PRIMER: 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.

PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons: The CD uses an interactive/lecture format to 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 financial planning for surgical practice.

PRACTICE MANAGEMENT for Residents and Young Surgeons: The CD uses an interactive/lecture format to equip residents and young surgeons 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 career pathways; and surgical coding basics.
The trauma system agenda for the future includes a move toward developing inclusive trauma care systems. Trauma centers are only one aspect of an inclusive system. Optimal care needs to be delivered along the entire continuum of care, including prevention; pre-hospital; acute care facilities, including at trauma centers; and rehabilitation. The last—and definitely not the least important—stop for the trauma patient may be a rehabilitation facility. Monthly, we have highlighted various types and causes of acute traumatic injury.

A common thread among all these categories is the fact that a significant number of injured patients are unable to be discharged directly from the hospital and return home to their previous level of function. This group of patients requiring additional care is often discharged to a rehabilitation facility. In rehabilitation facilities, these patients are often treated by a physiatrist-led multidisciplinary team, including nurses, physical and occupational therapists, speech/language therapists, vocational counselors, respiratory specialists, social workers, rehabilitation engineers, recreation therapists, chaplains, and other health professionals.

According to the records contained in the National Trauma Data Bank™, there were 56,764 trauma-related deaths; 898,731 were discharged to their home, a nursing home, or another unspecified location; and 90,655, or one in 10, were discharged to a rehabilitation facility. These data are depicted in the figure on this page. It is not surprising that the number of patients requiring treatment beyond acute medical care outweighs the deaths by three to one. Patients who were discharged to a rehabilitation facility were on average 48 years of age, had an average hospital length of stay of almost 14 days and an intensive care unit length of stay of just more than six days, an average injury severity score (ISS) of 16.6, average charges close to $69,000, and of those tested for alcohol at admission, almost one in three tested positive. Patients discharged to rehab had higher ISS scores, longer hospital stays, and required more resources at a greater cost. These are the patients who need rehab. As evidenced by the large number of patients requiring rehab, we need to embrace the trauma system agenda for the future. By building a more inclusive trauma system, we can improve the continuum of care from injury through rehab, which should have a direct effect of improved patient outcomes.

Throughout the year, we will be highlighting these data through brief reports monthly in the Bulletin. The full NTDB 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.
December EBRS focuses on meta-analysis

In October, the American College of Surgeons announced its collaboration with the Canadian Association of General Surgeons (CAGS) to provide Evidence-Based Reviews in Surgery (EBRS), an Internet-based journal club, as a benefit for its members. Designed to teach the critical appraisal skills needed by practicing surgeons and residents to interpret and evaluate the surgical literature, EBRS consists of eight monthly packages per academic year, from October to May.

Each package includes a clinical article that is relevant to the practice of general surgery, plus a methodological article that can be used to assist in the evaluation of the clinical article. In addition, methodological and clinical reviews are provided by experts in the field, and surgeons may participate in an expert-led listserv discussion of the article. Six continuing medical education (CME) credits are available to surgeons who complete a series of multiple-choice questions related to each month’s package.

The December EBRS package features a clinical article on a meta-analysis on the evidence-based value of prophylactic use of drains in gastrointestinal surgery, while the methodological article examines the general use of meta-analysis. The December package is available online as of Monday, December 5.

Members of the College can access EBRS by visiting http://www.facs.org/education/ebrs.html. Because this is a “members only” benefit, you will need your ACS user ID and password to access it. Those surgeons who would like to participate in the listserv discussion and receive six CME credits should register with Marg McKenzie via e-mail at mmckenzie@mtsina.on.ca.
ACS Career Opportunities

The American College of Surgeons’ online job bank

A unique interactive online recruitment tool provided by the American College of Surgeons, a member of the HEALTHeCAREERS™ Network

An integrated network of dozens of the most prestigious health care associations.

Candidates:
• View national, regional, and local job listings 24 hours a day, 7 days a week—free of charge.
• Post your resume, free of charge, where it will be visible to thousands of health care employers nationwide. You can post confidentially or openly—depending on your preference.
• Receive e-mail notification of new job postings.
• Track your current and past activity, with toll-free access to personal assistance.

Employers:
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Chapter news

by Rhonda Peebles, Division of Member Services

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

Connecticut Chapter meets U.S. representative

Last May, a small group of Connecticut Chapter members participated in a fundraising evening (see photo, right) for U.S. Rep. Nancy Johnson (R), who serves as Chair of the Subcommittee on Health of the House Ways and Means Committee. The event was a success, and at the function, Representative Johnson indicated she is open to reviewing the Chapter’s concerns relative to improving access to bariatric surgery.

Chapters target Resident Members

Last spring, two chapters—New Mexico and North Dakota—announced plans to subsidize Resident Members’ ACS dues. In addition, the North Dakota Chapter also announced plans to cover College dues for Medical Student Members. For more information on memberships for residents and medical students and for electronic application forms, go to http://www.facs.org/memberservices/documents.html.

Michigan Chapter recognizes winning residents

Last May, at its 2005 annual meeting, the Michigan Chapter recognized the winners of the annual Residents’ Competition. Edward R. Laws, MD, FACS, the College’s Immediate Past-President, served as Chief Judge of the judging committee.

The first-place winners included the following:

• Frederick A. Coller Award: Alisha Arora, MD,* Neoadjuvant Intratumoral Cytokines and Superior to Post-operative Vaccines in Generating Systemic Anti-tumor Immunity.

