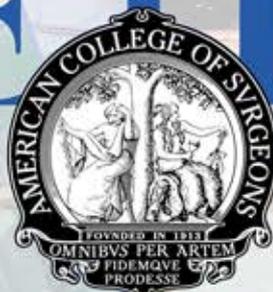


# BULLETIN

AMERICAN COLLEGE OF SURGEONS



February 2005  
Volume 90, Number 2

## OUTCOMES & SPECIALTY SURGERY

# BULLETIN

AMERICAN COLLEGE OF SURGEONS



FEBRUARY 2005  
Volume 90, Number 2

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## About the cover...

All surgical specialties are affected by increasing demands for improved quality and better outcomes. In this month's cover story, page 8, the authors discuss a multi-state pilot study that tested the feasibility and utility of surgical quality measure for future implementation nationally. This effort was led by Health Care Excel, a Medicare quality improvement organization, and received broad support from participating surgical specialists dedicated to providing excellent patient care.

NEWS

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

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# From my perspective

Of all the problems afflicting our health care system, perhaps none is as troubling to many surgeons as the professional liability crisis and some policymakers' unwillingness to effect the tort reforms needed to reverse this ever-worsening situation. As we strive to secure necessary changes, it is understandable and easy to lash out at other professionals, particularly the trial lawyers and biased legislators. By and large, however, such outpourings of frustration and emotion are fairly fruitless, albeit momentarily satisfying. Rather than engendering the ill will of other stakeholders, those of us who are committed to attaining reforms need to look critically at the situation and ask ourselves what we can do to improve the system.

## *Patient safety*

Of paramount concern to all of us at this time should be making certain that surgical care is delivered safely. The College's ongoing and growing contributions to the development of standards of care and the creation of evidence-based guidelines will advance this objective.

To further ensure patient safety, the profession must ensure that surgeons are appropriately credentialed and trained before doing new procedures. We also need to encourage the development of processes within hospitals that are centered on patient safety.

As surgeons adopt new, scientifically proven methods of care, as hospitals become more committed to developing supportive medical and surgical teams, and as we more stringently monitor the qualifications of members of our profession, the occurrence of medical "incidents" will decrease. And, I believe, as fewer of such incidents occur, the public will be less inclined to file malpractice claims.

## *Expert witnesses*

Another subject that demands our attention when examining the liability situation is the use of expert witnesses. On an annual basis at the College, we receive numerous complaints and allegations about Fellows providing expert testimony for the plaintiff and against other members of this organization. This activity inevitably incites the ire of the defendants, who, at first, are upset that anyone would question or testify against their



“ To address the problem of surgeons giving questionable testimony in medical liability lawsuits, the College has developed several documents to clarify the role of the expert witness. ”

course of treatment, and then by the fact that another member of the College is the one questioning their patient care decisions.

The College takes these complaints seriously and analyses the records used in the case. Our Central Judiciary Committee (CJC), which meets three times a year, selectively reviews the complaints and the testimony provided. The CJC reviews, on average, about two new cases of questionable expert witness testimony at each of its meetings. Over the course of the last several years, the CJC has considered 45 cases of questionable expert witness testimony. Eleven of those individuals have been referred to the CJC for review of their Fellowship status, and five have been charged with Bylaws violations.

## *Expert witness qualifications*

To address the problem of surgeons giving questionable testimony in medical liability lawsuits, the College has developed several documents to clarify the role of the expert witness. In June 2000 the

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College published a Statement on the Physician Acting As an Expert Witness. This position paper was further revised in 2004 and clearly outlines the qualifications of the physician who acts as an expert witness. (The revised statement was published in the March 2004 issue of the *Bulletin*, page 22, and can be found on the College's Web site at [http://www.facs.org/fellows\\_info/statements/st-8.html](http://www.facs.org/fellows_info/statements/st-8.html)).

This document indicates that a physician who serves as an expert witness must possess an unrestricted medical license, specialty board recognition, current privileges to perform procedures relevant to the case, and a familiarity with the standard of care under question. The expert witness must also carefully study all of the pertinent material, be impartial, and provide a balanced analysis. The physician expert should be able to differentiate between a negative occurrence and true malpractice and should avoid hindsight analysis of the case. Rather, his or her testimony should take into account the judgment of the defendant at the time care was rendered and the particulars of the environment in which the treatment was provided.

Closely linked to the qualifications of the physician giving expert testimony are ethical issues. Clearly, monetary compensation provided to the expert that is based on the outcome of a lawsuit is unethical.

Last year, the College also issued an Expert Witness Affirmation, which is intended for voluntary use by Fellows who want to make explicit their commitment to knowledgeable and ethical expert witness testimony. Fellows who testify in medical liability cases may sign this affirmation and give it to the attorney representing the party on whose behalf they intend to testify. We anticipate that if surgeons will review and sign this statement, reliable and appropriate expert testimony will be the end result. (See <http://www.facs.org/education/ethics/> for a copy of the Expert Witness Affirmation.)

Because few states have passed laws governing the qualifications of an expert witness, the College has also adopted model state legislation on this subject, which was distributed to the chapters of the College in February 2004 for introduction in their state legislatures. This prototype bill outlines the necessary qualifications for an expert witness.

Additionally, at its recent interim meeting, the American Medical Association (AMA) adopted a resolution regarding expert witness qualifications, which the College and other surgical organizations sponsored. The AMA also adopted an affirmation statement and, by a clear majority, agreed that an expert witness must be board certified in the defendant's specialty—a clear departure from the organization's previous stance. The AMA's consideration and passage of these items further demonstrates the entire medical community's support of credible expert witness testimony that is offered only by qualified professionals.

### *Watching out for patients*

While court testimony by one surgeon against another is on occasion necessary and warranted, it is a very serious, contentious, and polarizing act. Surgeons should offer such testimony only in cases where the plaintiff clearly received substandard care and only when they are confident that they can offer an unbiased opinion that draws on their knowledge and credentials. The American College of Surgeons is fully aware of its members' strong feelings about the use of expert witnesses, and we believe we are making significant strides toward resolving this contributor to the medical liability crisis.

At the same time, we acknowledge that some actions endanger the safety and health of surgical patients. Hence, we are fully committed to uncovering new means of ensuring that our patients receive proven care from qualified surgeons.

The medical liability crisis is not about to be resolved overnight, especially when some members of Congress are opposed to passing tort reform legislation. However, as we move forward in delivering effective treatments and ensuring that expert witnesses offer sound and reasonable testimony, the impact of this situation is likely to diminish.



*Thomas R. Russell, MD, FACS*

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

# Dateline Washington

prepared by the Division of Advocacy and Health Policy

## Fellow wins congressional runoff election

On December 4, Charles Boustany, MD, FACS, won his runoff election for the Seventh Congressional District of Louisiana. Dr. Boustany is the first Republican to represent Louisiana's Seventh District and is the third Fellow of the College elected to the U.S. House of Representatives in 2004. He joins Tom Price, MD, FACS (R-GA), and Joe Schwarz, MD, FACS (R-MI), in the freshman class.

A thoracic and cardiovascular surgeon, Dr. Boustany received a medical degree in 1982 from Louisiana State University (LSU) School of Medicine, New Orleans, LA. He was a general surgery resident at the LSU Division Charity Hospital in New Orleans and then moved on to become chief resident in thoracic and cardiovascular surgery at the University of Rochester, NY. After completing his residency, Dr. Boustany returned home to Louisiana and was in private practice for 14 years.

## MedPAC drafts recommendations to Congress

On December 9 and 10, the Medicare Payment Advisory Commission (MedPAC) met to consider a number of issues of interest to surgeons. The panel will recommend that Congress craft legislation that would:

- Institute pay-for-performance for hospitals, physicians, and home health agencies.
- Fund the adoption of health information technology in physician offices.
- Extend the moratorium on physician ownership of specialty hospitals until the Centers for Medicare & Medicaid Services (CMS) adjusts the diagnosis-related group (DRG) system so that the relative profitability across DRGs is the same. (Current law calls for the moratorium to expire June 8.)
- Enact a positive update to the Medicare fee schedule in 2006, based on the Medicare Economic Index minus an allowance for productivity growth. A preliminary estimate of the recommended update is 2.7 percent.

These recommendations and others will be presented to Congress in a report set for release in March.

## OIG reports on outpatient resident training payment strategy

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) issued a report to Congress and CMS entitled, *Alternative Medicare Payment Methodologies for the Costs of Training Medical Residents in Non-hospital Settings*. The report fulfills a mandate in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, identifying and describing the pros and cons of five alternative methodologies for paying the costs of training these residents.

The College is recommending that before CMS implements any option, it should work with Congress to: (1) further analyze the current financial arrangements and incentives among teaching hospitals, nonhospital settings, and supervisory physicians in nonhospital settings; (2) study the potential impact of any revisions to the current policy; and (3) clarify the definition of "all or substantially all" of the costs associated with training residents in nonhospital settings. The report (A-02-04-01012) may be found online at <http://www.oig.hhs.gov/oas/reports/region2/20401012.pdf>.

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## CMS aims to improve Medicare payment error rates

CMS has announced new steps to more accurately and comprehensively measure error rates in Medicare payments at the contractor level. The agency also hopes to further reduce improper payments by more than half, to 4 percent, in four years, through targeted error improvement initiatives. These initiatives will build on recent reforms in payment oversight and new authorities in the Medicare law.

Since 1996, the HHS OIG annually has determined the error rate for fee-for-service claims paid by the insurance organizations that serve as Medicare contractors. Medicare processes more than one billion claims each year. In fiscal year 2004, CMS reviewed more than 160,000 Medicare claims from the preceding year to learn where errors were being made. Of the total payments sampled, the new measurement program indicates the following problems:

- 4.1 percent of payments had errors due to insufficient documentation (2.6% was reported in the 2003 analysis, which included much less information on fiscal intermediaries).
- 2.8 percent had errors due to nonresponses to request for medical records (an unadjusted 5.0% rate was found in 2003).
- 1.6 percent had errors due to medically unnecessary services (as opposed to 1.3% in 2003).
- 0.1 percent had other errors (compared with 0.2% in 2003).

