Surgical lifestyles: Collecting Photographic Memories
FEATURES

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About the cover...

Photographs chronicling the ravages, treatment, and societal views of disease and death are contained in the archives of Stanley B. Burns, MD, FACS. As a photographic historian, a major part of his life’s work has been devoted to the compilation of pictorial memories of medicine. The photos on this month’s cover are included in Dr. Burns’ collection and depict a mother holding her dead child and the first clinical photograph of a patient with polio. Further information may be found in the surgical lifestyles feature article on page 8. (Photos © Stanley B. Burns, MD, and The Burns Archive.)
NEWS

April 16-19: 33rd Spring Meeting to be held in Hollywood, FL

International Guest Scholarships available for 2006

Fellows in the news

Applications sought for 2005 Wylie Scholar Award

NTDB™ data points:
NTDB breaks the 1 million record mark
by Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

Chapter meetings
From my perspective

As we begin a new year and reflect on the holiday season that has just passed, we must prepare for the challenges ahead. This month marks the fifth anniversary of the release of the Institute of Medicine’s report, *To Err Is Human: Building a Safer Health Care System*. This landmark study galvanized all medical and health care professionals to undertake an effort to critically examine our current health care delivery system and seek out opportunities for improvement. Clearly, the College has taken its role in this process very seriously, and the delivery of safe, cost-effective surgical care is foremost in our minds and on our agenda and always will be.

Concomitantly, we are facing a myriad of changes with respect to the design of our health care system. As I said in last month’s column about residency training, many of these transformations are really cultural in nature, pitting the traditional ways of practicing medicine against the innovative. All of us can think of examples of how these shifts have affected our beliefs about health care and the delivery of medical services. The cultural changes include the team approach to providing services, adoption of standards of care and best practices, a focus on an aging population with chronic diseases, and outcomes assessment. The list could go on, but suffice it to say that medicine will never retreat to the practices of the past; rather, it will continue to be driven by new demands for cost and quality controls and the development of a true health care system.

An “immature” model

As I travel around the country and observe how physicians and hospital administrations interact, I am often surprised at how poorly some of them coordinate services and that they don’t really strive to achieve mutual objectives. This situation is in stark contrast to how physicians and hospital administrators acted toward each other in the past. Indeed, in some hospitals outright conflict and hostility surface over such issues as emergency room coverage and requirements for hospital privileges. Likewise, both hospital administrators and health care professionals are often at odds with insurance companies and other payors, largely because of reimbursement levels.

A system containing this much discord could be described as “immature.” This overemphasis on self-interests is inherent to a system based on fee for service and results in a patchwork of care for our patients.

Medicine will never retreat to the practices of the past; rather, it will continue to be driven by new demands for cost and quality controls and the development of a true health care system.
A “mature” model alignment

In contrast, some providers operate in a manner that allows physicians, other health care professionals, hospital administrators, and payors to work in alignment—with all stakeholders acting in the spirit of cooperation and collaboration. Unquestionably, the physicians in these plans have had to relinquish some of their autonomy, at least as measured by the standards of the past. However, in return, they have gained the opportunity to work in environments in which they, their hospital officials, and the plan administrators all have the same overall mission of delivering quality care at affordable prices.

Such groups look at the broader picture of how care can be provided to ensure long-term positive medical and fiscal results, rather than worrying about the immediate incentives sought by the providers of fee-for-service care. They are often self-governed with respect to disciplinary actions and physician education. They analyze efforts to prevent problems and errors, the management of chronic disease, and spending, and they impose appropriate controls as necessary. What emerges is a more mature model that manages not only the quality of care, but also its cost.

Physician interest increasing

It is estimated that more than 300 medical groups in this country now include in excess of 100 physicians each. Perhaps the oldest and best-known large group model is Kaiser Permanente. Although it may have had problems attracting the best physicians and specialists in the past, Kaiser Permanente now finds itself in the enviable position of having to turn away health care professionals seeking positions because they are already filled. The way in which Kaiser Permanente and other groups that follow its model currently manage benefits, pay, incentives, and time off clearly appeals to the new generation of physicians, who are often concerned about quality of life issues. Furthermore, these systems are clearly in a better position to respond to the evolving needs and demands of the marketplace and purchasers of care.

Only time will tell if these integrated models will be applicable to the country as a whole. But two points are indisputable: The debate over health care reform will continue, and the models that are most likely to survive the imminent turbulence will be those that are best able to adjust to the increasing demands for quality, cost-effective care.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
On November 2, 2004, the Centers for Medicare & Medicaid Services (CMS) released a final rule outlining changes to the 2005 Medicare fee schedule. The regulation included refinements to practice expense relative value units (RVUs) as well as other payment policy changes. Of particular interest:

- The RVUs assigned to compensate physicians for their medical liability costs were updated to reflect more recent premium data. However, methodological changes proposed by the College and others that would have directed relatively more liability RVUs toward high-risk services were not adopted.
- Policies involving the 10 percent health professional shortage area (HPSA) bonus payments were revised, and a new 5 percent physician scarcity area (PSA) bonus payment system was established. Included in the new PSA program are specialty shortage areas. (Details about both bonus payment programs are available at http://www.cms.hhs.gov/providers/bonuspayment.)
- Payments for physician-administered drugs were revised, although estimates of net reductions to oncologists and others who provide these services were far lower than originally predicted.
- Medicare will base all payments for diagnostic and screening mammography services on the physician fee schedule, including those services provided under the outpatient prospective payment system.
- The congressionally mandated 1.5 percent update to the Medicare fee schedule raised the 2005 conversion factor to $37.8975. Absent this action by Congress, the sustainable growth rate mechanism would have produced a 3.3 percent payment reduction.

Following are estimates of the impact that RVU changes in the 2005 fee schedule will have on aggregate Medicare payments for the surgical specialties (before applying the 1.5 percent conversion factor update):

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac surgery</td>
<td>1%</td>
</tr>
<tr>
<td>Colon and rectal surgery</td>
<td>1%</td>
</tr>
<tr>
<td>General surgery</td>
<td>1%</td>
</tr>
<tr>
<td>Hand surgery</td>
<td>0%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>-1%</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>0%</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>0%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0%</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>1%</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>4%</td>
</tr>
</tbody>
</table>

Overall payments to urologists are expected to decline by about 8 percent, due to additional changes that were made in policies and payment rates pertaining to drugs provided incident to physician services.

Sample payment rate changes for some key surgical services include:

<table>
<thead>
<tr>
<th>CPT/Procedure</th>
<th>2004 Average</th>
<th>2005 Average</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>19240, Removal of breast</td>
<td>$979</td>
<td>$996</td>
<td>1.8</td>
</tr>
<tr>
<td>27130, Total hip replacement</td>
<td>$1,370</td>
<td>$1,396</td>
<td>1.9</td>
</tr>
<tr>
<td>31255, Removal of ethmoid sinus</td>
<td>$436</td>
<td>$447</td>
<td>2.4</td>
</tr>
<tr>
<td>33512, CABG, three vein</td>
<td>$2,012</td>
<td>$2,044</td>
<td>1.6</td>
</tr>
<tr>
<td>35301, Rechanneling of artery</td>
<td>$1,115</td>
<td>$1,129</td>
<td>1.2</td>
</tr>
<tr>
<td>44140, Partial removal of colon</td>
<td>$1,204</td>
<td>$1,223</td>
<td>1.6</td>
</tr>
<tr>
<td>49505, Repair inguinal hernia</td>
<td>$457</td>
<td>$468</td>
<td>2.3</td>
</tr>
<tr>
<td>52601, Prostatectomy (TURP)</td>
<td>$687</td>
<td>$694</td>
<td>1.1</td>
</tr>
<tr>
<td>63047, Removal of spine lamina</td>
<td>$1,030</td>
<td>$1,047</td>
<td>1.6</td>
</tr>
<tr>
<td>66984, Remove cataract, insert lens</td>
<td>$684</td>
<td>$684</td>
<td>0.0</td>
</tr>
</tbody>
</table>
All payment policy changes became effective on January 1. The full text of the final rule, which was published in the November 15 Federal Register, can be accessed through the CMS Web site at http://www.cms.hhs.gov/physicians/pfs/.

Also on November 2, CMS released a final rule setting policies and payment rates for the hospital outpatient prospective payment system (OPPS). It is projected that the aggregate impact of the payment policy changes for hospitals and outpatient services will be a 6.5 percent increase in total payments. For the various hospital categories, payment increases are expected to be:

<table>
<thead>
<tr>
<th>Hospital Category</th>
<th>Payment Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospitals</td>
<td>4.0%</td>
</tr>
<tr>
<td>Urban hospitals</td>
<td>3.9%</td>
</tr>
<tr>
<td>Rural hospitals</td>
<td>4.5%</td>
</tr>
<tr>
<td>Teaching hospitals</td>
<td>2.6%</td>
</tr>
<tr>
<td>Cancer hospitals</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Although the final OPPS conversion factor for calendar year 2005 increased 4.4 percent, net payment increases for hospitals were lower primarily because of the decline in the statutory minimum payment for sole source specified covered outpatient drugs.

The entire regulation can be viewed on the CMS Web site at http://www.cms.hhs.gov/providers/hopps/.

According to a recent report released by PriceWaterhouseCoopers’ Health Research Institute, growing federal budget deficits coupled with increased health care spending and an aging population will very likely force deep Medicare reimbursement cuts. The last time the nation faced a mounting budget deficit, the report notes, Congress enacted the Balanced Budget Act of 1997, which significantly reduced Medicare payment for most provider services.

Expected annual deficits of $300 billion, combined with growing health care cost pressures, could produce budget balancing legislation that targets physicians. At the very least, the budget environment will probably make it difficult for Congress to commit the funding necessary to restructure Medicare’s flawed physician payment system. There also are concerns that some of the payment increases allocated by the Medicare Modernization Act of 2003 will be rolled back, including quality bonuses for reporting on specific quality indicators and payment increases to rural and teaching hospitals.

There is also an indication that the Bush Administration’s policy of creating an “ownership society” will place more emphasis on high deductible health plans and health savings accounts, which could encourage consumers to become more engaged and more conscious of cost. In addition, it is possible that competition between providers will increase, bad debt levels will grow, and utilization rates for many health care services may fall. The report maybe viewed at www.pwc.com/healthcare.
Surgical lifestyles:

Surgeon has "PHOTOGRAPHIC MEMORY" of historical advances

by Karen Sandrick,
Chicago, IL
As an ophthalmologist, Stanley B. Burns, MD, FACS, New York, NY, is quick to use the workings of a camera as a model for the functions of the eye. He explains to patients that retinal disease or macular degeneration is like having a camera with a perfect lens and apertures but no film. “You can take pictures all day long but see nothing,” he said. Meanwhile, he equates cataracts with foggy or dirty lenses that create blurry spots or hazed-over images.