• Alexander J. Walt Award: Jules Lin, MD,* Inhibition of the Ubiquitin-Conjugating Enzyme E2C: A Potential Therapeutic Agent in Esophageal Adenocarcinoma.

• Robert V. Danto Cancer Research Award: Chaim B. Colen, MD, Inhibition of Lactate-Pyruvate Transport in Malignant Glioma: A Novel Chemo-radio Sensitizing Approach.

• The Gift of Life (Transplantation) Award: Noreen Durrani, MD,* The Effects of Gradually Increased Blood Flow on Ischemia-Reperfusion Injury in Rat Kidney.

• Michigan Committee on Trauma—Clinical Science: Krishna Athota, MD,* Pulmonary Complications in Trauma Patients Using Airway Pressure Release Ventilation.

• Michigan Committee on Trauma—Basic Science: Kellie McFarlin, MD,* Trauma Laparotomy: Effects of Stem Cell Therapy on Facial Wound.

• D. Emerick Szilagyi Michigan Vascular Prize: Stephen D. Berry, MD, Results of Infrapopliteal Bypass in African-Americans: Is Race a Factor?

Tennessee Chapter sets course

In late July, the Tennessee Chapter conducted its annual meeting and residents competition at the Paris Landing State Park on Kentucky Lake. With regard to chapter business, the members agreed to (1) send $1,000 contributions to the Tennessee Medical Foundation and to the College; (2) increase the number of its delegates in the Tennessee Medical Association’s House of
Delegates to seven from six; and (3) forward a resolution to the College concerning Medicare funding for residents who are training in rural areas. The chapter also elected the following new officers (all MD, FACS): Ray Compton, President; Bill Richards, President-Elect; Tony Haley, Vice-President; and Julie Dunn, Secretary-Treasurer.

Three separate competitions were conducted for the Residents at this meeting. First-place winners were as follows:

* **Trauma:** J.G. Christiano, MD,* Prioritizing Trauma Prevention Efforts Using the University of Tennessee Prevention Ranking Score.

* **Basic Science:** Dan Shell, MD, Rapamycin Coated ePTFE Grafts Exhibit Decreased Anastomotic Neointimal Hyperplasia in a Porcine Model.

* **Clinical Science:** Benjamin K. Poulose, MD,* Cost Effectiveness Evaluation of Bariatric Surgery Strategies.

### Chapter meetings

For a complete listing of all of the ACS chapter education programs and meetings, please visit the ACS Web site at [http://www.facs.org/about/chapters/index.html](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.

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<td>South Florida (CS)</td>
<td>Location: The Doral Golf Resort and Spa, Miami Contact: Bill Bouck, 305/687-1367</td>
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<td>Jan. 20–22</td>
<td>Southern California (CS)</td>
<td>Location: Bacara Resort and Spa, Santa Barbara Contact: C. James Dowden, 323/937-5514</td>
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<td>Louisiana (CS)</td>
<td>Location: Marriott Hotel, New Orleans Contact: Janna Pecquet, <a href="mailto:pecquet@laacs.org">pecquet@laacs.org</a></td>
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<td>South Texas (CS)</td>
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<td>Location: Cityplace Conference Center, Dallas Contact: Joseph Kuhn, MD, FACS, 214/824-9963</td>
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vices” (HB 117). In his letter to Rep. Tim Shaffer (R-Columbus), Chair of the House Commerce and Labor Committee, Ohio Chapter President Gary Williams, MD, FACS, observed that “... it is inappropriate and dangerous for lawmakers to allow an unlicensed health care practitioner to use titles such as ‘physician’ and ‘doctor’ that are synonymous with the extensive training required of ‘true’ physicians.” For more information about the Ohio Chapter’s advocacy activities, visit its new Web site at http://www.ohiofacs.org/.

Kansas Chapter executive retires

After serving nearly 20 years as Executive Director of the Kansas Chapter, Harold Riehm will officially retire this month. Mr. Riehm served adeptly from the Topeka headquarters. At the chapter’s 2005 annual meeting in September, the chapter membership presented Mr. Riehm and his wife with a gift certificate for an Alaskan cruise (see photo, above).

Beginning in January 2006, Mr. Charles “Chip” Weelen will take over the management responsibilities for the Kansas Chapter in Topeka.

New Mexico holds annual meeting

The New Mexico Chapter held its 2005 annual meeting September 9 in Albuquerque, and R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, presented the College’s perspective on pay-for-performance. The new officers elected at this meeting include (all MD, FACS, see photo, this page): Jacob George, President-Elect; Thomas Howdieshell, President; Steven Haynes, Governor; Albert Kwan, Secretary-Treasurer; and J. Ralph Macfarlane, Immediate Past-President.

New Chapter in Iran

The College’s newest chapter is located in Iran and was approved by the Board of Regents at its meeting October 7–8. On Sunday, October 16, Courtney Townsend, Jr., MD, FACS, Chair of the Board of Governors, presented the charter for the Iran Chapter to Heshmatollah Kalbsi, MD, FACS, who serves as the Governor for Iran and will serve as the first President of the Iran Chapter; other officers include (all MD, FACS): Siavash Sihhat, Vice-President; Masoud Saleh, Second Vice-President; Abolghassem Abasahl, Treasurer; and Mohammad Reza K. Motamedi, Secretary.

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