The claims included in this analysis were submitted before the agency's recently implemented initiatives to reduce error rates took effect. To reduce the error rates, CMS contractors will be required to:

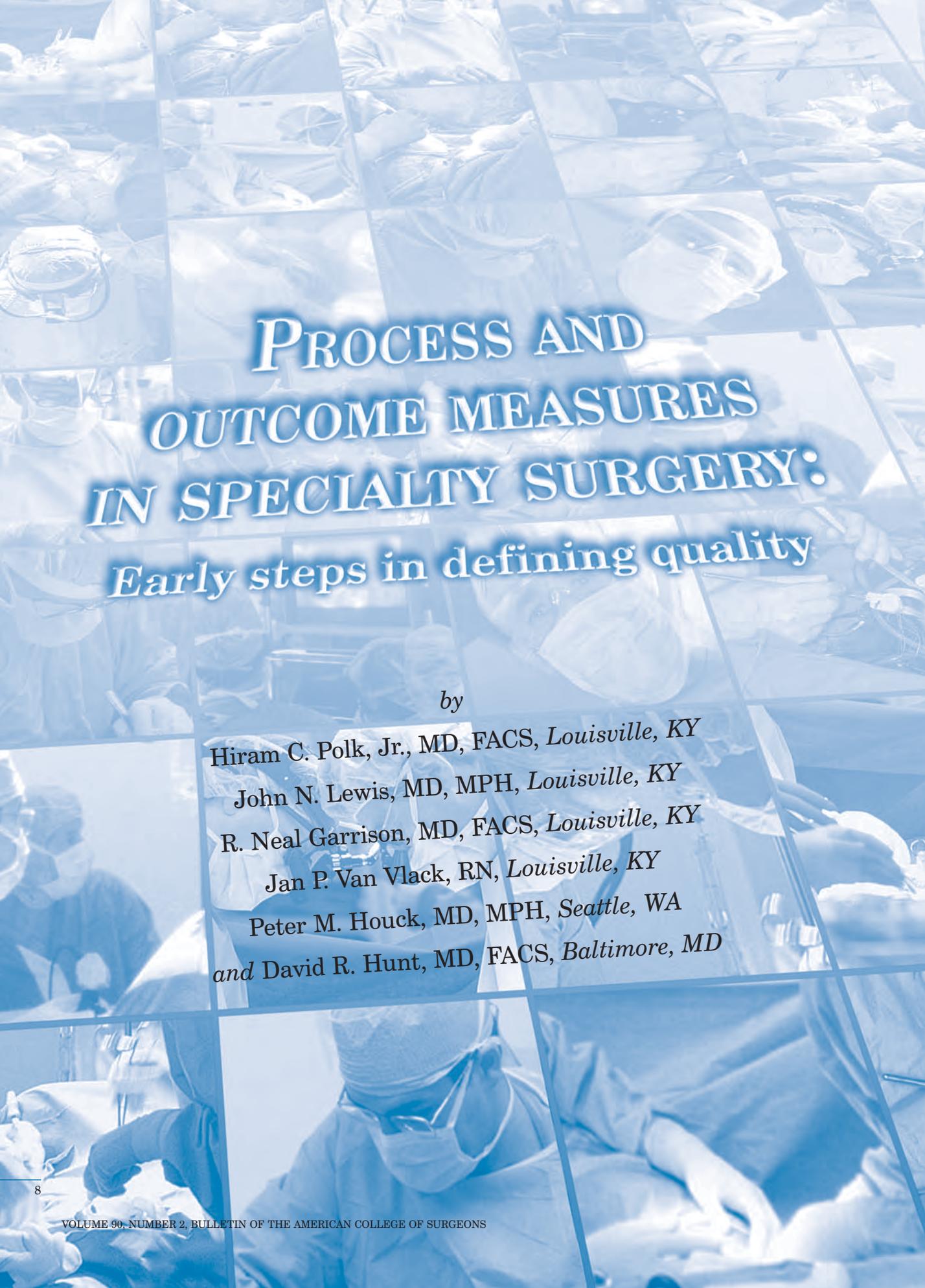
- Develop corrective efforts to educate providers about the importance of submitting complete medical records.
- Identify where additional review of claims and education on submitting claims is needed.
- Use the performance results to develop local efforts to lower the error rates by addressing the cause of errors and outlining corrective steps.

CMS is continuing to develop material for health care providers as part of The Medicare Learning Network. These articles can be found at [www.cms.hhs.gov/medlearn/matters](http://www.cms.hhs.gov/medlearn/matters). The error rate report can be located at [www.cms.hhs.gov/CERT](http://www.cms.hhs.gov/CERT).

## Proposed ASC list is released

CMS has published a new proposed list of procedures that Medicare will cover in ambulatory surgical centers (ASCs). The agency proposes to add 25 procedures to and delete 100 from the current list. The additions and deletions are partly a response to January 2003 OIG recommendations, indicating that Medicare could save up to \$14 million annually by removing certain procedure codes from the list. CMS deleted procedures that are performed in a physician's office more than 50 percent of the time or predominantly in the inpatient setting. Also deleted were procedures about which medical specialty organizations had safety concerns. CMS accepted public comments on the ASC procedure list through January 25. It is scheduled to become effective July 1.

The entire rule can be viewed on the *Federal Register* Web site at <http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/pdf/04-25968.pdf>.



# PROCESS AND OUTCOME MEASURES IN SPECIALTY SURGERY: *Early steps in defining quality*

by

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**P**roviding quality surgical care is not a new objective. Indeed, quality has been one of the quintessential expectations of surgery since Codman<sup>1</sup> espoused outcome measures and the assessment of quality practices at the beginning of the last century. Furthermore, the American College of Surgeons was founded on these concepts and has always promoted them.<sup>2</sup> Similarly, over the last two decades, the American Board of Surgery (ABS), through its examination process and the Residency Review Committee of the Accreditation Council for Graduate Medical Education (ACGME), has increasingly emphasized surgical quality improvement.

However, a new wave of concern and enthusiasm regarding medical practice quality and the avoidance of medical error has washed over the profession.<sup>3-5</sup> This movement has spawned entire specialties and an associated vocabulary in the field of health services research, in part supported by the Agency for Healthcare Research and Quality (AHRQ). For more than 10 years, the Centers for Medicare & Medicaid Services (CMS) has increasingly promoted improved quality as its primary mission<sup>6</sup> and has contracted with Medicare quality improvement organizations (QIOs) in each state to measure and improve quality in a variety of health care settings. Minimizing error in the health care industry has created a framework for these efforts.<sup>7</sup>

These and other efforts spurred the Institute of Medicine (IOM) to publish two important monographs, *To Err Is Human: Building a Safer Health System*<sup>8</sup> and *Crossing the Quality Chasm: A New Health System for the 21st Century*.<sup>9</sup> The first states the problem, while the second offers suggestions regarding its resolution. Interestingly, surgeons and surgery departments, for the most part, have been excluded directly or indirectly from this process. Only now is awareness growing about surgery as a major public health factor in the U.S. More than 42.5 million inpatient surgical procedures are performed in this country annually, representing a substantial number of individuals. By increasing specific standards for surgery and improving quality, some people believe that many postoperative deaths and complications could be avoided.

There also is a growing recognition that medical practice quality and patient safety are differ-

ent faces of the same coin. CMS's decision to focus on quality in surgical specialties is an outgrowth of the successful national Surgical Infection Prevention (SIP) program, which addresses the optimal use of prophylactic antibiotics to prevent infection in elective surgical operations.<sup>10,11</sup> From the earliest developmental stages of the SIP project, expansion beyond the use of prophylactic antibiotics was expected.

This expectation has proven accurate, resulting in the Surgical Care Improvement Project (SCIP), a partnership of CMS, the Centers for Disease Control and Prevention (CDC), the ACS, the Department of Veteran Affairs (VA), and a host of other governmental and nongovernmental organizations. Though SCIP is still under development, it uses some of the same principles as SIP, while setting broader goals and potential applications. At the heart of this endeavor is a plan to improve quality of surgical care and reduce morbidity and mortality nationally.

Ultimately, there will likely be a link to payment adjustment and public reporting on the quality of surgical care. Much of this can be attributed to the substantial accomplishments of the VA surgeons and their work with the National Surgical Quality Improvement Program (NSQIP), which has been published widely over the past decade.<sup>12-14</sup> Within the VA system, NSQIP culminated in a statistically significant reduction of more than 25 percent of risk-adjusted morbidity and mortality rates after surgical procedures.<sup>14</sup> It obviously is not a leap of faith to expand this effort into the broader private and public community of surgical specialty practice. This report describes the SCIP developmental work being performed in Kentucky.

### **Background**

In addition to serving as the Medicare QIO for Indiana and Kentucky, Health Care Excel (HCE) provides a variety of health quality services in four other states. HCE has transitioned from a peer review organization conducting individual case review to a facilitator of quality improvement in a number of settings.

HCE of Kentucky and Ohio KePRO, the Ohio QIO, contracted with CMS to implement the SCIP special study to explore a broader set of measures of surgical quality, develop a workable data collection system, and test the feasibility of their use in

surgical practice. HCE recruited Quality Surgical Solutions (QSS) to work collaboratively in the SCIP pilot, and Ohio KePRO recruited the Oklahoma Foundation for Medical Quality, the Oklahoma QIO, to conduct a portion of the pilot and provide administrative support for the executive committee.

Several surgical specialists developed QSS six years ago as a physician-led initiative in Kentucky. The surgeons were required to be certified by the American Board of Medical Specialties (ABMS) and to be Fellows of the ACS or of the American Academy of Orthopaedic Surgeons (AAOS), with at least volunteer faculty appointments in an appropriate medical school. The early experience with QSS has recently been described in the *Annals of Surgery*.<sup>15</sup> Table 1 on this page defines the specialties of the surgeons involved, the number of Current Procedural Terminology (CPT)-based protocols, and the initial number of surgical cases reported. The QSS framework served as a nucleus for the development of further quality studies.

### First steps

HCE and QSS chose to implement a two-pronged approach to recruit surgeons and hospitals to this study. A series of small face-to-face meetings followed initial contact via personal letters and telephone calls to leading surgical specialists and high-profile surgical leaders in Kentucky. Leaders of a select group of hospitals, including chief executive officers, directors of nursing, surgeons, quality teams, infection control nurses, and operating room managers and supervisors attended the meetings. Of the 20 hospitals invited to join the study, 15 agreed to participate. There was a tremendous advantage in having one of the Kentucky hospitals, an alpha test site for transitioning NSQIP from the VA to the civilian hospital setting, participate in SCIP. Furthermore, another participating Kentucky hospital has been actively involved in the surgical component of the National Nosocomial Infection Surveillance System (NNIS) with the CDC.