Camera doesn't lie

As a photographic historian and author, Dr. Burns mesmerizes the eye and engages the heart and mind. In his compilations of photographic memories of medicine, he does not follow the “pick and choose” method of retelling events, or, as he writes in the introduction to his volumes on respiratory disease and oncology tumors and treatment, believe in offering the “daydream of history, that part we want to remember…so it seems there is an unbroken line of good choices leading to current philosophies.” He opts rather to present true history, “the whole picture, the good with the bad.”

Dr. Burns consequently chooses depictions that span the gamut of the events of medicine. Some of the triumphs include: William S. Halsted, MD (1852-1922), and his “field of operation” of a radical mastectomy, a surgical procedure that is considered to be the “greatest advance in the treatment of breast cancer during the nineteenth century”; and a German soldier after facial reconstruction by plastic surgeons and a wax model of an injury he suffered during World War I in which the left side of his lower jaw was blown off. Missteps include: physicians removing ice from the body of a patient who had been placed in “frozen sleep” for five days in 1939 as treatment for cancer; and placement of an external electrode on the abdomen of a woman before insertion of a uterine electrode for electro-gynecologic treatment of uterine disease.

He also showcases both the reversals and the ravages of disease: a breast tumor the size of an adult head that was successfully excised; an exposed nasal cavity eaten away by basal cell carcinoma or “rodent cancer” that was miraculously resolved after being dressed in 1865 with a mixture of arsenic, iodine, and mercury and packed with zinc chloride paste; a deadly sarcoma of the arm so large it eclipsed the patient’s chest; and lower limbs freakishly swollen by elephantiasis following scarlet fever.

In the process, Dr. Burns illustrates how photography has contributed to the development of medicine. Since photography was introduced in 1839, it has been used by physicians to document unusual manifestations of disease, seek consultative advice, record the stages of treatment, teach medical and surgical principles, portray physicians in formal settings and at the bedside, advertise “treatment breakthroughs,” and memorialize all-star medical occurrences, such as the opening of the operating room at Johns Hopkins Hospital in 1904 with premier surgeons Dr. Halsted, Harvey Cushing, MD (1869-1939), and Hugh Hampton Young, MD (1870-1945), at the operating table.

Although he has always harbored an interest in history, it was not the written but the pictorial representations of chronology that have held Dr. Burns in thrall. He became impressed in particular by the clarity of the photographic record in 1975, when he started his first collection of medical photographs with a daguerreotype of a South American Indian who had a growth on the jaw that was misidentified in a caption as a carotid, rather than a parotid, tumor.

And he has readily recognized the power of photographic images. “There have been tens of thousands of books written about medical history, but I don’t think people can recite too many sentences from any of them. Most of us, probably 99 percent-plus, think in pictures and remember them. So my concept is that by presenting pictures, I will provide a vivid remembrance of history the way it was and is,” he said.
“WW I German Soldier Posing with a Wax Model of His Wound.” In trench warfare of World War I the most exposed part of the body was the head and neck. Reconstructive, maxillofacial, and oral surgical specialties were advanced with the treating of thousands of massive head injuries. Germanic surgeons at times made wax models (moulage) of a patient prior to treatment. This photograph was taken by a German-Jewish military dental surgeon at the Krügszahnklinik der IV Armee, in Lubin, Poland.

**Archives**

Dr. Burns has been a solitary admirer of medical memorabilia as well. Among his more than 700,000 historical photographs are about 70,000 medical pictures, most of which clinical institutions or physicians’ families had cast aside because they were too burdensome or disturbing to keep. In flea markets in and around New York City, where he resides, Dr. Burns has unearthed photographic treasures from Algernon B. Reese, MD, the ophthalmologist whose name is associated with Cogan-Reese disease, also known as iris-naevus syndrome or iridocorneal endothelial syndrome, and Henry Pickering Bowditch, MD (1840-1911), former dean of the Harvard Medical Faculty and cofounder of the American Physiological Society.

Dr. Burns has been more than willing to assume the tasks of sleeving, categorizing, and archiving historical photos that others have shunned. Devoting the second and third floors of his Murray Hill townhouse to photographic preservation, he acts as a medical archaeologist, “saving artifacts of our profession that most people discard because they don’t want to see pictures of bad diseases,” he said.

But Dr. Burns does not lock away his pictorial collections, which also include photographs of the African-American experience, war and revolution, and Judaica as well as disease and clinical medicine. He works tirelessly to make sure items in The Burns Archive are seen, contributing to gallery and museum exhibitions, supplying vintage photographs for the films The Others and Gangs of New York, and writing on medical photography for seven journals. He also has produced more than a dozen books, including two on photography in the late 1800s and beginning 1900s: Forgotten Marriage: The Painted Tintype and The Decorative Frame and Early Medical Photography in America.

However, his books typically focus on medicine in America and how physicians practice and think about their patients. Dr. Burns noted that in the nineteenth and early twentieth centuries, physicians could do little for patients with cancer or severe traumatic injuries. Photographic records from that period, therefore, show physicians and patients as they struggled and coped with disease.

When he pieces together his books on medical history, he seeks out the “surprises that make you want to turn the pages.” As a result, his volumes do not present linear, chronological sto-
“Frozen Sleep as Cancer Treatment” (1935). During the 1930s, a wide variety of physical-chemical therapies were devised for cancer treatment including heat, cold vibration, ultrasound, diathermy, hydrotherapy, and all forms of electricity. This photo from a Springfield, IL, hospital documents “frozen sleep,” a new treatment for cancer. For five days the patient remained “frozen” under the scrutiny of three physicians. The patient was then thawed to consciousness; it was hoped that the lowered temperature would positively affect the cancer.

At right: “Sarcoma of the Arm” (circa 1874). The face of this young man mirrors the suffering typical in bone sarcoma patients of the nineteenth century. Surgery was so dangerous and cancer treatment so haphazard that patients did not present themselves until the disease was far advanced. This patient consented to removal of the arm. He died in the postoperative period.

“Rodent Cancer of the Nose” (1865). English surgeon Charles H. Moore published this photograph in his 1865 text, Rodent Cancer. Dr. Moore initially treated basal cell carcinoma with applications of “Donovan’s solution,” an unnerving mixture of arsenic, iodine, and mercury. Two months later the wound was packed with “chloride of zinc paste,” which hardened and helped slough the lesion. Vulcanite prosthetic masks were used by cancer patients to hide the defect.
ries but link isolated bits of the clinical past into a contextual whole. “I’m able to pick up a tree and put it in place so you can see the forest,” he explained.

His published volumes on respiratory disease and oncology, as well as an upcoming book on cardiovascular surgery, probe the roots of modern surgical therapies. In the series on respiratory disease, The Pioneer Era 1845-1870 traces the hermetic sealing of penetrating chest wounds to 1863, when U.S. Army Assistant Surgeon Benjamin Howard, MD, described his experience to Surgeon General Alexander Hammond. The Antiseptic Era 1871-1895 links the fall of the dictum, “Do Not Enter Here,” against performing surgery on the brain, abdomen, neck, and chest to the rise of aseptic techniques. The X-ray Era 1896-1920 credits the development of maxillofacial, head and neck plastic surgery to the need for reconstructing faces exposed to shrapnel and bullet injuries during World War I trench warfare. The Serology Era 1921-1945 heralds the creation of surgical specialty organizations and board certification.

The books also revere some of the forgotten pathfinders of surgical practice, such as Addinell Hewson, MD (1828-1889), who described 93 patients whose wounds from ulcers, burns, gun shots, and various surgical procedures healed within 15 days after being packed with earth in 1872. Coming just after the discovery of antiseptic wound treatment and surgery by Joseph Lister, MD, in 1867, Dr. Hewson’s “dirt dressings,” though grounded on the action of antibacterial microbes, were the antithesis of the push for cleanliness. 6

“This was an era when 20 percent of patients got gangrene, and 20 percent died from infections. When wounds were healing by secondary intention over weeks and months, Dr. Hewson’s patients would heal in 15 days even after a mastectomy and other major operations,” Dr. Burns said.

**Cultural lens**

An impetus for Dr. Burns’ work is his desire to explore aspects of American culture that have all but disappeared, such as the practice of photographing the dead. He explained that it was common in the late 19th century for families to

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**The Burns Archives houses rare, influential syphilis photos**

According to many art critics, Pablo Picasso’s Les Demoiselles d’Avignon has provoked more paintings and drawings than any other single work. It is credited as the first work of modern art and an inspiration to some of the genre’s giants, including Jackson Pollock and Willem de Kooning.

Painted in 1907, Les Demoiselles depicts five female nudes, two of whom bear distorted, angular facial features. For many years, art historians believed that Picasso had modeled the pair of faces after stylistic, primitive African masks of syphilis and the ill. However, William Rubin, director emeritus of the department of painting and sculpture at the New York Museum of Modern Art, questioned that theory when he learned those African masks had been unavailable to Western culture until 1917.

Believing that Picasso had fashioned his contorted representations from syphilitic faces he had seen while visiting hospitals in Barcelona, Spain, and Paris, France, Rubin scoured the world for photographs to support his thesis. However, he was unable to find a single image of a disfigured syphilitic face until he happened upon The Burns Archive’s collections of historical medical photographs.

“There can be no doubt that the most horrendous facial deformities caused by disease are those of congenital syphilis,” wrote Stanley B. Burns, MD, FACS, as an explanation accompanying a 1912 photograph of a person with syphilis whose face is aswarm with raw, open wounds. 6 Photographs of syphilitic faces have been eliminated from most archives because of their shocking imagery, said Dr. Burns, whose photographic collection seeks to preserve the history of medicine and, therefore, highlight its beauty and its ugliness.

Photographs of syphilitic deformations from The Burns Archive, which were published in Studies in Modern Art 3, Les Demoiselles d’Avignon in 1994, coauthored by Rubin and Helene Seckle, curator and chief of the Musee Picasso, Paris, thus changed the view of the origins of modern art.

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At right: "The First Clinical Photograph of Polio" (1871). The founder of French neurology, Salpetrière's Hospital, Jean-Martin Charcot, MD (1825-1893) was also a pioneer in the use of medical photography and in studying polio. In 1871, he published this photograph of a patient with polio in the world's first medical photographic journal. Collaborating with Dr. Alex Joffrey, Charcot found the prime lesion in polio was the atrophy of the spinal cord's anterior horn cells.

"The 'All Star' Operation" (1904). Taken to commemorate the opening of the new operating room at Johns Hopkins Hospital, October 5, 1904. William Halsted, MD, one of America’s greatest surgeons and educators of the twentieth century, is the “operator.” First assistant is John M.T. Finney, MD; second assistant, Harvey Cushing, MD; third assistant, Joseph C. Bloodgood, MD; instrument man, Hugh Hampton Young, MD; anesthesiologist, James Mitchell, MD; nurse, Miss Crawford; in charge of radiography, Frederick H. Baetjer, MD.
photograph their dead loved ones, particularly infants and children, often posing them in affectionate and memorial ways. His first book of postmortem photographs, Sleepy Beauty, placed in sharp contrast the difference between past and present attitudes about death. “Death and postmortem photographs were a natural part of American life in the 1800 and 1900s. The death rate among children was 30 to 50 percent. So the photographs were often the only pictures of their loved ones. But today we remove death from everyday life. We do not easily photograph the dead,” he said.

Dr. Burns’ photographs of the dead, gathered with the help of his wife Sara, who is his chief collaborator and head archivist of the collection, have resonated with the public. Sleepy Beauty, published in 1990 and reviewed on the front page of the book review section of The New York Times in 1991, already is out of print. Copies frequently are stolen from library book shelves.

Although they may be considered repellent or even sacrilegious, the postmortem photographs are curiously affecting and peaceable, and they support the growing recognition that postmortem photographs, particularly of stillborn and
neonatal deaths, assist in the grieving process, Dr. Burns said.

The second volume of postmortem photographs, Sleeping Beauty II, published in 2002, includes more than 140 images that express three themes that reside not only in the distant past but in more current times—family bonds during grief and mourning, the differences between American and European postmortem photography, and the artistry of posthumous mourning photographs. The book also bears testament to a new tradition of grieving using photographs, which arose following the bombing of the World Trade Center.

Although many of the photographs in Dr. Burns’ volumes have never been published before, some are especially rare: a surgeon in his office, circa 1910, preparing to irrigate an openly draining wound on a patient’s back; the first clinical photograph of polio, circa 1871; and perhaps the only existing depiction of the pulmonary disease in a Native American and its treatment by a shaman.

“My whole purpose in collecting photographs as historical documentation is to show what you haven’t seen,” Dr. Burns said.

References


Ms. Sandrick is a freelance writer in Chicago, IL.
This article summarizes changes in the 2005 Current Procedural Terminology (CPT) codes that are relevant to surgery. The first three sections focus on the CPT codes for procedures that inherently involved conscious sedation of the patient, ultrasound examinations, and online medical evaluations. The fourth section pertains to a new “G” code that the Centers for Medicare & Medicaid Services (CMS) developed for vessel mapping to establish an arteriovenous shunt for hemodialysis access. Other changes in vascular surgery in CPT also are discussed in this section of the article. Lastly, this article provides an overview of a variety of new codes of interest to general surgeons and closely related specialties.

Numerous codes discussed in this article are category III for emerging technology. Language in the CPT introductory notes to the category III codes directs the use of a relevant category III code instead of a category I unlisted code.

Conscious sedation

Codes for procedures that inherently include conscious sedation are now marked with a special symbol (a “bull’s-eye”) in front of the code in the main portion of CPT. They also are listed in appendix G, along with detailed instructions on reporting the services. More specifically, introductory notes in appendix G clarify that it is inappropriate for the same physician to report both a substantive procedure that includes conscious sedation and one of the conscious sedation codes (codes 99141 or 99142). If another physician monitors the patient, the physician performing the substantive procedure is not expected by CPT to report a reduced service by using modifier –52. Of course, if the physician performs a procedure not on the list in appendix G and also supervises trained personnel to monitor conscious sedation as defined in the introductory notes to the conscious sedation codes, it is appropriate to report both the substantive procedure and one of the conscious sedation codes.

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

Additions to the introductory language for diagnostic ultrasound, 76506-76999, clarify that:

- Ultrasound examinations, including those using handheld ultrasound, require permanently recorded images with measurements when they are clinically indicated. They are unnecessary when the sole diagnostic goal of the ultrasound examination is a biometric measure, as in ophthalmic ultrasound codes 76514, 76516, or 76519.
- A written report should be added to the patient's medical record. In some instances there are separate codes for a "limited" and "complete" examination of an anatomic site. If the complete examination is selected, the report should contain a description of each element that comprises a complete report (or explain why an element could not be visualized). A prescription for an intraocular lens satisfies the requirement for a written report for code 76519, ophthalmic ultrasound with intraocular lens power calculation.
- If both limited and complete examinations are available, the limited examination should not be reported for the same patient encounter as the complete examination. Similarly, the limited examination of an anatomic region should be used only once per patient encounter.
- Doppler evaluation of vascular structures is separately reportable. However, color flow Doppler used only for identification of anatomic structures is not separately reportable.
- Permanently recorded images of the site to be localized, together with a documented description of the localization process, are required when performing ultrasound guidance procedures. These items may be included in the report of the procedure for which the guidance is used or in a separate report.

Notes specific to ultrasound of the abdomen and retroperitoneum and non-obstetrical ultrasound of the pelvis clarify what is included in 76700, Ultrasound, abdominal, B-scan and/or real time with image documentation; complete, 76770, Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), B-scan and/or real time with image documentation; complete, 76856, Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete, and 76857, Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; limited or follow-up (e.g., for follicles). Additionally, the notes describe the applicability of codes 76770 and 76857 to the urinary tract and code 76856 to the male.

Online medical evaluation

A category III code has been introduced for online medical communications between a physician and an established patient. The descriptor for code 0074T, Online evaluation and management service, per encounter, provided by a physician, using the Internet or similar electronic communications network, in response to a patient's request, established patient, is very restrictive. Introductory notes further limit the use of code 0074T, stating that the communication exchange must be permanently recorded (in either electronic or hard copy) and a reportable encounter encompasses all the other communications (such as telephone calls, laboratory orders, and prescription provision) related to the online communication. The note also cautions that the online patient encounter should not be reported when it constitutes a pre- or postservice contact related to another encounter.

Vascular procedures

CMS has established a new "G" code for reporting vessel mapping of the arterial and venous vessels to provide the information necessary to create an autogenous fistula for hemodialysis. The code and descriptor are G0365, Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis conduit, including arterial inflow and venous outflow). This new code is part of the agency's "Fistula First" initiative, one of several initiatives undertaken to improve the quality of care for the dialysis patient.

Code G0365 may only be used for patients who have not had a prior hemodialysis access prosthetic graft or autogenous fistula. If both sides of the body have to be evaluated, report the code with a modifier indicating the vessel mapping was performed bilaterally (modifier -50). This code may only be reported twice in a year. Code 93971, Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study, cannot be reported on the same day unless it is performed for a separately identifiable reason in a different anatomic region and a -59 modifier is attached. The -59 modifier has several uses, but...
one of them is to distinguish between two procedures performed on a different site or organ system.

To reflect the increasing complexity of hemodialysis access surgery, code 36818, Arteriovenous anastomosis, open; by upper arm cephalic vein transposition, was added. A code for upper arm basilic vein transposition already exists.

Code 34803, Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs) was created as a category I code; it had been a category III code. A family of category III codes was added to report the placement of a fenestrated aortic endograft to treat abdominal aortic aneurysms involving the visceral arteries and the associated radiologic supervision and interpretation. The codes for reporting the placement of the prostheses are code 0078T, Endovascular repair of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral vessels (superior mesenteric, celiac or renal; using fenestrated modular bifurcated prosthesis (two docking limbs), and code 0080T, for the radiologic supervision and interpretation.

The codes to visceral extensions during fenestrated endograft repair are code 0079T, Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch, and code 0081T for the related radiologic supervision and interpretation. Both codes 0079T and 0081T are add-on codes, meaning they may only be reported along with codes 0078T and 0080T, respectively. Furthermore, because they are add-on codes, code 0079T and 0081T are not reported with a -51 modifier. Both codes may be reported once for each additional visceral branch in which a prosthesis is placed.

Two codes for the direct repair of aneurysm, pseudoaneurysm, or excision and graft insertion were deleted because they are too nonspecific to value fairly. They are code 35161, for aneurysm, pseudoaneurysm, and associated occlusive disease in other arteries, and code 35162, for ruptured aneurysm in other arteries. Code 37799, Unlisted procedure, vascular surgery, should be used if it is necessary to report an aneurysm repair for which there is no specific code. The coding of in situ vein bypass grafts has been clarified by the deletion of code 35582, In-situ vein bypass; aortofemoral-popliteal (only femoral-popliteal portion in-situ), and the addition of a note directing how to report three combinations of bypasses that could have been reported using code 35582 (see table below).

Breast procedures

Extensive notes were added to the breast excision procedures to clarify that:

- Breast biopsies are reported using codes 19100-19103. (The four types are needle core without imaging guidance, needle core with imaging guidance, percutaneous using biopsy device, and open.)
- Open excision of any type of lesion, without attention to adequate surgical margins, and with or without the preoperative placement of radiologic markers, is reported using 19110-19126. That includes code 19120, Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19140), open, male or female, one or more lesions.
- Partial mastectomy procedures include codes 19160, partial mastectomy, and 19162, partial mastectomy with axillary lymphadenectomy. The operative report must document that efforts were made to ensure adequate margins surrounding the lesion.
- The remaining mastectomy procedures, containing the words “simple,” “subcutaneous,” “radical,” and “modified radical” are total mastectomy procedures.
- The remaining procedures in the section,
codes 19260-19272, are all for the excision or resection of chest wall tumors. They are not restricted to breast tumors and are used to report the resection of any chest wall tumor, including those originating in the ribs.

In addition, codes for a partial mastectomy, codes 19160 and 19162, were clarified by adding a parenthetical statement in the descriptor that they include a lumpectomy, tylectomy, quadrantectomy, and segmentectomy.

Three codes were added for placement of radiotherapy balloon or brachytherapy catheters into the breast for subsequent radioelement application. Code 19296 is for a balloon catheter placed on a date after the partial mastectomy. Code 19297 is for a balloon catheter placed during the mastectomy procedure; it is an add-on procedure, meaning it must be reported with one of the partial mastectomy codes and does not need a modifier -51 indicating multiple procedures were performed. Code 19298 is for placing brachytherapy catheters, either during or after the partial mastectomy.