The surgical procedures selected are enumerated in Table 2 (this page). Although the SCIP is not limited to Medicare beneficiaries, these procedures are frequently performed on the Medicare population and are of sufficient magnitude to have appreciable complication and death rates. To bridge

**Table 1**

#### Profile of quality surgical solutions

66 surgical specialists

- General surgery
- Colorectal
- Digestive
- Endocrine
- Endoscopy
- Gynecologic
- Orthopaedic
- Otolaryngologic
- Surgical oncology
- Trauma
- Urologic
- Vascular

43 CPT-based protocols

16,028 surgical cases reported in first four years

**Table 2**

#### Procedures selected for study

- Cholecystectomy, including laparoscopic
- Hysterectomy
- Total hip replacement
- Total knee replacement
- Coronary artery bypass graft
- Other cardiac procedures
- Colorectal resection
- Vascular procedures

the artificial distinction between inpatient and outpatient procedures, laparoscopic cholecystectomy was added.<sup>16</sup>

Hospitals are expected to report a set of data on the procedures studied. Because high-volume hospitals have more than the requisite number of cases that could be included for the state as a whole (target, n=6,000), a smaller sequential or random sample from those institutions was selected. This stratification allowed better representation of small hospitals. Members of QSS are expected to perform approximately one-fourth of the operations studied and to provide separate surgeon-generated reports for comparison with the hospital-generated reports of the same cases. Each of these two distinct data sources has benefits and limitations. For example, the surgeon would be able to record office follow-up, patient ability to return to

**Table 3****Process measures****Surgical infection module**

Measure 1: Percent of surgical patients with on-time prophylactic antibiotic administration.

Measure 2: Percent of surgical patients with appropriate selection of prophylactic antibiotic.

Measure 3: Percent of surgical patients receiving prophylactic antibiotics, whose antibiotics were discontinued within 24 hours after surgery end time.

Measure 4: Percent of major cardiac surgical patients with controlled perioperative serum glucose ( $\leq 200$  mg/dL). (Perioperative is defined as the 24 hours preceding surgery through 48 hours following surgery.)

Measure 5 (test measure): Percent of major surgical patients with appropriate surgical site hair removal. No hair removal, or hair removal with clippers or depilatory is considered appropriate. Shaving is considered inappropriate.

Measure 6 (test measure): Percent of major colorectal surgical patients who maintained normothermia ( $36^{\circ}$ – $39^{\circ}$  C or  $96.8^{\circ}$ – $100.4^{\circ}$  F) during the perioperative period.

Measure 7 (test measure): Percent of major surgical diabetic patients with controlled perioperative serum glucose ( $\leq 200$ mg/dL). Perioperative is defined as the period beginning 24 hours prior to surgery and ending 48 hours after surgery.

**Cardiovascular module**

Measure 1: Percent of major noncardiac vascular surgery patients, without contraindications to receiving beta-blockers, who received beta-blockers during the perioperative period.

Measure 2: Percent of patients with known coronary artery disease or other atherosclerotic cardiovascular disease diagnoses, without contraindications to beta-blockers, who received beta-blockers during the perioperative period.

Measure 3: Percent of major surgery patients, maintained on a beta-blocker prior to surgery, who received a beta-blocker during the perioperative period.

**Venous thromboembolism (VTE) module**

Measure 1: Percent of major surgical patients who received any perioperative prophylaxis for VTE.

Measure 2: Percent of major surgical patients who received appropriate perioperative prophylaxis based on the surgical level of risk for VTE.

**Respiratory complications module**

Measure 1: Percent of major surgical patients on a ventilator, in any intensive care or step-down unit, whose postoperative orders included elevating the head of the bed greater than or equal to 30 degrees.

Measure 2 (test measure): Percent of major surgical patients on a ventilator, in any intensive care or step-down unit, without contraindications to PUD prophylaxis, who received PUD prophylaxis.

Measure 3 (test measure): Percent of major surgical patients on a ventilator, in any intensive care or step-down unit, who are placed on a ventilator-weaning protocol.

**Outcome measures**

Measure 1: Postoperative wound infection diagnosed during index hospitalization.

Measure 2: Intra- or postoperative acute myocardial infarction diagnosed during index hospitalization.

Measure 3: Intra- or postoperative cardiac arrest diagnosed during index hospitalization.

Measure 4: Intra- or postoperative pulmonary embolism diagnosed during index hospitalization.

Measure 5: Intra- or postoperative deep venous thrombosis diagnosed during index hospitalization.

Measure 6: Postoperative ventilator-assisted pneumonia diagnosed during index hospitalization.

Measure 7: 30-day admission/readmission.

Measure 8: Mortality within 30 days of surgery.

**Risk data elements**

Serum albumin

ASA class

Age

Operative complexity score

Functional status

Chronic obstructive pulmonary disease

Hemoglobin

Disseminated cancer

White blood cell count

Weight loss >10 percent in six months

Serum creatinine

Smoking history

---

work, and other postoperative developments. These data are not typically available to hospitals or CMS. Based on prior experience with surgical measurements in Kentucky, confidence was placed in the reliability and confidentiality of the QSS data system and hospital data reported to HCE.

CMS and QIO SCIP study teams in Kentucky, Ohio, and Oklahoma developed a surgical processes and outcomes tool (SPOT) for hospitals to use in collecting data relevant to quality measures, outcomes, and risk adjustment. Analytic flowcharts for reporting purposes also were created. The data collection tool was adapted to be compatible with the NSQIP and NNIS systems, enabling hospitals to select a preferred version. For data abstraction by QSS surgeons, the procedure-specific tools in use by QSS were modified to include data elements needed for the study.

Participating hospitals were concerned about the burden of collecting a new set of data in addition to other ongoing quality initiatives. Since many institutions were already collecting usable surgery data, specific reporting forms were developed and staff was retrained to make current data collection compatible with SCIP requirements. To overcome discouragement about the high volume of material, the use of staff time, and a history of minimal feedback from many related initiatives, the participating hospitals were assured that frequent feedback and follow-up would be offered. Formal collaborative learning sessions have been held and interventions have begun, even though the clinical data collection is incomplete.

### *Discussion*

The concept of measuring surgical quality has been actively discussed for much of the past three decades, with the caveat that most surgeons believe they personally perform the more difficult cases and have an adverse case mix. This presumption has been discredited, according to NSQIP's pace-setting strategy of operative risk adjustment and data from the Society of Thoracic Surgeons (STS). Surgical specialists involved in this pilot agree it is critical to use a legitimate and fair estimate of operative risk. Postoperative death and other severe complications of surgery occur infrequently, even among older patients undergoing major elective operations. Death and complications

will be monitored, but with an expected total of fewer than 10,000 cases, those outcomes will be uncommon.

In line with other CMS and QIO quality initiatives, this study emphasizes a number of process measures that represent valid predictors of improved outcomes for each case. The outcomes studied include but are not limited to length of stay, readmission, morbidity rates, and mortality rates. Table 3 (page 11) details the general process measures as well as outcome measures.

Because this is a small pilot study, it should not be used as a scorecard comparison of performance by study participants on outcomes or processes. Some improvement in surgical care is expected, but the study primarily tests the feasibility and usefulness of measures of surgical quality for future implementation nationwide.<sup>17</sup>

To gain peer input, proposed measures, procedures, and necessary data elements were discussed with Kentucky surgeons during specialty-specific conference calls. These teleconferences included leaders in their fields. A high rate of participation, attention to detail, and outward concern for patients' interests demonstrated the invited surgeons' commitment.

Based on suggestions from surgeons in the state, additional data elements were added to the Kentucky version of the hospital data collection tool. Expansion of the QSS report forms, as they were revised and tested to include the SCIP performance measures, moved from grudging acquiescence to agreement and wide general use among QSS surgeons.

### *Interim conclusions*

In many cases, indications for surgery are subjective. In other cases, such as a hysterectomy, indications can be readily and easily referenced to American College of Obstetrics and Gynecology guidelines.<sup>18</sup> The prior work of this and other specialty groups make the actual parameters for quality performance relatively easy to agree upon.

In evaluating many risk factors as predictors of outcomes, both the STS work in cardiac surgery and the NSQIP studies in the VA clearly identified some important factors. For example, serum albumin, presumably an indicator of chronic disease or poor nutrition, is a marker very close to the ASA score as a prime predictor of risk.

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Another high priority suggested by Kentucky specialty surgeons is patient education and documentation. Early data in this pilot study suggest that amazingly detailed and clear patient education activities, often supplemented by videos and brochures, are conducted in the physician's office but rarely documented in the hospital medical records. As a result, steps have been taken to improve the transfer of this information from the physician's office to the hospital medical record.

Attention to co-existing illnesses in older patient populations is a crucial aspect of surgical practice. Strict glucose control for patients with hyperglycemia is one example; use of beta blockade in patients undergoing vascular surgery or having a significant history of cardiovascular disease is another.

Appropriate, up-to-date, preprinted standardized orders address many patient safety issues and represent better practice in the best sense. Interestingly, the data collection showed that a number of preprinted orders in participating hospitals had not been updated in five years.

Antibiotic prophylaxis, including timing and choice of antibiotic, has been emphasized extensively and repeatedly. Many surgical specialty groups are finally developing guidelines that address proper termination of antibiotic prophylaxis within 24 hours after closure. Similar concerns exist regarding antibiotic management of community-acquired pneumonia.<sup>19,20</sup> Because specialty surgeons still fail to meet this performance measure 50 percent of the time, the guideline has recently been published in *Clinical Infectious Diseases*<sup>10</sup> and is being republished in the *American Journal of Surgery*. The AAOS has recently published a practice advisory that calls for no more than 24 hours of antibiotic prophylaxis following joint replacement surgery,<sup>21</sup> and the STS is currently reviewing evidence that supports the duration of prophylaxis in cardiac surgery.

Deep venous thromboembolism prophylaxis was one of the most interesting subjects discussed with surgeons, with virtually *no* agreement within any specialty group for any operation. Specialty opinions suggest that after taking patient-specific risk factors into account, any form of mechanical or pharmacologic prophylaxis, or none at all, is considered acceptable. There is a vast amount of fascinating evidence in this field, but the authors

agree with a recent National Institutes of Health (NIH) consensus conference on total knee replacement, which stated that "there is no persuasive evidence supporting or opposing prophylaxis of deep venous thrombosis in these patients."<sup>22</sup>

Regarding perioperative care, the importance of the precise, accurate, and minimally traumatic approach to the operation should not be forgotten. Clearly, the skill and experience of both surgeon and hospital remain important factors for all surgical procedures.

The traditional mortality and morbidity conference is a useful venue for quality improvement, but it can be further adjusted. For example, the University of Louisville mortality and morbidity conference was modified to be a quality improvement session with emphasis on "near-misses."<sup>23</sup>

Clinical pathways and protocols are sometimes abused, misused, and misunderstood as quality

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improvement tools. There is interest, however, in postoperative order sets in which each day of normal patient care in the hospital is defined with specific processes and medications. This lends confidence to the nursing staff when they have a high volume of similar cases.<sup>24</sup> Minor variations to adjust for patient needs may occur, but the capacity to put standard orders in print for repeated use has become a benchmark of the high standards encountered in prior clinical studies.

Office follow-up and return to work also are important factors in quality of care. They are outcomes that are not measured in the available CMS database.

### Summary

This study is currently under way in Kentucky, Ohio, and Oklahoma. So far, thousands of cases have been reported to HCE by participating Ken-

tucky hospitals, and hundreds of cases reported to QSS by its surgeons. Many standards of practice quality are being accepted and followed. A shining feature of the early observations of the pilot is how far surgical practitioners in the region exceed the anticipated norms for patient education. Collaborative meetings have been held in different parts of the state, uniformly attended by hospital representatives and a growing number of physicians, including some nonsurgeons. This study will conclude later this year and yield a significant report on the measures, standards, and capacity for ongoing improvement. It is perhaps most important to recognize that while actual data collection is unfinished, areas for improvement already have been identified. Hospital quality improvement teams and physicians are actively implementing several of these process improvement interventions. It has been said that perfection is an enemy of quality; the first step toward best practices is to implement, refine, and improve better practices. □



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# 2004 election may affect ability to push surgery's agenda

by Adrienne Roberts, Government Affairs Associate,  
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**T**he 2004 election produced big wins for the Republicans in the White House, the Senate, and the House of Representatives. President George W. Bush was reelected to a second term with 51 percent of the popular vote and 286 electoral votes. He was inaugurated on January 20.

Six Senate seats changed from Democratic to Republican (Georgia, Florida, North Carolina, South Carolina, South Dakota, and Louisiana), while two Senate seats changed from Republican to Democratic (Colorado and Illinois). Therefore, the current breakdown of Republican and Democratic Senate seats is 55-44, respectively, with one Independent, Sen. James Jeffords (I-VT), caucusing with the Democrats. Moreover, Tom Coburn, MD (R-OK), a family physician, won his bid for the Senate, thereby adding a second physician in that branch of Congress. The good news for Fellows is the possibility that these changes could lead to an additional four new votes for medical liability reform in the Senate.

House Republicans captured four additional seats, bringing the current membership breakdown to 232-202-1 (Republican-Democrat-Independent). More importantly, three Fellows of the American College of Surgeons (ACS) have been elected to the House: Tom Price, MD, FACS (R-GA), Joe Schwarz, MD, FACS (R-MI), and Charles Boustany, MD, FACS (R-LA). The American College of Surgeons Professional Association Surgeons' political action committee (ACSPA-SurgeonsPAC) supported all three Fellows, along with more than 100 additional candidates who support policies that are critical to surgical practice.

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## Senate

Of the Senate seat turnovers from Democratic to Republican, all were open-seat races involving retiring members, except one, and that was a huge loss to the Democratic Party. Senate Minority Leader Thomas Daschle (D-SD) was defeated in the general election 51 to 49 percent by John Thune (R-SD), a former member of the House of Representatives. This was Senator Thune's second attempt at a Senate seat. In 2002, he came within 400 votes of defeating Sen. Tim Johnson (D-SD).

In the wake of Senator Daschle's defeat, Democrats elected Sen. Harry Reid (D-NV) as the new Senate Minority Leader. Sen. Richard Durbin (D-IL) replaces Senator Reid as Minority Whip. Sen. Bill Frist, MD, FACS (R-TN), continues to serve as the Majority Leader, and Sen. Mitch McConnell (R-KY) is Majority Whip.

Although Senator Frist now has more Republican votes to rely on in the 109th Congress, this new class of conservative senators may prove to be a mixed blessing. Conservative ideologues such as Sens. Jim DeMint (R-SC), David Vitter (R-LA), and Coburn could encumber negotiations with Democrats.

Nonetheless, the Republicans have clear control over the issues that will be debated within the various committees. With the Senate membership at 55-45, Republicans have expanded their margin from one seat to two on most committees. Party leaders negotiated this ratio according to how many seats are held by each party. Also, along with an expanded ratio, Republicans received an increase in staff and budget resources.

More importantly, the 109th Congress is the first in which the committees are affected by Republican term limits, under which GOP senators may only serve as chairs for six years. The term limits resulted in the following chairs passing the gavel to other senators: Sen. Ted Stevens (R-AK) of Appropriations, Sen. John McCain (R-AZ) of Commerce, Sen. Orrin Hatch (R-UT) of Judiciary, and Sen. Arlen Specter (R-PA) of Veterans' Affairs.

Three of these senators have gone on to chair other committees. Senator Specter took over the Judiciary Committee and passed the gavel at Veterans Affairs to Sen. Larry Craig (R-ID). Sen. Thad Cochran (R-MS) took control of the Appropriations Committee, and Senator Stevens moved

to chair Commerce. Senator McCain took over at Indian Affairs.

With respect to the key Senate health committees, Sen. Charles Grassley (R-IA) continues as chairman of the Finance Committee, and Sen. Mike Enzi (R-WY) has taken the reins at the Health, Education, Labor, and Pensions (HELP) Committee. The HELP Committee's previous Chairman was Sen. Judd Gregg (R-NH), who has moved on to chair the Budget Committee.

At press time, new members had not yet been appointed.

## House of Representatives

The party breakdown in the House of Representatives is now 232-202-1 (Republican-Democrat-Independent). Of the seven House incumbents defeated for reelection, only two were Republicans: Reps. Max Burns (R-GA) and Philip Crane (R-IL).

Most House chairs kept control of their committees, and with an overall increase of three seats in the House, Republicans are expected to push a very conservative agenda in the 109th Congress. The issues most commonly mentioned by the White House as top priorities for the 109th Congress are tax reform, overhaul of the Social Security program, continued support of the war on terrorism, and medical liability reform.

The only major chairmanship change in the House took place in the Appropriations Committee. Rep. C.W. "Bill" Young (R-FL) will turn over control to either Rep. Ralph Regula (R-OH), Rep. Harold Rogers (R-KY), or Rep. Jerry Lewis (R-CA). All three made 30-minute presentations to the 29-member GOP Steering Committee, in whose hands the decision rested. A moderate and currently chairman of the Labor, Health & Human Services, and Education (L-HHS-E) Subcommittee, Rep. Regula is a strong supporter of increased health research funding. The change at the full committee level may cause a minor shuffle of subcommittee chairmanships. In addition to Representative Regula at the L-HHS-E panel, Representative Rogers is chairman of the Homeland Security Subcommittee, and Representative Lewis is chairman of the Defense Subcommittee.

Additionally, the Appropriations Committee also had two Republican vacancies due to Rep. David Vitter's (R-LA) move to the Senate and Rep.

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George Nethercutt's (R-WA) loss to Sen. Patty Murray (D-WA). These are viewed as "Southern" and "Western" seats; historically, Appropriations seats have been assigned by region, and Republicans sought to secure them.

The tax-writing House Ways & Means Committee had seven (five Republican and two Democratic) openings available. Retiring Republicans include Amo Houghton (R-NY), Jennifer Dunn (R-WA), and Scott McInnis. Rep. Philip Crane (R-IL) was defeated in the general election, and Rep. Mac Collins (R-GA) lost a Senate primary race. On the Democratic side, Rep. Gerald Kleczka (D-WI) is retiring, and Rep. Max Sandlin (D-TX) lost in the general election.

There were six vacancies (three Republican and three Democratic) opening up at the Energy & Commerce Committee. Reps. Billy Tauzin (R-LA) and James Greenwood (R-PA) retired and Rep. Richard Burr (R-NC) was elected to the Senate. On the Democrat's side Rep. Peter Deutsch (D-FL) was defeated in a Senate primary, Rep. Chris John (D-LA) was defeated in the Louisiana Senate race, and Rep. Karen McCarthy (D-MO) retired.

At press time, decisions regarding how to fill the vacant committee seats had not been made.

## Outlook

With the reelection of President Bush and the increased Republican majorities in both the House and the Senate, the GOP is more confident in the prospects for their health care agenda. Two health care issues that are expected to take center stage this year are medical liability reform and the impending sharp cuts in Medicare reimbursement. In addition, an overhaul of Medicaid, the introduction of market-based incentives to help the uninsured, the reauthorization of trauma care, and the reintroduction of patient safety measures are all expected to receive the attention of lawmakers in the 109th Congress. Yet, large deficits and the busy legislative calendar may prevent the Republicans from moving as aggressively as they would like.

## Liability reform

The federal effort to curtail the skyrocketing medical liability premiums that are driving surgeons from practice and making access more diffi-

cult for patients continues to lead the nation's health care agenda. President Bush has indicated that his top health care priority for the 109th Congress will be the passage of medical liability legislation. The College's hard work has helped to push this important legislation to the forefront, but much work remains to be done. Last year, the Help Efficient Accessible Low Cost Timely Health Care (HEALTH) Act passed in the House, but the bill was stymied in the Senate. This legislation would have set a ceiling of \$250,000 on recovery of non-economic damages, such as pain and suffering. This crucial legislation, which promises greater protections for both patients and physicians, is expected to be reintroduced early this Congress with the strong support of the President. The new composition of the Senate, combined with continued pressure from the ACS and the current administration's support, should improve the chances of passing this legislation.

## Medicare reimbursement

Lawmakers are feeling intense pressure from the College and other medical organizations to circumvent a series of sharp cuts in Medicare physician payments that are scheduled to occur in 2006. Adding to the difficulty of averting the reimbursement cuts are plans to introduce a deficit reduction package, and it remains to be seen how the shrinking budget will affect the billions of dollars Medicare pays to insurers, hospitals, physicians, and so on. The College will continue to pressure Congress to achieve changes in the currently flawed Medicare physician payment update formula to ensure equitable and stable reimbursement for physicians, so they may continue to deliver quality health care to beneficiaries.

## Medicaid

Lawmakers also could be forced to aim their deficit reduction efforts at the Medicaid program. Many experts say the administration is likely to revive its proposal to cap Medicaid funding, but this plan may prove difficult to implement when governors continue to struggle to meet their share of the funding for the federal-state program. Without help from Congress, many states will continue to trim their Medicaid programs, resulting in po-

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tential cuts to physician rates. Energy and Commerce Chairman Joe Barton (R-TX) plans to hold hearings this year on ways to overhaul the program. The ACS will continue to monitor these developments closely.