Finally, code 0061T, a category III code, was added to report microwave thermotherapy of a malignant breast tumor.

Gastric restrictive procedures
Two codes were added to the section on laparoscopic procedures on the stomach. Code 43644 is a new code for a laparoscopic gastric bypass and Roux-en-Y gastroenterostomy where the roux limb is 150 cm or less. Code 43645 is a new code for a laparoscopic gastric bypass and small intestine reconstruction. There is one new code and one revised code in the section on open procedures on the stomach. Code 43845 was added to report a biliopancreatic diversion with a duodenal switch. The full descriptor for code 43845 is Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (duodenal switch). Code 43846, the open Roux-en-Y procedure, was revised to change the maximum length of the roux limb from 100 cm to 150 cm.

Transplantation
Introductory notes were added to the codes for lung, heart-lung, heart, intestinal, pancreatic, liver, and kidney transplantation, which explain that transplantation involves three components: recovering the organ or parts of an organ from a cadaver or living donor; backbench work; and the transplant itself, including postoperative care of the recipient. Accompanying each explanation is a new code or, in some cases, several new codes for backbench work; the details of how the backbench work is described are dependent on the organ being transplanted. In addition, code 44137 describes the removal of a transplanted intestinal allograft.

Neonatal/pediatric intensive care
The definition of neonate was changed from 30 days or less to 28 days or less. This change was made throughout the introductory notes in the critical care section and in the code descriptors themselves. In addition, a change was made to the codes that are considered bundled into the critical care codes. These are code 51701, Insertion of nonindwelling bladder catheter (e.g., straight catheterization for residual urine), and code 51702, Insertion of temporary indwelling bladder catheter; simple (e.g., Foley). Previously, a deleted code was shown as being bundled into these critical care codes.

Acknowledgment
The authors acknowledge that many of the changes discussed in this article occurred while John T. Preskitt, MD, FACS, was the College’s CPT Advisor. They also wish to thank Robert M. Zwolak, MD, FACS, for reviewing the article.

Dr. Bothe is professor of surgery and compliance officer at the University of Chicago (IL).
The following statement was developed by the Subcommittee on Injury Prevention and Control for the Committee on Trauma (COT) to support legislation that would improve safety measures for children in and around cars. Recently, with the help of the National Highway Traffic Safety Administration, the federal government passed legislation that requires all car manufacturers to meet safety standards for power windows that kill and injure hundreds of children each year. However, still pending is legislation that would address backovers and blindspots that are responsible for an increasing number of childhood injuries and deaths each year. The COT supports legislation and other efforts to increase the safety of children in and around cars. This statement was reviewed and approved by the Board of Regents at their February 2004 meeting.

Statement on prevention of nontraffic vehicle-related injuries in children

The American College of Surgeons recognizes that injuries are the greatest cause of death and disability in children, despite the fact that the means to prevent these injuries are readily available. In particular, when children are left unattended in and around cars, the following facts pertain:

- More than 9,000 children age 14 and younger are treated annually in emergency departments in the U.S. for injuries that occur when they are left unattended in and around motor vehicles.
- In 2002, more than 100 children died in nontraffic vehicle-related incidents because adults left them unattended in or around a vehicle.
- Approximately 27 percent of the deaths that occur in this situation result from children overheating while being left in a car in hot weather.
- More than 50 percent of the deaths are caused by a child being run over by a motor vehicle that is backing up, and in these incidents, the driver is usually a parent.
- In 20 percent of driveway fatalities, a child puts the car in motion.
- The National Highway Traffic Safety Administration does not maintain a database for nontraffic, noncrash incidents and deaths.

In addition to educating parents about the dangers of leaving their children unattended around motor vehicles, the American College of Surgeons endorses the following prevention activities:

- Supporting legislation that allows parents/caregivers to be fined for leaving children unattended inside vehicles.
- Encouraging the National Highway Traffic Safety Administration to maintain a database for nontraffic vehicle-related incidents and fatalities.
- Promoting the installation of “backover prevention devices” in trucks, minivans, and other large vehicles.
- Studying the effectiveness of sensing devices that would sound an alarm when a child is left in a car seat and the key has been removed from the ignition.
Bibliography


The Governors’ Committee on Chapter Activities (GCCA) is composed of four subcommittees. Each subcommittee addresses various issues and individual challenges. This report summarizes their most substantial activities during the last year.

Meetings and Organization
The Subcommittee on Meetings and Organization this year again sent a Chapter Performance Checklist to all domestic chapters. I am pleased to report an overall improvement from last year’s results. More than one-half of the chapters are now using the online advocacy resource Web site to contact their members of Congress or members of their state legislatures.

With regard to another performance standard, many more chapters should consider participating in the Resident-Associate Society (RAS). Selection and appointment of resident representatives to the RAS governing council should be a high priority for all chapters, regardless of size.

In addition, it is imperative that chapter leaders and executives participate in the annual Chapter Leadership Conference. As ACS Executive Director Thomas R. Russell, MD, FACS, said, well-prepared chapter leaders are assets to each chapter. We must take advantage of this opportunity offered by the College.

On a more somber note, a number of chapters, as evidenced by their checklist responses, are thought to be underachieving. It is the consensus of the GCCA that the Chair will contact the President of each such chapter by telephone to discuss this state of affairs in a supportive and collegial, rather than pejorative, fashion. We would also expect the appropriate Governor-at-Large to aid and abet his or her chapter council in an effort to show improvement.

Membership and Diversity
The Membership and Diversity Subcommittee, as you may recall, has issued and the College approved a statement to increase diversity throughout the College. Various initiatives aimed at achieving this goal are in process currently.
International Activities

The International Activities Subcommittee reports that a new chapter has been formed in Turkey and that a proposal is forthcoming for the possible formation of a Pan-Africa Chapter. International Governors continue to believe that this subcommittee is an appropriate vehicle to continue global communications and cooperation.

Advocacy and Coalitions

The Subcommittee on Advocacy and Coalitions has confronted a number of issues this year, including chapter involvement in state trauma systems development and continuing evaluation of the State Surgery Legislative Action Center. But, I must report, it is the perception of too many of our colleagues that the legal system and legislative process both nationally and in many of the states have failed our profession. All other advocacy issues at this point pale in significance when compared with this cancer. The most affected Fellows feel that they have the dubious honor of occupying the mythical “bearing point,” where all weights from all directions bear. Many surgeons believe that this issue has been transformed from a political into a labor dispute and seem inclined and poised to force the issue in another venue and by other means. Such action of course holds once unimaginable negative implications for our profession.

The GCCA understands and appreciates the College leadership’s past and continuing efforts to avert this calamity. We have no magic answer to suggest to the Fellows, but we do believe that this issue affects us all, and that it affects all of our patients across all state lines. The bond between surgeons is universal and timeless. Those of us who for now find ourselves in relatively more favorable circumstances should support in every reasonable form and fashion our colleagues who are not. The College should help identify those locales of greatest concern and bring the full weight of all surgeons to bear in a reasonable manner to protect our profession, which is of course composed of the sum of all its parts. The GCCA is pleased to report our belief that the future of our profession has not been and never should be entrusted to tort law.

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April 16-19

33rd Spring Meeting
to be held in Hollywood, FL

The American College of Surgeons invites you to attend its 33rd Annual Spring Meeting, which will be held April 16-19, 2005, at the Westin Diplomat Resort and Spa, Hollywood, FL.

To emphasize its strong commitment to and support of general surgery, the American College of Surgeons devotes its annual Spring Meeting to the interests and needs of the practicing general surgeon. The objective of the Spring Meeting is to provide practicing surgeons with the knowledge and skills necessary to enhance the care of their surgical patients.

The American College of Surgeons (ACS), the Society of American Gastrointestinal Endoscopic Surgeons (SAGES), and the American Hepato-Pancreato-Biliary Association (AHPBA), will sponsor a joint Welcome and Assembly: Modern Management of Colon Cancer during the ACS Spring Meeting. For the first time, the three organizations will conduct a joint meeting day on Saturday, April 16.

The College, SAGES, and AHPBA are cosponsoring this session as part of the 2005 Surgical Spring Week. The ACS, SAGES, and AHPBA are holding their respective spring meetings in a back-to-back format, thus providing an opportunity for participants to attend each group’s meetings within one trip. The SAGES meeting dates are April 13-16, the AHPBA will convene April 14-17, and the ACS Spring Meeting occurs April 16-19.

The Advisory Council for General Surgery has planned a program for the Spring Meeting that will be of interest to all general surgeons. The 2005 Excelsior Surgical Society/Edward D. Churchill Lecture, Primary Hyperparathyroidism: The Changing Surgical Paradigm, will be delivered by Jon A. van Heerden, MB, FACS, FRCSC, FRCS(Edin)(Hon), Sunday, April 17.

A number of skills-oriented and didactic postgraduate courses are scheduled over the four days, including: Breast Ultrasound; Contemporary Bariatric Surgery 2005; Vascular Surgery; Minimal Access Surgery; Breast Imaging for the General Surgeon; Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons; Multidisciplinary Approaches to Multisystem Trauma: Issues and Priorities; Mobile and Wireless Computing: Practical Applications; and Mastering Surgical and Office-Based Coding. General Session highlights include: Current Treatment of Pancreatic Necrosis; Management of Catastrophic Injuries; Ablative Options for Breast Cancer; and Making the Operating Room As Safe As the Cockpit.

Sunday’s program will highlight a number of programs for residents, including Clinical Abstract Presentations by Residents, Spectacular Cases...
from Residents, and Surgical Jeopardy.

The meeting will take place at the Westin Diplomat Resort and Spa, located on the beachfront of the Atlantic Ocean and Intracoastal Waterway, just 10 minutes from the Fort Lauderdale/Hollywood Airport and 30 minutes from the Miami International Airport.

In addition to being a premier meeting facility, the hotel features a championship golf course and country club, tennis center, health spa, marina and yacht club, on-property retail shopping, and several dining options.

Make plans now to attend this important meeting. Information regarding the general sessions, postgraduate courses, and registration follows. Registration is also available online at www.facs.org.

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**ACS Advisory Council for General Surgery**

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Mark Peterson, Chicago, IL

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**Preliminary program**

Program is subject to change.