### Covering the uninsured

Many experts believe Congress may be moving closer to returning to an effort that has been off the radar for a number of years—extending coverage to the millions of Americans who lack health insurance. The Republican majority supports increasing the accessibility of coverage by expanding tax-free health savings accounts (HSAs) and by offering small businesses tax credits with opportunities to pool their resources and form association health plans (AHPs). AHPs would be exempt from state insurance regulations. The College continues to support federal efforts to expand access to health insurance coverage.

### Trauma funding

Over the last several years, the College has successfully resurrected federal funding for state trauma care system planning and development grants under Title XII of the Public Health Service Act. This section of the Public Health Service Act was established by the Trauma Care Systems Planning and Development Act (P.L. 101-590), which the College strongly supported in 1990, when Congress originally approved the legislation. For the last five years (FYs 2001-2005), the trauma program has received \$17 million in funding.

In addition to continuing the fight for increased federal funding, the College and many other specialty groups will be working together in a coalition to have legislation introduced and passed that will reauthorize this crucial program. The program's reauthorization expired after FY 2003.

### Patient safety

Nearly five years after the landmark Institute of Medicine report, *To Err Is Human: Building a Safer Health System*, showed that as many as 98,000 people die annually because of preventable medical errors, patient safety legislation almost passed last year. However, the bill became mired

in a standoff between competing House and Senate plans. The House and Senate versions were alike in that both would allow physicians to confidentially report medical errors to patient safety organizations, which would analyze the data in order to prevent the reoccurrence of similar mistakes. However, the bills differed in that the House version would permit data collected through the patient safety system to be used in criminal prosecutions, while the Senate bill was stricter with regard to how this information would be discoverable. Despite the 108th Congress' failure to pass patient safety legislation, the College will support the reintroduction of this initiative in the 109th Congress. □



# What's right and wrong *in my world of medicine*

by Charles A. Fager, MD, FACS, *Burlington, MA*

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The developments in medicine during the years that I have enjoyed the privilege of its practice have been, by any standards, extraordinary. The remarkable achievements in less invasive procedures and transplant surgery, as two examples, have had dramatic effects on patient care.

Given that we are able to do so much more for our patients, one must agree that what is right in medicine today outweighs what is wrong. Physicians often disagree about what may be positive or negative, and I, too, my have own biases.



## What's right

My internship began in the spring of 1946, at the height of a measles epidemic. Children arrived at the hospital in the throes of encephalitis due to the virus, some stuporous or comatose, others convulsing beyond control, the less serious with raging fever and delirium. Some died; others recovered, but sometimes with varying degrees of brain damage. Meanwhile, survivors of poliomyelitis often contended with permanent paralysis in one or more limbs. I never dreamed that these dreadful infections would eventually be controlled in my lifetime.

At that time, some medical professionals believed that tuberculosis (TB) responded to rest. Wealthier patients would go to mountain retreats for long periods of inactivity, while the less affluent were confined to bed. The next attempt to treat TB, seemingly in logical sequence, involved putting the infected lung at rest, collapsing it, by pneumothorax or, for more serious cases, thoracoplasty, and the removal of ribs, resulting in permanent collapse of one side of the chest. Whether the TB patients who recovered did so because of or in spite of these procedures remains a mystery.

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Fortunately, the antibiotic era, starting with penicillin, following rapidly on the heels of the bacteriostatic agents (sulfonamides), brought dramatic treatment for bacterial endocarditis, pneumonia, the dreaded streptococcal infections, meningitis, and venereal disease. Streptomycin and adjuvant agents proved effective against tuberculosis. We finally gained the means to control many fatal infections.

I also have the troubling recollection of young women during my residency years admitted to the hospital in shock from blood loss or with high fever, desperately ill with infection. Some did not survive despite all our efforts, and a few died from uterine perforation. These problems, of course, were due to illicit abortions stealthily done under poor conditions. As distasteful as abortion may seem, most physicians in practice today are too young to recall the horrific cases of sepsis and hemorrhage that women presented prior to the procedure's legalization. The sanctimonious politicians who pass laws to protect the lives of "unborn children" do so without any knowledge or understanding of maternal health or fetal dysmorphism. There has seldom been such blatant disregard for the cherished physician-patient relationship as the recent law passed by Congress and supported by President Bush abolishing "late-term abortions." It contains no provision for a hopelessly deformed fetus or the state of the mother's health and was passed under the guise of preventing a rarely used procedure.

Infection control was only a part of the technological revolution that swept medicine and, really, all other fields of endeavor. With it has come the age of specialization and subspecialization. Interventional radiologists now pass catheters through the arterial system for dilating and stenting arteriosclerotic arteries and use thrombotic coils to actually seal off some aneurysms within the brain, reducing the need for craniotomy in some cases.

Drugs for blood pressure control and the many psychotropic and antidepressant agents used today cast an aura of barbarism over our early destructive operations, such as thoracolumbar sympathectomy and frontal lobotomy, to treat hypertension and psychiatric conditions. In other areas aggressive surgery has been replaced by medical measures and less invasive approaches as well.

Diagnostic acumen has improved with the arrival of computerized tomographic scanning, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine. Endoscopic procedures in my own field—directed at pituitary gland tumors, internal brain structures, and spinal disorders—have had spectacular results. And, of course, coronary artery bypass surgery and organ transplants have extended many lives.



### hat's wrong

If all these advances represent what is right in medicine—adding years to life expectancy, offering palliation or cure for many problems, and bringing relief from much suffering when little existed in the past—then what possibly is wrong with medicine today? Determining what may be wrong is particularly relevant during an era focused on escalating costs of medical care, increasing numbers of uninsured and because the existing medical systems fail to provide for them and the indigent, and heightening calls once again for universal health care coverage.

### Waste

Perhaps the greatest problem lies within the profession itself, as practitioners of medicine come to this great feast with a tendency toward overindulgence. Despite attempts at controlling cost, patients have more diagnostic tests, receive more medications, and undergo more procedures than medical necessity dictates. While modern imaging techniques have made it possible to more accurately determine medical conditions, they are used far out of proportion to their need.

The number of spine or brain MRIs done for the common symptoms of back pain or headache that prove to be normal is evidence enough to show that these studies are conducted excessively. In fact, spinal MRI illuminates the normal degenerative spine changes better than ever, leading to reports of "abnormalities" that do not exist<sup>1</sup> and even to unnecessary spinal surgery. Much of this increased use of technology has been in response to patient demand and physician compliance. Personal injury litigation is awash with such reports of presumed abnormality suggesting a relationship to minor vehicular or workplace trauma.

The demand for MRI has spawned a massive proliferation of expensive imaging equipment; one

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company operates a chain of 16 imaging centers. Many hospitals have more than one MRI but need to run them 24 hours a day at monumental cost to the system. Such imaging stands at the top of a list that includes many other diagnostic studies, at times referred to as “defensive medicine,” conducted to prevent malpractice litigation. In reality, liability claims are seldom prevented by excessive tests.

### **Access**

Canadians come to our northern cities at their own expense because it may take as long as six months or more to have an MRI performed in their country. Rationing of care and inordinately long waiting periods for elective treatment are inherent to the nationalized health care system in many nations. On the other hand, our system of private health care, voluntary health insurance, health maintenance organizations, and Medicare and Medicaid still denies access to care for many Americans. At the same time, our attempts at cost containment have been unsatisfactory, largely due to excessive studies and unnecessary treatments and surgery. Would that some common ground could be found between the two systems!

### **Overmedication**

In addition to being overdiagnosed our society is now overmedicated. So many superb drugs have become available—anti-inflammatory agents, antacids, numerous psychotherapeutic agents, drugs to control hypertension and lower cholesterol. However, their widespread use seems excessive, as does that of vitamins and antioxidants. All of these agents are particularly marketed to elderly people, whose television programs, magazines, and newspapers are punctuated with many commercials proclaiming the efficacy of so many pharmaceuticals. Many older people in particular take a number of these drugs in addition to the diuretic, cardiac, and other medications they often need. Recent studies suggesting even further lowering of blood cholesterol must be viewed with skepticism. So many public health statistical reviews have failed in subsequent analysis or have proved of little benefit.

As an example of how freely drugs are prescribed, a friend at age 84 had a typical left cerebral stroke resulting in severe dysphasia and right hemiplegia.

Few events are more frustrating, and his family questioned the eight different drugs prescribed by his physician, including an anticonvulsant and one to keep his blood pressure down. The reason given, to prevent another stroke, in my view had no rational basis. I wrote to his physician, and said that I personally would be unwilling to take any drugs. The logic of preventing another vascular incident escapes me. In fact, I might well accept the risk of another myself as a peaceful event. His daughter has told me of the cost of all this medication, adding a significant drain without evidence of any real benefit. No answer came; the drug therapy continued. This situation is common; I regularly see elderly people who have their lists of seven or eight drugs, many of which they do not need, and I have visited a number of nursing homes in recent years to see people in similar situations subject to the same illogical and costly therapy.

The legislation expanding Medicare coverage to prescription drugs will quite likely open the way for even more exorbitant drug use if there is less financial barrier. As the situation stands, Medicare costs per individual are already twice as high in Manhattan, NY, as in Portland, OR, far greater in Miami, FL, than in Minneapolis, MN.<sup>2-4</sup> Is the harsh Minnesota winter more favorable to the health of the elderly, or is it possible that Floridians and New Yorkers are more demanding and their physicians more amenable? It also appears likely that major costs of medical care are expended on extraordinary treatment during the final six months of life, hardly rational care of the terminally ill.

### **Unnecessary surgery**

More egregious than all of the previously mentioned wrongs is unnecessary surgery. Coronary bypass surgery has undoubtedly saved many patients' lives, but others for whom it has been advised, at times even urgently, have done as well without surgery.<sup>5</sup> Many patients have had arthroscopic knee surgery, only to fare no better than those receiving nonsurgical treatment.<sup>6</sup>

In neurosurgery the many forms of cervical and lumbar spinal surgery that have evolved have been the source of controversy. In recent years, fusions have experienced a massive renaissance. While the advanced techniques used to perform these operations have resulted in higher success rates, the procedures are inordinately overdone, and many pa-

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tients experience inadequate relief of neck or back pain, and some have even more pain as a result of the procedure: the so-called failed spinal surgery syndrome. A small number of these operations have even resulted in various degrees of paralysis. The irony is that most patients with herniated discs and other back problems get better without any treatment or surgery.<sup>7</sup> They find their problems more tolerable with conservative measures and exercise. In the areas of work-related incidents, motor vehicle accidents, and other injuries involving litigation, excessive surgery of questionable necessity has also been done with a significant failure rate.<sup>8</sup>

### **Cancer**

Unfortunately, we have also become overly enthusiastic about our ability to treat malignancy. False hopes are at times raised with the appearance of each new drug for cancer. Reports of large numbers of patients may show life expectancy extended by five to six months, hardly a noteworthy achievement. The usually fatal brain glioblastoma has little better outcome now than it did in the past. The combination of surgery, radiation, and chemotherapy may defer the inevitable for months or even years. In some centers, however, repeated operations or other measures are conducted when the tumor recurs. These efforts may briefly extend a patient's survival but not the quality of his or her life.