**General Sessions**

**Saturday, April 16**

8:00–9:00 am

**Managing Nutrition in the ICU (GS01)**

**MODERATOR:** Jeffrey M. Nicholas, MD, FACS, Atlanta, GA

This course is designed to review current concepts related to enteral versus parenteral nutritional support in the critically ill surgical patient. Emphasis will be placed on the role of immune enhancing/modulating enteral nutrition. Gastric versus jejunal feeding, techniques for enteral access, and complications of enteral nutrition will be reviewed. The timing of enteral nutritional support and specific strategies in the trauma patient, septic patient, and patient with adult respiratory distress syndrome (ARDS) will be addressed.

9:30–11:00 am

**Management of Catastrophic Injuries (GS02)**

**MODERATOR:** David V. Feliciano, MD, FACS, Atlanta, GA

This course will focus on operative management of catastrophic injuries to the pancreas/duodenum, the pelvis, and the difficulties encountered with secondary sequelae in patients with multisystem blunt trauma.

1:00–5:00 pm

**ACS/SAGES/AHPBA Welcome and Assembly**

**Modern Management of Colon Cancer (GS03)**

**MODERATORS:**

Frederick L. Greene, MD, FACS, Charlotte, NC

Steven D. Wexner, MD, FACS, Weston, FL

This session will present a multidisciplinary comprehensive review of the diagnosis, management, and science of colon cancer. This world-class panel will discuss the latest in imaging, surgical techniques, and research initiatives for the comprehensive care of the cancer patient. The modern and evolving role of genetic profiling will be discussed, as well as the medical and surgical treatment for advanced and metastatic disease. The role of the current ACOSOG trials will also be presented.
Sunday, April 17

7:30–9:15 am
Clinical Abstract Presentations by Residents (GS04)
MODERATOR: Steven D. Wexner, MD, FACS, Weston, FL
RESIDENT MODERATOR: Barry Jenkins, MD, Augusta, GA

The abstract authors (surgical investigators in-training) will present summaries of hypothesis-testing research, completed or in progress, that have not been presented or published previously. This session will provide a forum for residents to present their research findings and discuss the results of their research with experts and peers.

9:30–11:00 am
Spectacular Cases from Residents (GS05)
MODERATOR: Frederick A. Schild, MD, FACS, Miami, FL
CO-MODERATOR: Juan C. Paramo, MD, Miami, FL

Unusual cases selected from those submitted by members of the Candidate Group will be presented in clinicopathologic conference style to a panel of local experts. This session will emphasize the conduct of the investigation, surgical techniques, and the postoperative management of challenging cases from the experience of surgical residents and Fellows. This session will offer residents the opportunity to present extraordinary cases to a group of expert panelists and to discuss various aspects of these cases.

10:00–11:30 am
Noncolorectal Genetics (GS06)
MODERATOR: Ronald J. Weigel, MD, PhD, FACS, Philadelphia, PA

This course will review the current knowledge of the basic molecular genetics involved in the oncogenesis of a variety of cancers commonly treated by general surgeons. The role of genetic testing will be discussed for specific cancers in which the familial linkage has been determined.

11:00 am–12 noon
Excelsior Surgical Society/Edward D. Churchill Lecture
Primary Hyperparathyroidism: The Changing Surgical Paradigm (GS07)
INTRODUCER: Edward R. Laws, MD, FACS, Charlottesville, VA
INTRODUCER: Mark A. Malangoni, MD, FACS, Cleveland, OH
LECTURER: Jon A. van Heerden, MD, FACS, FRCSC, Rochester, MN

This lecture is named for the Excelsior Surgical Society, a group of 80 medical officers who met for the first time in 1945 at the Excelsior Hotel, Rome, Italy. This lecture also honors Col. Edward D. Churchill, a famous surgeon and consultant to the U.S. Army in the World War II Italian Theater, who presented the first keynote address at this meeting.

1:00–2:30 pm
How to Get Out of Trouble in the OR (GS08)
MODERATOR: Michael G. Sarr, MD, FACS, Rochester, MN

Several speakers will address difficult situations encountered in the operating room, including vascular catastrophes, trauma catastrophes, gastrointestinal catastrophes, and injuries to the biliary tree, followed by a panel discussion. We will encourage questions from the audience.

1:00–3:30 pm
Surgical Jeopardy (GS09)
MODERATOR: Mark W. Bowyer, MD, FACS, Burke, VA

Pit your surgical knowledge against the best and brightest from residency programs across the country. This session will feature teams of residents who will test their general and specific surgical knowledge against that of their peers. This will be a great opportunity to enhance the residents’ knowledge and promote camaraderie. A variety of practice issues important to the general surgeon will be raised.

3:00–4:30 pm
Best Practices for the Repair of Common Hernias (GS10)
MODERATOR: Leigh A. Neumayer, MD, FACS, Salt Lake City, UT

Attendees can expect to learn about evidence-based recommendations for the repair of inguinal hernias and ventral/incisional hernias.

Monday, April 18

9:30–11:30 am
Treatment of Acute Pain: Every Surgeon’s Responsibility (GS11)
MODERATOR: Joseph M. Civetta, MD, FACS, Farmington, CT

Acute pain is an expected part of most perioperative states. Because prior education of residents and current
surgeons has been limited, statistics show that under-
treatment of pain occurs in 60 percent of surgical pa-
tients. Yet, the principles of treatment and the dimen-
sions of both caregiver and patient perceptions form a 
small and easily attainable knowledge base. The ques-
tion-and-answer series of case-based scenarios, with live
audience participation and feedback, can provide the 
basic information necessary and kindle the “tension to
learn” adult learners need.

10:00–11:30 am  
Current Treatment of Pancreatic Necrosis (GS12)  
MODERATOR: Mark A. Malangoni, MD, FACS, Cleveland, OH

Attendees can expect to learn about key treatments in 
nonoperative care of patients with pancreatic necro-
sis; when an operation is indicated for patients with pan-
creatic necrosis; and the main complications of the op-
eration and treatment for pancreatic necrosis.

10:00–11:30 am  
Successful Implementation of New Paradigms for 
Surgical Residency Training (GS13)  
MODERATOR: Richard H. Bell, Jr., MD, FACS, Chicago, IL

This course will examine new models for resident edu-
cation that have recently been implemented. The panel 
will examine the impact of these models on the quality of 
resident training, patient care, and the workplace 
environment.

1:00–2:30 pm  
Ablative Options for Breast Cancer (GS14)  
MODERATOR: V. Suzanne Klimberg, MD, FACS, Little Rock, AR

Ablative techniques have been used in the treatment of 
metastatic hepatic tumors for several years. Surgeons 
treating both benign and malignant breast abnormali-
ties have taken great interest in the advantages of per-
cutaneous ablation over open surgical excision. Several 
small pilot trials attempting to treat fibroadenomas or 
small breast cancers with cryosurgery, laser ablation, and 
radiofrequency have been reported. All of these ablative 
techniques employ indirect heat to ultimately induce cell 
death. This session will review these options in greater 
depth.

3:00–4:30 pm  
Ablation or Resection for Hepatic Metastases 
(GS15 )  
MODERATOR: William C. Chapman, MD, FACS, St. Louis, MO

This course will address the indications, patient se-
lection, techniques, and role of hepatic ablation in treat-
ment of primary liver tumors and hepatic metastases. 
Important factors for patient selection and outcomes will 
be reviewed.

Tuesday, April 19

8:00–9:30 am  
Update on Approaches to Anal Diseases (GS16)  
MODERATOR: Robert D. Fry, MD, FACS, Philadelphia, PA

At the completion of this session, attendees can ex-
pect to understand new approaches to the treatment of 
hemorrhoidal disease, to recognize the significance of 
anal intraepithelial dysplasia and appropriate methods 
of treatment, and to be aware of new surgical approaches 
to the treatment of anal incontinence.

8:30–11:30 am  
Vascular Access (GS17 )  
MODERATOR: Frederick A. Schild, MD, FACS, Miami, FL

This course will emphasize practical issues associated 
with vascular procedures. It will address preoperative 
and postoperative care as well as surgical techniques and 
new technologies in vascular access surgery.

1:00–2:30 pm  
Making the Operating Room As Safe As the Cock-
pit (GS18)  
MODERATOR: C. Wright Pinson, MD, FACS, Nashville, TN

Attendees will learn how training in teamwork and 
communication, using a successful aviation-based Crew 
Resource Management model, is used to improve patient 
safety and efficiency in operating rooms in a variety of 
hospitals.

3:00–4:30 pm  
Outcomes Research: Implications for Your Prac-
tice (GS19)  
MODERATOR: J. Patrick O’Leary, MD, FACS, New Orleans, 
LA

“Outcomes” has emerged as a buzzword in modern 
medicine. The difference between this new concept and 
the more pedestrian “results” implies a national bench-
mark for comparison. This panel bridges the gulf—from 
the management of a national database in cardiac sur-
sery, to hospital administration evaluating the results 
of the most demanding of technical procedures, to the
private practitioner of surgery in a midsized community that lurks in the shadow of a major metropolis. A spirited discussion is anticipated as each of these experts makes his or her case in an erudite and interactive forum.

### Video-Based Education

**Sunday, April 17**

7:00–9:30 pm

**Highlights from the 2004 Clinical Congress Video Session (VE01)**

**COORDINATOR AND PRESIDING OFFICER:** Michel Gagner, MD, FACS, New York, NY

Videotaped surgical procedures performed and narrated by general surgeons will be presented during this evening session. An interactive panel discussion will encourage participants to present questions or challenges to the video authors and guest panelists. These videos were previously shown during the Bariatric Surgery, General Surgery, and Unusual Problems in Surgery video sessions at the 2004 Clinical Congress.

### Postgraduate Courses

The Spring Meeting offers a wide variety of postgraduate courses from which to choose. This year, we have several skills-oriented courses (designated as SC) and didactic courses (designated as PG).

#### Breast Ultrasound (SC01)

**Saturday, April 16—Lecture, 8:00 am–12 noon**

**Sunday, April 17—Workshop, 8:00 am–12:00 noon**

**CHAIR:** Eric B. Whitacre, MD, FACS, Tucson, AZ

The objective of this course is to introduce the practicing general surgeon to a focused module in diagnostic and interventional breast ultrasound. The program will consist of lectures and hands-on skill stations using a variety of ultrasound equipment. Live models and phantom breast moulages will be used to develop skills in breast ultrasound imaging and ultrasound-guided breast biopsy.

7 credits (2 sessions); fee: $1,000

#### Contemporary Bariatric Surgery 2005 (SC02)

**Sunday, April 17—Lectures, live telesurgery, and dinner, 8:00 am–4:40 pm and 6:30–8:45 pm**

**Monday, April 18—Lectures and live telesurgery, 8:00 am–5:30 pm**

**CHAIR:** Henry Buchwald, MD, PhD, FACS, Minneapolis, MN

**CO-CHAIR:** Sayeed Ikramuddin, MD, FACS, Minneapolis, MN

This intense, two-day course will feature didactic presentations, panels, and live, interactive, closed-circuit televised sessions to provide a broad overview of bariatric surgery. Participants will be able to describe the epidemiology, etiology, and incidence of morbid obesity and outline the physiologic basis for bariatric surgery. Criteria for identification of appropriate surgical candidates will be outlined, and various bariatric surgical procedures, such as laparoscopic adjustable gastric banding, vertical banded gastroplasty, gastric bypass, and duodenal switch, will be presented. The pre-, intra-, and post-operative care associated with each procedure will be described, along with the possible postoperative complications and their appropriate management and prevention strategies. In addition, principles underlying a multidisciplinary approach to bariatric surgery and the consequences of postbariatric weight loss will be discussed. Live, interactive, closed-circuit televised operations, primarily featuring laparoscopic techniques, will be performed by world-renowned surgeons. The psychological aspects of caring for the bariatric surgery patient, postoperative reconstructive surgery, and bariatric surgery in the adolescent will also be reviewed.

16 credits (6 sessions); fee: $850

#### Minimal Access Surgery (PG03)

**Sunday, April 17, 8:00–11:30 am and 1:00–4:30 pm**

**CHAIR:** C. Daniel Smith, MD, FACS, Atlanta, GA

Minimal access surgery is now an integral part of a general surgeon’s practice. This course will cover not only current topics related to the use of minimal access surgery for stone disease of the gallbladder, but also the controversial areas of minimal access surgery for colon disease and hernia repair. Finally, new horizons in minimal access surgery will be discussed. The course will focus on issues important to a general surgeon in practice, especially given that these are the most common surgical conditions of the abdomen cared for by general surgeons today.

6 credits (2 sessions); fee: $400

#### Breast Imaging for the General Surgeon (SC04)

**Monday, April 18—Lecture, 8:00 am–12:30 pm**

**CHAIR:** Edward J. Donahue, MD, FACS, Phoenix, AZ

This course is designed to provide the practicing surgeon with increased imaging skills in the analysis of both mammographic and breast sonographic images. Empha-
sis will be placed on correlating normal breast anatomy to both image types. The pathology of breast disease will be highlighted by analyzing these kinds of images and correlating the pathophysiology presented to the image seen.

4 credits (1 session); fee: $250

**Multidisciplinary Approaches to Multisystem Trauma: Issues and Priorities (PG05)**

*Monday, April 18, 8:00–11:30 am and 1:00–4:30 pm*

**CO-CHAIRS:**
- Eric R. Frykberg, MD, FACS, Jacksonville, FL
- Lawrence Lottenberg, MD, FACS, Gainesville, FL

The purpose of this course is to acquaint the practicing surgeon with the critical decisions and multidisciplinary considerations and options necessary for the proper care of the multiply injured patient. A variety of challenging combinations of injuries to multiple body systems will be discussed to demonstrate the appropriate priorities of care, available diagnostic and treatment modalities, and controversial issues. These include combined head and torso, abdomen and chest, and nonoperatively managed injuries, as well as a number of confounding conditions, such as cervical spine injury, pregnancy, and the elderly.

6 credits (2 sessions); fee: $325

**Vascular Surgery (PG06)**

*Monday, April 18, 8:00–11:30 am and 1:00–4:30 pm*

**CHAIR:** James M. Seeger, MD, FACS, Gainesville, FL

The objective of this course is to review current strategies and recent advances in the management of patients with peripheral vascular disease. The major focus will be on carotid artery occlusive disease, limb salvage surgery and interventions, aortic aneurismal disease, and venous insufficiency.

6 credits (2 sessions); fee: $325

**Mobile and Wireless Computing: Practical Applications (SC07)**

*Monday, April 18—Lecture, 1:00–4:30 pm*

*Tuesday, April 19—Workshop, 8:00 am–12:00 noon or Tuesday, April 19—Workshop, 1:00–5:00 pm*

**CO-CHAIRS:**
- David A. Krusch, MD, FACS, Rochester, NY
- Ronald B. Hirsch, MD, FACS, Ann Arbor, MI

This session will highlight the role of personal digital assistants (PDAs) and the use of interactive information for the surgeon’s daily practice. The workshop session, designed for beginners who have never owned or used a PDA, will feature a hands-on demonstration of the use and function of PDAs. A PDA will be provided to participants. Participants are required to attend the lecture session and select one workshop session.

6.5 credits (2 sessions); fee: $325

**Mastering Surgical and Office-Based Coding (SC08)**

*Tuesday, April 19, 8:00–11:30 am and 1:00–4:30 pm*

**CHAIR:** Albert Bothe, Jr., MD, FACS, Chicago, IL

The objective of this course is to teach participants the finer distinctions of appropriately reporting Current Procedural Terminology (CPT) codes for surgical services. This course will discuss CPT coding changes that become effective in 2005, when to apply modifiers to surgical procedures and office encounters, and how to correctly use the evaluation and management codes for consultations, critical care services, and prolonged services. The differences between the American Medical Association’s definition of the surgical package and Medicare’s definition of the global surgical package will be examined. Instruction will be given on the use of the Medicare physicians’ fee schedule and the information contained in the explanation of benefits (EOB) forms.

At the conclusion of this advanced coding program, participants will be better able to appropriately report and receive reimbursement for the services provided to their patients.

Surgeons and their staff members with two years of solid coding experience may attend. Participants are required to bring their copy of *Current Procedural Terminology Coding, 2005 edition.*

6 credits (2 sessions); fee: $350

**Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons (PG09)**

*Tuesday, April 19, 8:00 am–12:00 noon and 1:00–5:00 pm*

**CO-CHAIRS:**
- Charles D. Mabry, MD, FACS, Pine Bluff, AR
- Frank G. Opeka, MD, FACS, Boston, MA

This course is designed for surgeons interested in improving the management and efficiency of their surgical practices. The course will include lectures as well as skills laboratories, in which participants will work with the instructors to solve real-life practice management problems.

7 credits (2 sessions); fee: $450
Spring Meeting Program at a glance

Key:
SC = Skills-Oriented Postgraduate Course
PG = Didactic Postgraduate Course
GS = General Session
VE = Video-Based Education Session
* = Prerequisite required for registration

Saturday, April 16

GS01
Managing Nutrition in the ICU
8:00–9:30 am

SC01
*Breast Ultrasound (Lecture)
8:00 am–12:00 noon

GS02
Management of Catastrophic Injuries
9:30–11:00 am

GS03
ACS/SAGES/AHPBA Welcome and Assembly—Modern Management of Colon Cancer
1:00–5:00 pm

Sunday, April 17

GS04
Clinical Abstract Presentations by Residents
7:30–9:15 am

SC01
*Breast Ultrasound (Workshop) (continued)
8:00 am–12:00 noon

PG03
Minimal Access Surgery
8:00 am–4:30 pm

SC02
Contemporary Bariatric Surgery 2005
8:00 am–4:40 pm

GS05
Spectacular Cases from Residents
9:30–11:00 am

GS06
Noncolorectal Genetics
10:00–11:30 am

GS07
Excelsior Surgical Society/Edward D. Churchill Lecture—Primary Hyperparathyroidism: The Changing Surgical Paradigm
11:00 am–12:00 noon

GS08
How to Get Out of Trouble in the OR
1:00–2:30 pm

GS09
Surgical Jeopardy
1:00–3:30 pm

GS10
Best Practices for the Repair of Common Hernias
3:00–4:30 pm

VE01
Highlights from the 2004 Clinical Congress
7:00–9:30 pm

SC02
Contemporary Bariatric Surgery 2005 (continued)
8:00 am–5:30 pm

Monday, April 18

SC04
Breast Imaging for the General Surgeon
8:00 am–12:30 pm

PG05
Multidisciplinary Approaches to Multisystem Trauma: Issues and Priorities
8:00 am–4:30 pm

PG06
Vascular Surgery
8:00 am–4:30 pm

SC02
Contemporary Bariatric Surgery 2005 (continued)
8:00 am–5:30 pm
GS11
Treatment of Acute Pain: Every Surgeon’s Responsibility
9:30–11:30 am

GS12
Current Treatment of Pancreatic Necrosis
10:00–11:30 am

GS13
Successful Implementation of New Paradigms for Surgical Residency Training
10:00–11:30 am

GS14
Ablative Options for Breast Cancer
1:00–2:30 pm

SC07
Mobile and Wireless Computing: Practical Applications (Lecture)
1:00–4:30 pm

GS15
Ablation or Resection for Hepatic Metastases
3:00–4:30 pm

Tuesday, April 19

GS16
Update on Approaches to Anal Diseases
8:00–9:30 am

SC07
Mobile and Wireless Computing: Practical Applications
8:00 am–12:00 noon (Workshop A) and 1:00–5:00 pm (Workshop B)

SC08
Mastering Surgical and Office-Based Coding
8:00 am–4:30 pm

PG09
Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons
8:00 am–5:00 pm

GS17
Vascular Access
8:30–11:30 am
**Registration information**

Registration for the 2005 Spring Meeting will open in January. Please visit [www.facs.org](http://www.facs.org) for more information as it becomes available.

**Registration location and hours**

Registration will be held at the Westin Diplomat Resort & Spa.

- Saturday, April 16 .......... 7:00 am – 6:30 pm
- Sunday, April 17 ........... 7:00 am – 5:00 pm
- Monday, April 18 .......... 7:30 am – 4:00 pm
- Tuesday, April 19 .......... 7:30 am – 3:00 pm

**Registration fees**

Registration fees for the 2005 Spring Meeting will be available in January. Please visit [www.facs.org](http://www.facs.org) for more information as it becomes available.

**International attendees**

International Fellows, guest physicians, and meeting attendees: Please be aware that the process of obtaining a visa to attend meetings in the U.S. takes much longer than in the past. You are strongly urged to apply for a visa as early as possible, preferably at least 60 days before the start of the meeting. You may request a letter welcoming you to the meeting from the College by contacting the International Liaison Section via e-mail at postmaster@facs.org or by fax at 312/202-5001.

**Technical exhibits**

To enhance the educational value of the meeting, more than 50 companies will display products or services related to the practice of surgery. Your registration includes a reception on Saturday, April 16, 5:30–6:30 pm, in the exhibit hall. Spouses/guests will receive a ticket for the reception if they register under the appropriate registration category.