Relief of nonmalignant intractable pain may be a worthwhile objective. Specialties dedicated to pain management, including anesthesiology, physical therapy, and neurosurgery, have been multiplying around the country. Patients with painful disorders are increasingly referred to pain clinics. There, they are treated with a number of injected drugs that work on the nerves, spinal facet joints, and other "trigger points." The physicians who carry out these procedures have opened up a field of medicine aimed at treating people previously considered untreatable. Neurontin, a drug intended for the control of seizures, is widely and excessively used, at times in large doses, as an adjuvant for controlling pain.

The most common pain control procedure is epidural steroid injection, combining a steroid and saline or an anesthetic injected into the spinal canal, intended by its placement to be outside of the dura.

Many of the patients who have had this procedure done have experienced chronic back and neck pain, sometimes after unsuccessful spinal surgery. Most show no signs of an inflammatory disorder. Some patients have gained a measure of pain relief, but the overall results raise serious questions about the value of this procedure.<sup>9,10</sup> The placebo effect is of course significant, as it is in any group of patients with unexplained pain. The procedure's failure to have any lasting benefit would be of less concern were it not for some disasters—a few injections into the spinal cord, blood clot formation compressing the spinal cord, and some instances of devastating abscess formation as a direct result of the injection.

### **Alternative medicine**

Some patients with diffuse areas of pain are thought to have "fibromyalgia," a condition ascribed commonly to people who exhibit evidence of emotional stress. These individuals typically have undergone trigger point injections at multiple sites over muscle areas said to be painful and tender, without any evidence of underlying objective muscular abnormality. This and a number of other similar conditions have sustained the field of "alternative medicine"—the guise for nonscientific therapies of many types. Alternative it may be; medicine it is not.<sup>11</sup>

The tendency to depart from conventional therapies has, in some measure, come from physician attitudes. Physicians' disdain for the hypochondriacal or histrionic personality all too often becomes evident. And their frustration in dealing with psychosomatic manifestations of illness as well as their patients' frequent unwillingness to accept them combine, driving this group of patients into the hands of alternative therapists.

As strange as it may seem, incurable conditions still exist, and human beings continue to grasp at any hope, as futile as that effort may be. The more powerful element is the emotion underlying a disease process or causing the symptoms. The term psychosomatic originated more than a half-century ago when we were awakening to the realization that anxiety and emotional stress could have profound effects on gastrointestinal, cardiovascular, and other functions.

Chiropractic leads the field of alternative therapies that use deceptive and misleading practices.

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The unique jargon of chiropractic derives from ideas that have no scientific basis. The term “subluxation” denotes displacement or misalignment of vertebrae, often at multiple levels, so that “adjustments” can be made by manipulation of one sort or another to restore alignment of spinal structures. Some chiropractors treat more than the common neck and lower back problems, including asthma, intestinal disorders, and migraines. Objective studies discredit their ability to treat these conditions.<sup>12</sup>

If chiropractic is the frontrunner in alternative therapies, acupuncture runs a close second. Some physicians seem to have accepted this ancient Chinese system, largely those who have found that it has some benefit in treating pain disorders resistant to conventional therapy. Much study has already been undertaken in an attempt to explain how this centuries-old Chinese ritual, which makes no sense at all in terms of modern medicine, can possibly be beneficial.<sup>13</sup>

Those who claim improvement from alternative treatments with few exceptions have often improved despite, rather than because of, the procedures employed. It has been said that it is “time for the scientific community to stop giving alternative medicine a free ride. There cannot be two kinds of medicine—conventional and alternative. There is only one medicine that has been adequately tested and medicine that has not, medicine that works and that which may or may not work.”<sup>14</sup>

### **Medical legal concerns**

As someone with experience in medical legal affairs and as physician participation in this area has become more active, some comment must be directed at the depth of social and economic problems related to personal injury, industrial accidents, and medical liability. Unfortunately, physicians, because of their desire to help their patients or to support the cause of a plaintiff or defendant, sometimes provide inaccurate and misleading reports or testimony.

The cause of unscrupulous attorneys would be worthless if not for physicians who confirm exaggerated and prolonged symptoms of injured parties or testify incorrectly to negligence of physicians or hospitals.<sup>15</sup> On the other hand, true negligence and liability should be recognized in a rea-

sonable and just settlement. With ever-increasing premiums for liability insurance causing some physicians to forego coverage, medicine and the law are approaching a crossroads. At one intersection is tort reform, with the capitation of awards and the possibility of professional panels and judges rather than juries. But so far liability reform is stalled at a stop sign in most states. At another intersection is a no-fault system that would provide recognition and settlement to an injured person beyond the legal implications of negligence.

### **Listening**

Much of what is wrong with medicine today can be defined as the extravagance of progress. However, I am an old-fashioned doctor. I try to listen to my patients, as difficult as it can be at times, preferring to hear their symptoms and examine them before looking at their MRIs. Patients today find it difficult to understand why I do not immediately look at the MRI envelope held in the outstretched hand. But they are reassured and relieved when I tell them that their problem does not require surgery, and, not surprisingly, the symptoms frequently become less troublesome. It remains my belief, as I was taught in medical school well over a half-century ago, that listening to patients and examining them continues to be the first and foremost example of what is right in medicine today. □

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### **References**

1. Jensen MC, Brant-Zawadzki MN, et al: Magnetic resonance imaging of the lumbar spine in people *continued on page 36*

**Dr. Fager** is chairman emeritus, department of neurosurgery, Lahey Clinic, Burlington, MA.



# Statement on restrictive covenants

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*This statement was prepared by the College's Committee on Young Surgeons and was approved by the ACS Board of Regents at their October 2004 meeting.*

Surgeons may be asked to enter into terms of employment that entail a “restrictive covenant” or “covenant not to compete” upon their voluntary separation or involuntary dismissal from that employment. Any restrictive covenant that interferes with the uninterrupted delivery of qualified surgical care to patients is considered unethical.

Restrictive covenants should be specific with regard to:

1. The defined geographic area.
2. The duration of the restrictive covenant.
3. The presence of a restrictive covenant clause in subsequent contract renewals.

While the College recognizes the intent and the perceived necessity of restrictive covenants, members of the College are advised to review restrictive covenants contained in proposed contracts and to negotiate mutually agreeable terms. The College also recommends the review of all contracts with an attorney who is familiar with local laws and precedents prior to signing any contract.

# Socioeconomic tips

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## Medicare offers bonuses for physician scarcity areas

by the Division of Advocacy and Health Policy

The Centers for Medicare & Medicaid Services (CMS) is implementing a new program that provides primary care and specialty physicians furnishing services in designated primary or specialty care scarcity counties with an additional payment equal to 5 percent of the amount paid for services rendered in those locales. The physician scarcity area (PSA) payment is mandated under the Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA) and adds to the payment to physicians who furnish medical care services in regions classified as health professional shortage areas (HPSA). Eligible physicians furnishing services in an area qualified as a PSA and HPSA would be entitled to receive both incentive payments, which would total 15 percent.

### *Eligibility for PSA bonus*

CMS uses the following methodology to designate PSAs for primary care physicians and repeats the steps for specialty physicians:

- Array the ratio of physicians to Medicare beneficiaries for counties and rural census tracts of metropolitan statistical areas from lowest to highest.
- Cut the list off when they have covered 20 percent of the national Medicare population.

Medicare will automatically pay the 5 percent scarcity bonus on a quarterly basis for services provided in zip codes that: (1) fall fully within a county designated as a PSA; (2) partially fall within a county designated as a PSA and are considered to be dominant for that county (as determined by the U.S. Postal Service); or (3) fall within an identified rural area. The payment will be made without the need for a modifier on claims for services provided in these areas. In cases where a service is provided in a county that is considered to be a PSA but not considered to be dominant for that area, physicians should include a new modifier, AR.

The PSA bonus payment became effective January 1 and expires December 31, 2007.

### *Eligibility for HPSA bonus*

In addition to creating the 5 percent PSA payment, the MPDIMA requires CMS to automate the 10 percent HPSA payment to physicians who provide care in zip codes that fall entirely in a designated county. In situations in which a physician provides care in a zip code that does not fall entirely within a HPSA, the physician must continue to use either the QB (physician providing a service in a rural HPSA) or QU (physician providing a service in an urban HPSA) modifier on claims to receive the bonus.

Determination of zip codes eligible for automated HPSA payment will be made annually with no mid-year updates. A zip code could become eligible for the HPSA bonus payment after the beginning of the year. Physicians furnishing covered services in HPSAs after the update may add a modifier to their Medicare claims to collect the incentive payment until CMS's next annual posting of eligible zip codes. Physicians can determine whether they qualify to receive a bonus payment and whether the payment is automated, or they need to include a modifier on their claims by reviewing information provided on the CMS Web site referenced later in this article.

### *Useful resources*

Surgeons should be familiar with the areas that qualify for the bonus payments, understand when they need to use related modifiers, and know what information is available from their Medicare carrier to ensure that their claims are submitted correctly. To help determine eligibility for a PSA or HPSA payment, CMS has issued a useful guide that can be found on its Web site at <http://www.cms.hhs.gov/providers/hpsa/guide.pdf>.

Other information, including a CMS "MedLearn Matters" article that provides additional guidance on HPSA and PSA bonus payments, can be found at <http://www.cms.hhs.gov/providers/bonuspayment/>. 

# College news

## Dr. Russell receives AMA award

ACS Executive Director Thomas R. Russell, MD, FACS, was a recipient of the 2004 Medical Executive Achievement Award, which is presented by the American Medical Association (AMA) to an executive of a medical association who has contributed substantially to the goals and ideals of the medical profession. The award was presented to Dr. Russell on Saturday, December 4, at the 2004 Interim Meeting of the AMA House of Delegates in Atlanta, GA.

“As executive director of the largest organization of surgeons in the world, Dr. Russell has reinvigorated the American College of Surgeons and fostered a more cohesive and collaborative advocacy approach among the surgical community,” said J. James Rohack, MD, chair of the AMA Board of Trustees. “He has reached out to numerous groups, both inside and outside of surgery, to forge consensus on quality measures and patient safety goals for the surgical patient.”