Technical exhibits will be open:

- Saturday, April 16 .. 10:00 am–2:00 pm, 5:00–5:30 pm
- Sunday, April 17 ..... 10:00 am–2:00 pm

**Children**

The ACS policy regarding children is as follows:

- Under 12: not permitted on Social Program Tours
- Under 16: not permitted on exhibit floor or in scientific sessions
- 16 and over: must have a badge to enter exhibit area or meeting rooms.

This policy includes infants in strollers and arms.

**Accreditation**

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

**CME credit**

The American College of Surgeons designates this educational activity for a maximum of 34 Category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those hours of credit that he or she actually spent in the education activity.

**Compact discs**

Selected postgraduate courses, general sessions, and named lectures will be recorded live and will be available for purchase on compact disc. Additional information will be available on-site in Hollywood, FL, at the National Audio Video booth near the registration area.

**Postgraduate course syllabi on CD-ROM**

A CD-ROM containing 14 select postgraduate course syllabi from the 2004 Clinical Congress will be available for purchase at the Spring Meeting registration desk.

**Tours and events**

A Social Program will be offered during the Spring Meeting in Hollywood, FL. A $50 nonrefundable advance registration fee is required for participation in the Social Program. The registration fee entitles you to attend scientific sessions, view the technical exhibits, attend the Saturday evening exhibit hall reception, and purchase event tickets. Registered Social Program attendees will also receive a tote bag.

This year, we will be offering the following tours: Snorkeling at John Pennekamp Coral Reef State Park; DCOTA—World of Design; and Paint and Play at the Las Olas Art Center.

Because tour capacities are limited, advance registration is strongly encouraged. For further information about Social Program tours, registration and cancellation fees, and child care arrangements, please visit the ACS Web site at [www.facs.org](http://www.facs.org).

**Meeting location and accommodations**

The 33rd annual Spring Meeting will be held in sunny Hollywood (Fort Lauderdale), FL, where you will find the newly expanded Fort Lauderdale/Hollywood International Airport spacious and convenient, and only minutes from the business district and hotels. The epicenter is downtown Fort Lauderdale, home to Las Olas Boulevard, the Riverwalk Arts and Entertainment District;
and charming Himmershee Village. More than 300 miles of navigable inland waterways wind through palatial estates, citrus groves, and the unique and exotic Everglades, while 23 miles of stunning Atlantic shoreline offer opportunities for yachting, fishing, snorkeling, jet skiing, scuba diving, sailing, windsurfing, or just relaxing. More than 3,500 restaurants with every cuisine can be found, some offering a panoramic view of the Intracoastal Waterway, while others offer waterside or beachfront dining.

The meeting venue is the Westin Diplomat Resort and Spa, located beachfront on the Atlantic Ocean and Intracoastal Waterway just 10 minutes from the Fort Lauderdale/Hollywood Airport (30 minutes from the Miami Airport). Rising 39 elegant stories, this new resort features 1,060 guestrooms, all showcasing water views and Westin’s Heavenly Bed and Bath products. Amenities include two unique outdoor pools, cabanas, beach activities, championship golf, complete tennis center, full-service garden courtyard spa, and a variety of dining options.

Reservations can be made by calling the hotel directly. Please indicate that you will be attending the ACS Spring Meeting in order to obtain the special group rates. Reservations can also be made online through a housing link in the Spring Meeting section of the ACS Web site, www.facs.org.

Westin Diplomat Resort and Spa
and Diplomat Country Club
3555 South Ocean Drive
Hollywood, FL 33019
Phone: 954/457-2000

ACS Group Rate: $239 single/double plus tax and $16 daily resort fee.

Accommodations are also being offered at the Marriott Hollywood Beach, a brand new property opening in March 2005. Located beachfront approximately two miles north of the Diplomat, this deluxe property offers water-view rooms with balconies, high-speed Internet access, complimentary newspaper, and in-room coffee. Resort amenities include beach access, oceanside dining, pool, sundeck, and fitness center.

Marriott Hollywood Beach Resort
2501 N. Ocean Drive
Hollywood, FL 33019
Phone: 954/924-2202

Rates: $195 single/double plus tax.

Transportation

Special meeting saver airfares are available on United Airlines. Choose from the following savings options:

• Receive a 5 percent discount off the lowest applicable domestic discount fare, including first class.
• Receive a 10 percent discount off midweek coach fares, purchased seven days in advance.
• Obtain a 5 percent additional discount on the previously mentioned fares if tickets are purchased at least 30 days in advance of your travel date.

Area/zone fares based on geographic location are also available with no Saturday night stay required. Minimum stay (two nights) varies by airline; seven-day advance purchase required. (Zone fares are not available through online ticket purchase; please call the numbers below).

These special discounts are available by calling the airline directly (independently or through a travel agent). Be sure to indicate the name of the meeting to which you will be traveling, and refer to the ACS file numbers to obtain the special fares.

United Airlines
800/521-4041
8:00 am–10:00 pm (ET)
ACS File 501CR

Car rental

Avis is designated as the official car rental company for the 2005 Spring Meeting. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

Avis Reservations
800/331-1600
Web site: www.avis.com
AWD number: B169699
The American College of Surgeons offers International Guest Scholarships to competent young surgeons from countries other than the U.S. or Canada who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $8,000 each, provide the scholars with an opportunity to visit clinical, teaching, and research activities in North America and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons Clinical Congress.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, FACS(Hon), former College Director. More recently, a bequest from the family of Abdol Islami, MD, FACS, and gifts from others to the International Guest Scholarship endowment have enabled the College to expand the number of scholarship awards.

The scholarship requirements are:

- Applicants must be graduates of schools of medicine.
- Applicants must be at least 35 years old, but no older than 44, on the date that the completed application is filed.
- Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location following completion of all formal training (including fellowships and scholarships).
- Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of the applicant’s country.
- Applicants whose careers are in the developing stage are deemed more suitable than those who are serving in senior academic appointments.
- Applicants must submit a fully completed application form provided by the College, either from the Web site or in paper format. The application must be typewritten and in English. Submission of a curriculum vitae only is unacceptable.
- Applicants must provide a list of all of their publications and must submit, in addition, three complete publications (reprints or manuscripts) of their choice from that list.
- Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment, or a Fellow of the American College of Surgeons residing in their country. The chair’s or the Fellow’s letter is to include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted in envelopes sealed by the recommenders. These letters are to be submitted with the completed application form.
- Applicants may submit a curriculum vitae of no more than 10 pages.
- Applicants may submit a photograph. (Passport size is preferable.)
- The International Guest Scholarships must be used in the year for which they are designated. They cannot be postponed.
- Applicants who are awarded scholarships are expected to provide a full written report of the experiences provided through the scholarships upon completion of their tours.
- An unsuccessful applicant may reapply only once and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

The scholarships provide successful applicants with the privilege of participating in the College’s annual Clinical Congress in October, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses plus admission to all lectures, demonstrations, and exhibits, which are an inte-
tegral part of the Clinical Congress. Assistance will be provided in arranging visits, following the Clinical Congress, to various clinics and universities of their choice.

In order to qualify for consideration by the selection committee, all of the above requirements must be fulfilled.

Formal American College of Surgeons International Guest Scholar application forms may be obtained from the College's Web site (www.facs.org) or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, USA.

Completed application forms for the International Guest Scholarships for the year 2006 and all of the supporting documentation must be received at the office of the International Liaison Section prior to July 1, 2005, in order for an applicant to receive consideration by the selection committee. All applicants will be notified of the selection committee’s decision in November 2005. Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing.

Nobility

No finer example of the College’s efforts to extol these virtues can be found than the initiation of the volunteerism award brought forth by the Governors’ Committee on Socioeconomic Issues. No one better exemplifies the nobility of our profession than the recipient of this year’s volunteerism award, Theodore Dubuque, Jr., MD, FACS, of St. Louis, MO, who has dedicated so much of his time and treasure to the people of Haiti. Surely, these gifts to humanity by so many Fellows do not go unnoticed.

Despite the uncertainty of these stormy times, Dr. Dubuque and so many like him have set a standard for all forms of human endeavor and behavior, professional or otherwise. During such a time of calamity in ancient Rome, the great stoic Emperor Marcus Aurelius chose the following words to honor those standard bearers who stood for and defended the institutions and customs of Rome that were most noble: “They stand as a promontory unto the sea, against which though the waves beat continually, yet they stand, and about them the swelling waves are stilled and quieted.” Just as in the days of the great Antonines, loyalty and allegiance to principle and purpose are still the most precious of virtues. With examples such as Dr. Dubuque—and countless others with him—the GCCA believes that our profession should face the future with confidence and assurance that a safe harbor may again be reached and that better weather in another season may yet be poised to begin.

Acknowledgments

Finally, I would like to thank the Governors and their Executive Committee for allowing me the privilege of serving as Chair of the GCCA for the last two years. Dr. Russell, Paul E. Collicott, MD, FACS, Director of the ACS Division of Member Services, and Courtney M. Townsend, Jr., MD, FACS, Chair of the Board of Governors, have been available at all times for consultation, and Rhonda Peebles, our ACS staff liaison, has been indispensable.

The College also owes a debt of gratitude to the committee’s retiring Governors: Stephen Deane, MD, FACS, of Liverpool, Australia; Erwin Thal, MD, FACS, of Dallas, TX; and Desmond Birkett, MD, FACS, of Boston, MA. Each of these Fellows during the last six years, in his own way, has exemplified those qualities that a Governor of the American College of Surgeons should exhibit.
The Royal College of Surgeons of England last year admitted to Fellowship ad eundem two Fellows of the American College Surgeons: Lael Anson E Best, MBBS, FACS, and Christopher James Linstrom, MD, FACS. Dr. Best (photo at right) is chief and director of thoracic surgery at The Rambam Medical Center in Haifa, Israel. Dr. Linstrom is associate professor of otolaryngology at The New York Eye and Ear Infirmary.

Timothy J. Eberlein, MD, FACS, has been elected to the National Academy of Sciences’ Institute of Medicine (IOM), one of the highest honors a medical scientist in the U.S. may receive. The IOM is a private organization that promotes and disseminates scientific knowledge to improve health care. Dr. Eberlein is the Editor-in-Chief of the Journal of the American College of Surgeons. He is Bixby Professor and chairman, department of surgery, Washington University School of Medicine, St. Louis, MO. Dr. Eberlein also is the Spencer T. and Ann W. Olin Distinguished Professor and director, The Alvin J. Siteman Cancer Center, Washington University, and surgeon-in-chief at Barnes-Jewish Hospital.