Dr. Russell’s strong involvement in efforts such as the National Surgery Quality Improve-



Dr. Russell (right) receives the AMA award from Dr. Rohack.

ment Program and development of patient safety principles for office-based surgery were noted as only a few examples of his leadership in the medical community. His hands-on approach and personal commitment to addressing concerns from surgeons across the country has

translated into a 10 percent increase in the College’s membership. Dr. Russell has increased efforts devoted to lobbying Congress and state legislatures, recognizing that surgeons have real problems in today’s practice environment that policymakers must address.



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# Advisory Council for General Surgery seeks nominations

The Membership Committee of the Advisory Council for General Surgery (ACGS) is soliciting nominations for two member-at-large positions on the Advisory Council. The following suggested guidelines will be used by the ACGS Membership Committee when reviewing the names of potential nominees for discussion by the ACGS and subsequent approval by the College's Board of Regents:

1. Individuals should be Fellows of the ACS and members of their state or local chapter.
2. Individuals being nominated should be in active surgical practice.
3. There should be recogni-

tion of the importance of their representing all who practice general surgery.

4. Also to be taken into consideration are geographic representation and type of practice.

5. The College encourages consideration of women and other underrepresented minorities.

6. Nominees should be loyal members of the College who have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

The functions performed by the Advisory Council are: to ad-

vice the Board of Regents on policy matters and policy formulations; to discuss matters which the council feels appropriate to be brought to the attention of the Board of Regents and/or other organizations; to serve as a liaison in the communication of information to and from general surgery organizations to the Board of Regents; to nominate individuals from general surgery to serve on College committees and other bodies; and to aid in the development of programs for the annual Clinical Congress.

Nominations may be submitted to [ms@facs.org](mailto:ms@facs.org) through April 1.

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## Clowes research award given

The George H.A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award for 2005 was granted to Sarah Thayer, MD, PhD, assistant surgeon, Massachusetts General Hospital, Boston, MA, for her research project entitled The Hedgehog Pathway and Pancreatic Neoplasia.

The purpose of the Clowes Award is to provide support for promising young surgical investigators. The award is sponsored

by The Clowes Fund, Inc., of Indianapolis, IN, in the amount of \$40,000 for each of five years, beginning July 1.

Information regarding the Clowes Award and the other scholarships, fellowships, and awards offered by the College appears on the College's Web site, [www.facs.org](http://www.facs.org). The requirements for the year 2006 will appear in an upcoming edition of the *Bulletin*.



Dr. Thayer

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## 2005 ACS German Traveling Fellow selected

Oscar J. Hines, MD, FACS, associate professor of surgery, University of California, Los Angeles School of Medicine, has been selected as the 2005 ACS Traveling Fellow to Germany.

This is the first time an exchange Fellow will go to Germany. As the German Traveling Fellow, Dr. Hines will participate in the annual meeting of the German Society of Surgery in

Munich, Germany, April 5-8. He will attend the Germany Chapter meeting during that event, and will then travel to several surgical centers in Germany.

Requirements for the 2006 Traveling Fellowship will appear in an upcoming edition of the *Bulletin*. They are also posted on the College's Web site, [www.facs.org](http://www.facs.org). The next application deadline will be April 1.



Dr. Hines

## 2005 International Guest Scholars chosen

Ten International Guest Scholarships for 2005 were awarded by the Board of Regents at the 90th annual Clinical Congress in New Orleans, LA. This program enables talented young academic surgeons from countries other than the U.S. or Canada to attend and participate in the activities of the Clinical Congress, then to tour surgical institutions of their choice in North America. The program is administered by the College's International Relations Committee. The requirements for applicants for the 2006 International Guest Scholarships will appear in a future edition of the *Bulletin*. They are also posted on the College's Web site at [www.facs.org](http://www.facs.org).

The 2005 International Guest Scholars are: Gaurav Agarwal, MBBS, Lucknow, India; Thierry Defechereux, MD, Liege, Belgium; Ching-Hua Hsieh, MD, Kaohsiung, Taiwan; Elias Kaperonis, MD, Athens, Greece; Lan Ping, MD, Guangzhou, China; Daniel M. Maffei, MD, Buenos

Aires, Argentina; Renato A. Mertens, MD, Santiago, Chile; Airton Schneider, MD, Porto Alegre,

Brazil; Diana V. Stoyanova, MD, Sofia, Bulgaria; and Juri Teras, MD, Tallinn, Estonia.

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## 2005 ACS Japan Traveling Fellow selected

David W. Chang, MD, FACS, associate professor, department of plastic surgery, M.D. Anderson Cancer Center, Houston, TX, has been selected as the 2005 ACS Japan Traveling Fellow.

As the Japan Traveling Fellow, Dr. Chang will participate in the annual meeting of the Japan Surgical Society in Nagoya, Japan, May 11-13. He will attend the Japan Chapter meeting during that event, and will then travel to several surgical centers in Japan.

Requirements for the 2006 Traveling Fellowship will be published in an upcoming edition of



Dr. Chang

the *Bulletin*. They will also be posted on the College's Web site, [www.facs.org](http://www.facs.org).

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## College participates in development of surgical care improvement project

The Surgical Care Improvement Project (SCIP) is a national partnership of organizations that are committed to improving the safety of surgical care through the reduction of postoperative complications. The SCIP steering committee consists of 10 public and private organizations, including the American College of Surgeons, the Agency for Healthcare Research and Quality, the American Hospital Association,

the American Society of Anesthesiologists, the Association of periOperative Nurses, the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, the Department of Veterans Affairs, the Institute for Healthcare Improvement, and the Joint Commission on Accreditation of Healthcare Organizations.

In summer 2005, the SCIP partnership will launch a col-

laborative, multiyear national campaign to substantially reduce surgical mortality and morbidity in four target areas: surgical site infections, and cardiac, respiratory, and venous thromboembolic complications. The goal is to reduce the national incidence of surgical complications 25 percent by the year 2010. For more information online, visit [www.MedQIC.org/scip](http://www.MedQIC.org/scip). (See related article, page 8.)

## Trauma and Critical Care 2005 course to be held in March

Trauma and Critical Care 2005 will present Maximizing Outcomes, Minimizing Errors, March 21-23, at Caesars Palace, Las Vegas, NV. Kenneth L. Mattox, MD, FACS, is program director. The program committee consists of M. Margaret Knudson, MD, FACS; Norman E. McSwain, Jr., MD, FACS; Michael J. Sise, MD, FACS; and Mary K. Allen, program coordinator.

The program objectives are to: (1) describe innovative and appropriate strategies for caring for the injured patient in the urban, rural, and military settings; (2) describe practical techniques and guidelines for the management of difficult traumatic injuries, including multicavity trauma, penetrating and blunt abdominal and thoracic trauma, genitourinary/perineal injuries, lung injuries, and

trauma in pregnant patients; (3) describe guidelines for optimal management of diverse trauma-related issues, including burns, pulmonary embolus, fat emboli, air emboli, hypothermia, pneumothorax, damage control laparotomy, hemorrhage control, pain management, resuscitation for transplantation, manpower shortages, legal ramifications, and performance improvement/patient safety issues; (4) discuss the application and efficacy of protocols in all phases of trauma care—from field to ICU; (5) discuss appropriate use and misuse of innovative imaging studies; (6) discuss the controversies surrounding use of old blood, splenectomy for trauma, appropriate treatment of aortic tears, and blunt carotid injury; (7) discuss the sources and applicability of trauma data to daily trauma

care; (8) discuss standards for pediatric trauma centers; (9) debate the effectiveness of nonoperative management of liver injuries; (10) discuss strategies for optimizing outcomes in the critical care setting, addressing management of sepsis, ARDS, ventilation, nutrition, and hyperglycemia; (11) discuss practical solutions to mass casualty situations; (12) discuss strategies for maintain competency and achieving certification; and (13) evaluate the benefit of knowledge gained in providing quality trauma care in the practice.

Complete course information can be viewed online through the American College of Surgeons Web site at [www.facs.org//trauma/cme/traumtgs.html](http://www.facs.org//trauma/cme/traumtgs.html). For further information, contact the Trauma Office at 312/202-5342.

# Introducing

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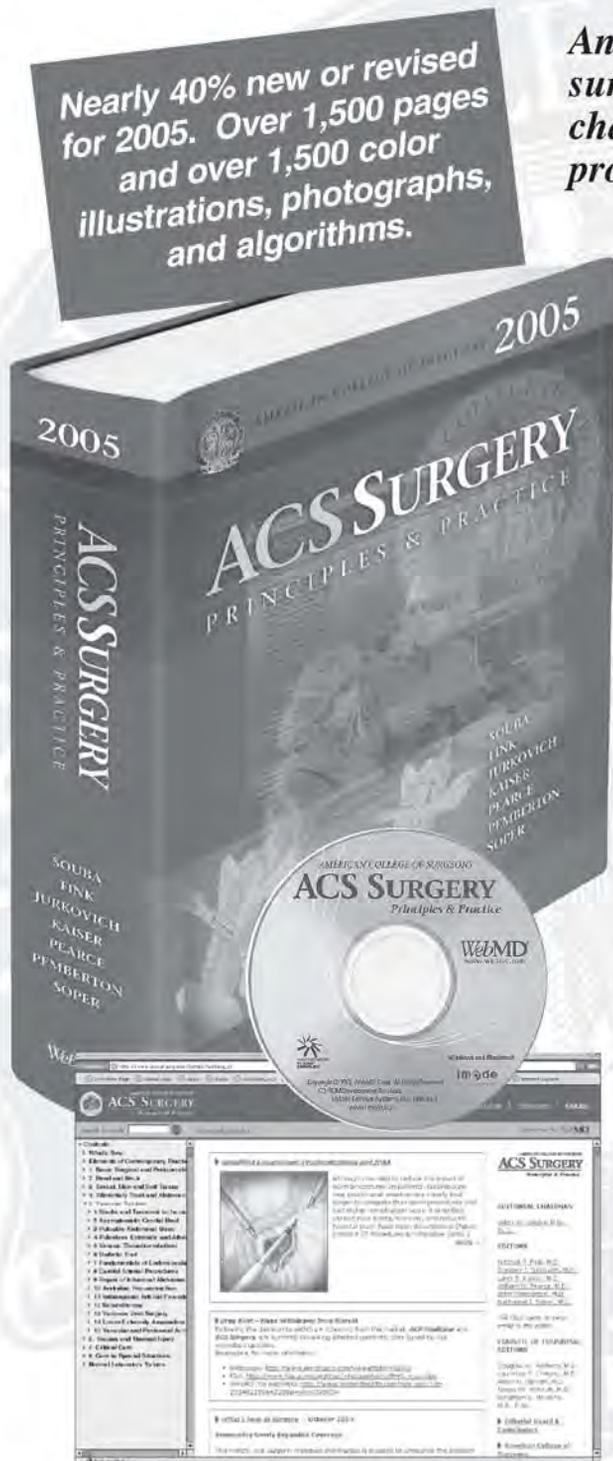
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## NTDB™ data points

# Can we insure the future of trauma?

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

The increase in the number of uninsured Americans is alarming and the magnitude of this national public health crisis shows no signs of slowing down. The U.S. Census Bureau announced that in 2003 the number of Americans without health insurance coverage rose by another million to 45 million, or 15.6 percent of the population. As providers of health care, we face this issue on a daily basis. Uninsured patients present to the emergency department of our hospitals with advanced stages of disease, significant comorbid factors from lack of preventive care, and are often victims of traumatic injuries. When looking at the records in the National Trauma Data Bank™ *Annual Report 2004*, we find that the single largest source of payment is self-pay. Self-pay accounts for

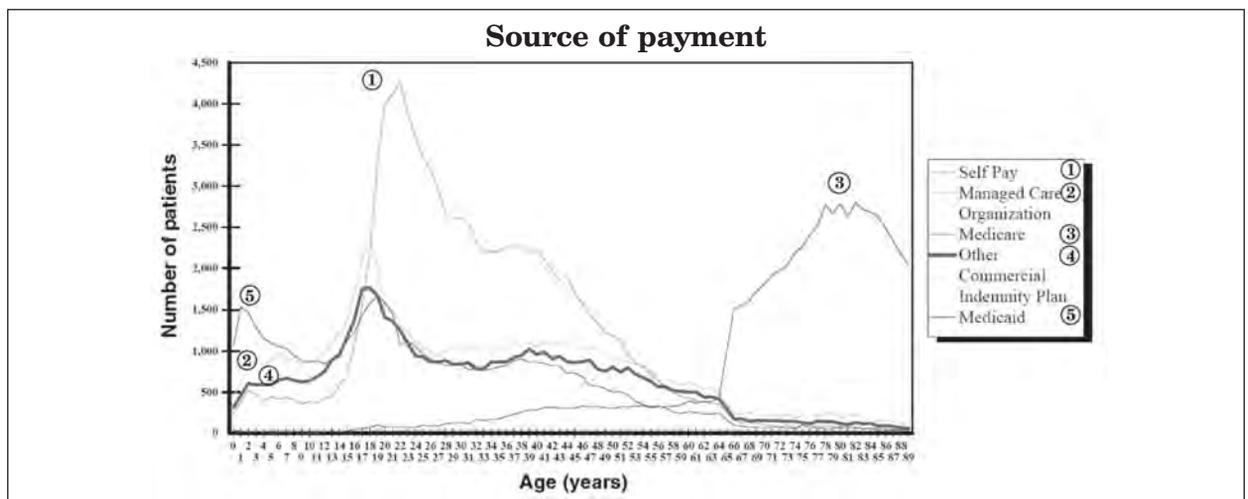
more than one out of every five records. Source of payment by age is displayed in the figure below.

The line representing the self-pay group is labeled by the number one and has a tall peak in the younger years. This peak is most likely composed of students and the working uninsured. Health insurance premiums continue to escalate. According to a 2003 employer health benefits report, average annual increases in health insurance premiums for all firms rose from 0.8 percent in 1996 to 13.9 percent in 2003. During this same period, the percentage of workers without health insurance increased as well. In fact, 83 percent of the nonelderly uninsured live in households where the head of the family works. Faced with these rising premi-

ums, small business owners are left with the decision to decrease or eliminate their benefits package, offload a greater share to the employee, or reduce the number of employees in order to maintain their bottom line.

The rise in health care premiums is multifactorial. A Price-WaterhouseCoopers report outlined several factors including medical advances, rising provider expenses, inflation, increased demands, government mandates, impact of litigation, and fraud/abuse. We need a multifactorial solution; otherwise, the future of trauma care and health care in general will suffer the consequences.

If you are interested in submitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at [mneal@facs.org](mailto:mneal@facs.org).



# Chapter news

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by Rhonda Peebles, Division of Member Services

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

## Merger in Wisconsin

After extensive deliberation and consideration, the Wisconsin Chapter (WC) and the Wisconsin Surgical Society (WSS) merged last October. The name of the new organization is Wisconsin Surgical Society—A Chapter of the American College of Surgeons. The current and former officers of the new organization are pictured at right.

Jane Melius serves as the Chapter Administrator.

## West Virginia presents Surgery Update 2004

The West Virginia Chapter presented Surgery Update 2004, in conjunction with the department of surgery at West Virginia University, September 24-25, 2004. The two-day education program featured a broad array of surgical topics, including bariatric, cancer, vascular, trauma, and endocrine surgery, as well as critical care. In addition, Marshall Urist, MD, FACS, from the University of Alabama, served as the visiting professor.

## Louisiana recognized for outstanding financial support

The Louisiana (LA) Chapter became the first recipient of the Gordon Holcombe, Jr., MD, FACS, Award during the Fellows Leadership Society's (FLS's) annual luncheon at the 2004 Clinical Congress. The award was established to recognize chapters that have donated at least \$100,000 to the College's endowment funds. It honors Dr. Holcombe, who is credited with encouraging the College to establish an endowment—supported by Fellows' voluntary contributions—to fund programs consistent with the College's mission. At the time of his suggestion, in 1971, Dr. Holcombe served as the Governor-at-Large from the Louisiana Chapter.



Wisconsin Chapter, left to right (all MD, FACS): Terry L. Gueldner, WC Immediate Past-President; Thomas H. Cogbill, WSS Immediate Past-President; Edward J. Quebbeman, President, WSS-WC-ACS; Paul S. Fox, ACS Governor; Thomas R. Russell, ACS Executive Director; Mary F. Otterson, WSS Secretary; and Gary R. Seabrook, WC Secretary.



Louisiana Chapter, left to right (all MD, FACS): Richard B. Reiling, Chair of the ACS Development Committee; Daniel J. Frey, Chapter Secretary; Edgar Feinberg II, Chapter President, and Richard R. Sabo, then-Chair of the Fellows Leadership Society.

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## Other chapters continue to support College funds

During 2004, 24 chapters contributed a total of \$28,365 to the College's Endowment Funds. The chapters' commitments to the various funds support the College's pledge to surgical research and education. Chapters may contribute to several different funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Fund. The chapters that contributed in 2004 include:

*Life Members of the FLS\**: Arizona, Southern California, Maryland, Nebraska, Brooklyn-Long Island (NY), Ohio, South Carolina, North Texas, Illinois, and Florida.

*Annual Members of the FLS*: Alabama, South Florida, Georgia, Metropolitan Chicago, Indiana, North Carolina, Metropolitan Philadelphia, South Dakota, Virginia, and Massachusetts.

*Contributors*: New Jersey, Maine, Southwest Missouri, and Montana-Wyoming.

## Chapter Showcase at 2004 Clinical Congress

The Division of Member Services hosted a Chapter Showcase at the last Clinical Congress, which featured reports and "how-to" information for two chapters' activities. The Connecticut Chapter was featured for its mentoring program for medical students; Kristen Zarfos, MD, FACS, Immediate Past-President, reported, while the Maine Chapter reported on its plans to develop a statewide database to measure surgical outcomes. William Horner, MD, FACS, Immediate Past-President of the Maine Chapter, and Frank Opelka, MD, FACS, discussed the impetus for the project and the components of the database.

In addition, reports on opportunities for chapters' involvement were presented by two experts: (1) Marilyn Leitch, MD, FACS, ACS Commission on Cancer (CoC), spoke about the CoC's Cancer Liaison Physician Program; and (2) David Hunt, MD, FACS, Centers for Medicare & Medicaid Services, reported on his agency's plans to involve the



Argentina Chapter, left to right (all MD, FACS): Alberto H. Cariello, Immediate Past-President; Enrique Caruso, Governor-at-Large; and Dr. Collicott display the fiftieth anniversary commemorative charter.

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College's Chapters in the activities of local quality improvement organizations.

Slides of the presentations that were presented at Chapter Showcase are available on the Chapters Web site at [www.facs.org/about/chapters](http://www.facs.org/about/chapters).

## Chapter anniversaries

Month	Chapter	Years
January	Northern California	53
	Louisiana	53
February	Arizona	53
	Australia-New Zealand	20
	South Florida	51
	Iowa	37
	Italy	19
	Lebanon	42
	Montana-Wyoming	40
	Eastern Long-Island, NY	37
	Peru	28
South Korea	18	
Washington State	53	

## Argentina Chapter observes landmark anniversary

Last October, the Argentina Chapter observed its fiftieth anniversary. Paul E. Collicott, MD, FACS, Director, ACS Division of Member Services,

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\*The FLS is the distinguished donor organization of the College. Chapters that contribute at least \$1,000 annually are members. Chapters that have contributed \$25,000 are Life FLS Members.



Lebanon Chapter, left to right (all MD, FACS): Jaber Abbas, Past-President; George Abi Saad, Secretary-Treasurer; Imad Kaddoura, President-Elect and Program Chair; Michel Daher, President; and Wihbi Shu'ayb, Governor.

presented the chapter with a commemorative charter (see photo, previous page). The Argentina Chapter observed the milestone during the Congress of Surgery conducted by the Association of Argentina Surgeons; more than 3,000 surgeons attended the four-day event. In addition to Dr. Collicott, J. Wayne Meredith, MD, FACS, Chair, ACS Committee on Trauma, also represented the College at this program.

## Lebanon Chapter celebrates fortieth anniversary

A gala dinner recognizing the Lebanon Chapter's fortieth anniversary took place September 17, 2004, with 120 guests attending. The dinner has become an annual event, where senior members are honored and new members are welcomed into the chapter.

The President of the Lebanon Chapter, Michel Daher, MD, FACS, addressed the audience and thanked the councilors for their continuous support and work to promote the mission and activities of the chapter. Imad Kaddoura, MD, FACS, chaired the program committee. (See photo, this page.)

## 2005 Leadership Conference

**Save the dates:** The 2005 Leadership Conference will be held June 12-14 at the Washington Court Hotel in Washington, DC.

Chapters are encouraged to send their Chapter Officers, two or three Young Surgeons (age 45 or under), and their Chapter Administrator. The College's Washington Office will schedule Capitol Hill visits for all participating chapters.

## WHAT'S RIGHT AND WRONG, from page 24

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