In October 2004, the California division of the American Cancer Society appointed Theodore X. O’Connell, MD, FACS, co-chair of its information, navigation, and support team. In this position, Dr. O’Connell will play an integral role in shaping a new centralized, coordinated model for delivering the society’s patient-related services in California. Dr. O’Connell is clinical professor of surgery/oncology at the University of California, Los Angeles, and chief of surgical oncology at Kaiser Permanente Medical Center in Los Angeles. He also is the state chair for the College’s Commission on Cancer.

On October 1, 2004, Bruce Lytle, MD, FACS, assumed chairmanship of the department of thoracic and cardiovascular surgery at the Cleveland Clinic in Ohio. Dr. Lytle succeeds Delos Cosgrove III, MD, FACS, who was named president and chief executive officer of the Cleveland Clinic. Dr. Lytle is president-elect of the American Association of Thoracic Surgery.

Donald J. Palmisano, MD, JD, FACS, has joined the board of governors of The Doctors Company, the leading national physician-owned medical liability insurance carrier, based in Napa, CA. Dr. Palmisano is a New Orleans, LA, general and vascular surgeon in private practice. He
also serves as clinical professor of surgery and clinical professor of medical jurisprudence at Tulane University School of Medicine. He is the immediate past-president of the American Medical Association.

Carlos A. Silva, MD, FACS, was appointed medical director of The George Washington University Hospital (GWUH), Washington, DC, effective October 1, 2004. Additionally, Dr. Silva continues to serve as director of surgical trauma service at the hospital. Dr. Silva has been a clinical professor of surgery at GWUH since 1973, and is a general surgeon with a special interest in burn treatment and rehabilitation.

Applications sought for 2005 Wylie Scholar Award

The Pacific Vascular Research Foundation is accepting applications for the 2005 Wylie Scholar Award in Academic Vascular Surgery. The award was established by the foundation to honor the legacy of Edwin J. Wylie, MD, by providing research support to outstanding vascular surgeon-scientists.

The award is designed to enhance the career development of academic vascular surgeons with established research programs in vascular disease. The award consists of a grant in the amount of $50,000 per year for three years. Funding for the second and third years is subject to review of acceptable progress reports. This three-year award is nonrenewable and may be used for research support, essential expenses, or other academic purposes at the discretion of the scholar and the medical institution. The award may not be used for any indirect costs.

The candidate must be a vascular surgeon who has completed an accredited residency in general surgery and who holds a full-time appointment at a medical school accredited by the Liaison Committee on Medical Educators in the U.S. or the Committee for the Accreditation of Canadian Medical Schools in Canada.

Applications are due by March 1, for the award to be granted July 1. Applications may be obtained from the Pacific Vascular Research Foundation’s Web site at www.pvrff.org, via e-mail at info@pvrff.org, or by writing to the Pacific Vascular Research Foundation, Wylie Scholar Award, 3627 Sacramento St., San Francisco, CA 94118.

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Just visit www.facs.org and go to the “Members Only” tab
NTDB™ data points

NTDB breaks the 1 million record mark

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

The Annual Report of the National Trauma Data Bank™ (NTDB), Version 4.0, is an updated analysis of the largest aggregation of trauma registry data that has ever been assembled. The NTDB currently contains more than 1.1 million records from 405 trauma centers in the 43 states, territories, and the District of Columbia. This total represents an increase of 394,414 records from the 2003 report. The Annual Report Version 4.0 is based on 633,435 records from the years 1999 to 2003. Prior to analysis, NTDB data are subjected to a quality screening for consistency and validity on such fields as age, gender, and length of stay.

The NTDB is committed to being the nonproprietary national repository for trauma center registry data. It is estimated that 55 percent of Level I and 37 percent of Level II centers in the U.S. contribute data to the NTDB. Our goal is to receive data on every patient treated in every trauma center in the U.S.

The purpose of this report is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in this country. It has implications in many areas including epidemiology, injury control, research, education, acute care, and resource allocation. This effort is in keeping with the mission of the American College of Surgeons’ Committee on Trauma to “improve the care of the injured through systematic efforts in prevention, care, and rehabilitation.”

This report marks our complete transition to the use of the mechanisms of injury and the external cause of injury code groupings that were developed by the international injury prevention community and published by the Centers for Disease Control and Prevention (CDC) in MMWR 1997, 46(RR14):1-30. The CDC and international partners developed this framework to create a uniform reporting language for injury mortality and morbidity.

The NTDB is an exciting program that has the potential to significantly improve the care of injured patients in this country. The NTDB committee would like to thank all the trauma centers that contributed data and hope that this report will attract new participants.

Throughout the year, we will be highlighting these data through brief reports in the Bulletin. The full NTDB Annual Report, Version 4.0 is available on the ACS Web site as a PDF file and a PowerPoint presentation at http://www.ntdb.org. For a complete copy of the NTDB Annual Report 2003 visit us online at http://www.ntdb.org. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.
Chapter meetings

For a complete listing of chapter meetings, please see [www.facs.org/about/chapters/index.html](http://www.facs.org/about/chapters/index.html).

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

**Clinical Congress**

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<thead>
<tr>
<th>Year</th>
<th>City</th>
<th>Dates</th>
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<tbody>
<tr>
<td>2005</td>
<td>San Francisco, CA</td>
<td>October 16-20</td>
</tr>
<tr>
<td>2006</td>
<td>Chicago, IL</td>
<td>October 8-12</td>
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<tr>
<td>2007</td>
<td>New Orleans, LA</td>
<td>October 7-11</td>
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**Spring Meeting**

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<tr>
<th>Year</th>
<th>City</th>
<th>Dates</th>
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<tbody>
<tr>
<td>2005</td>
<td>Hollywood, FL</td>
<td>April 16-19</td>
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<tr>
<td>2006</td>
<td>Dallas, TX</td>
<td>April 30-May 3</td>
</tr>
<tr>
<td>2007</td>
<td>Las Vegas, NV</td>
<td>April 22-25</td>
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**FEBRUARY**

**Kentucky (CS)** (in conjunction with the Hiram C. Polk, Jr., Surg. Soc.), Feb. 4-5, Camberley Brown Hotel, Louisville, KY. Contact: Cindy Thoene, 10207 Garlanreid Pl., Louisville, KY 40223; 502/629-3538.

**Utah**, Feb. 12, Canyons Resort, Park City, UT. Contact: Dr. Rebecka Meyers, Primary Children’s Med. Ctr., 100 N. Medical Dr., Ste. 2600, Salt Lake City, UT 84113; 801/588-3352.

**Puerto Rico**, Feb. 17-19, San Juan (PR) Hotel & Casino. Contact: Dr. Jose Sorrentino, G-5 Ruisenor, Tierra Alta II, Guaynabo, PR 00969; 787/731-2482.

**North Texas (CS)**, Feb. 25-26, Cityplace Center, Dallas, TX. Contact: Mollie Kuhn, Ste. 420, 3409 Worth St., Dallas, TX 75246; 214/824-9963.

**MARCH**

**South Texas (CS)**, Mar. 10-12, Texas Med. Ctr., Houston, TX. Contact: Dr. Christine Cocanour, 6431 Fannin, MSB 4.284, Houston, TX 77030; 713/500-7194.

**Metropolitan Washington (CS)**, Mar. 12, Georgetown University Conf. Ctr., Washington, DC. Contact: Ebony Harris, 1640 Wisconsin Ave., NW, Washington, DC 20007; 202/337-2701.

**Metropolitan Chicago (CS)**, Mar. 19, American College of Surgeons, Chicago, IL. Contact: Mary Hines, 20 N. Michigan Ave., Ste. 700, Chicago, IL 60602; 312/580-2455.

**APRIL**

**New York (CS)**, Apr. 8, The Bone and Joint Ctr., Albany, NY. Contact: Heather Bennett, 100 State St., Ste. 405, Albany, NY 12207-1805; 518/432-7471.

**Virginia (CS)**, Apr. 29-May 1, Inova Fairfax Hosp., Falls Church, VA. Contact: Susan McConnell, 1200 E. Clay St., Richmond, VA 23219; 804/643-6631.

**MAY**

**Metropolitan Philadelphia (CS)**, May 2, Philadelphia, PA. Contact: Leslie Howell, 777 E. Park Dr., Box 8820, Harrisburg, PA 17015-8820; 717/558-7850.

**Chile**, May 4-7, Hotel Sheraton Santiago, Santiago, Chile. Contact: Dr. Alejandro Mandujano, Av. Santa Maria 1710 Providencia, Santiago, Chile; 562/264-1878.

**West Virginia (CS)**, May 5-7, The Greenbrier, Sulphur Springs, WV. Contact: Sharon Bartholomew, Box 1107, Morgantown, WV 26507; 304/598-2802.

**Northern California (CS)**, May 7, Crown Plaza Hotel, San Francisco, CA. Contact: Annette Bronstein, 179 Canterbury Ave., Daly City, CA 94015; 650/992-1387.

**Ohio (CS)**, May 10-11, Hyatt on Capitol Square, Columbus, OH. Contact: Brad Feldman, Box 1715, Columbus, OH 43216-1715; 877/677-3227.

**Keystone (CS)**, May 13-14, Chateau Resort & Conf. Ctr. at Camelback, Tannersville, PA. Contact: Leslie Howell, 777 E. Park Dr., Box 8820, Harrisburg, PA 17105-8820; 717/558-7750.

**Michigan (CS)**, May 18-20, Amway Grand Plaza, Grand Rapids, MI. Contact: Tom Plasman, 120 W. Saginaw, East Lansing, MI 48823; 517/336-7586.

**Illinois (CS)**, May 20-21, Moline, IL. Contact: Carolyn Koch, 4003 46th Street Ct., Rock Island, IL 61201; 309/786-4227.

**Florida (CS)**, May 27-30, Boca Grande Club, Boca Grande, FL. Contact: Bob Harvey, 2589 Park St., Jacksonville, FL 32204; 904/384-8239.

**JUNE**

**Maine (CS)**, June 3-5, Asticou Inn, Northeast Harbor, ME. Contact: Dr. Joel D. Lafleur, 6431 Fannin, MSB 4.284, Houston, TX 77030; 713/500-7194.

**Alabama**, June 14-16, Destin, FL. Contact: John Hooton, 2589 Park St., Jacksonville, FL 32204; 904/384-8239.