A surgeon at Abu Ghraib
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Division of Advocacy and Health Policy

About the cover...

For three months, Jeffrey S. Upperman, MD, FACS, applied his surgical expertise in caring for detainees at Abu Ghraib Prison in Iraq as a member of the U.S. Army’s Task Force Oasis, 848th Forward Surgical Team. He recounts both the perils and the joys of his tour of duty in the article on page 8. (Photo courtesy of Dr. Upperman.)
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
Space sold by Elsevier
From my perspective

By now, surgeons in this country should have received the first two editions of the College’s newest communications vehicle—Surgery News, a tabloid-sized newspaper for surgeons in all of the surgical specialties. Our goal in developing this new publication in cooperation with the International Medical News Group (IMNG), a subsidiary of Elsevier, Inc., is to provide you and your colleagues with timely and concise information about advances in clinical practice, socioeconomic issues and related events in Washington, DC, and at the state level, College activities, and practice management trends. Because of cost constraints, a paper version of the newspaper is being mailed only to surgeons in the U.S. However, every month, the current issue will be posted on the College’s Web site at http://www.facs.org/surgerynews/index.html, making the newspaper available to surgeons around the world.

Why a newspaper from the College?

So many amazing advances and significant changes are taking place in the practice of medicine and surgery today that surgeons often find it difficult to stay as informed as they would like to be—and should be—about current trends and developments. Part of the College’s mission is to do all it can to help its members stay abreast of progress in these areas. Our educational programs, such as the Clinical Congress and the Spring Meeting, workshops, and practice management courses, have been a primary means of providing surgeons with such information. Moreover, our printed and electronic communications vehicles, including the Bulletin, ACS NewsScope, the Journal of the American College of Surgeons, and the ACS Web site, have provided our members with much useful information.

However, we believe that the addition of this newspaper will provide today’s time-pressed surgeons with current and concise information in a portable and easily readable format. We also believe the newspaper will be yet one more forum where surgeons can familiarize themselves with the advances and issues affecting colleagues in other surgical disciplines, as well as those that affect surgeons across the board.

We believe that Surgery News will provide today’s time-pressed surgeons with current and concise information in a portable and easily readable format.”

Read all about it

Surgery News is being published through a cooperative arrangement between the College and the IMNG. Lazar J. Greenfield, MD, FACS, is the Medical Editor of Surgery News, and, at press time, he was in the process of developing an editorial board of surgeons who will be vetted and approved by the College to work with him on the clinical and technical content of the newspaper. Dr. Greenfield is also the Associate Editor of e-FACS.org, the College’s soon-to-be-launched Web portal. His dual roles will create a synergistic relationship between these two important communications vehicles.

The College’s Director of Communications, Linn Meyer, is responsible for working with the Washington Office and Chicago staffs to provide content on socioeconomic issues, College news, and ACS programs and services. Dr. Greenfield and Ms. Meyer are in regular contact with each other and with the managing editor of Surgery News at the IMNG to ensure that all of the copy that goes into
the newspaper meets the College’s standards for quality and accuracy.

Science writers from IMNG’s news service are responsible for submitting articles on clinical and technical issues. These individuals attend selected surgical meetings and prepare reports based on the information they gather by attending sessions and press conferences. Because the College maintains total control over the editorial content of the newspaper, Dr. Greenfield and the other members of the editorial board screen and review topics to be covered for each issue of the newspaper, as well as the written reports themselves, to make certain we are providing surgeons with appropriate information.

Some of the topics that have been featured in Surgery News so far include safety and efficiency in the operating room, Medicare coverage for bariatric surgery, cancer treatment, the introduction of new surgical procedures, robotic surgical assistance, and transplant surgery, among many others. The newspaper identifies pages that are dedicated to topics of interest to specific specialties so that readers can quickly find the articles of most relevance to them. Again, our goal is to make sure that surgeons in all specialties are getting timely information in an efficient way.

Additionally, the College has two full pages devoted solely to reports from our Washington Office and to other ACS programs and initiatives. When important developments occur in the legislative or regulatory arenas that affect any or all surgical specialties, that information will be published in the “News From the College” section of Surgery News. In this section, readers also will find updates on clinical practice issues the College is addressing, announcements of new services and programs, and information about member benefits.

All of the articles in Surgery News emphasize brevity over detail, but the articles identify the sources of information so that individuals who are interested in learning more about certain topics know where to turn. We anticipate that many surgeons will find this publication to be a handy guide to the issues that affect them and their practices each month.

What it means for you

I am very enthusiastic about the College’s ongoing efforts to promptly provide surgeons with the information they need and in the format they want during this exciting period in the evolution of surgery and our health care system. With our now totally comprehensive publications program, I believe the College has only reinforced its role as a leader in providing relevant and up-to-date information to surgeons.

It is gratifying to report that the response to Surgery News to date has been uniformly positive. Typical comments we received from members of the College after mailing the first edition included the following:

“Surgery News came today, and it looks fabulous! It reads well.”

“It is well written and differs from the other newsletters in that there was a broader focus to include surgical subspecialties.”

“Congratulations on Surgery News. The first issue arrived today in my mail—interesting and concise.”

“Have just read the first issue of Surgery News. It would appear to be a useful, well thought-through effort at improved communication among surgeons. Best wishes for success.”

“The first issue arrived. I was a bit surprised to see it and almost passed it over as another ‘throw away!’ Well thought out and interesting. I think it will be in competition with one or another tabloid freebies; but, the College has the resources and the credibility.”

“I appreciate your work on the first issue of Surgery News. I believe it will be both very readable and valuable.”

To ensure our continued success with this publication, I encourage you to contact Dr. Greenfield, Ms. Meyer, or myself at surgerynews@facs.org to offer any suggestions you might have. As always, your input is key to our vitality as an organization representing all surgeons and the patients they serve.

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.
Coalition pressures VA to rescind directive

In response to heavy lobbying by the College and other members of a coalition representing surgical specialists, in December 2004, the U.S. Department of Veterans Affairs (VA) rescinded an administrative directive allowing nonsurgeons to perform laser eye surgery at VA facilities. More specifically, the new directive limits the performance of therapeutic laser eye surgery in the VA system to only qualified ophthalmologists.

This issue began to materialize in 1998, when Oklahoma became the first and only state to pass legislation allowing optometrists to perform laser eye surgery. The VA has a longstanding local facility privileging policy that allows health care practitioners to practice up to the limits of their state licenses, regardless of the facility’s location. In 2003, it was discovered that an Oklahoma optometrist had performed glaucoma- and cataract-related laser surgery at a VA medical facility in Wichita, KS. After initially refusing to revoke the optometrist’s surgical privileges, the VA temporarily suspended them and placed a moratorium on optometrists performing eye surgery in its health care facilities.

To ensure patient safety, Rep. John Sullivan (R-OK) introduced H.R. 3473, the Veterans Eye Treatment Safety (VETS) Act in November 2003. This legislation would have mandated that only licensed physicians and osteopaths perform eye surgery in the VA system. The bill enjoyed strong bipartisan support and ultimately gathered 74 cosponsors. The VETS Coalition, which includes the College, the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgeons, the American Medical Association, the American Osteopathic Association, and the American Academy of Family Physicians, advocated passage of the bill. Congress adjourned before the bill could achieve passage, but the VA’s recent action rendered the legislation unnecessary.

MedPAC issues reports on clinical staff

On December 30, 2004, the Medicare Payment Advisory Commission (MedPAC) issued two congressionally mandated reports pertaining to reimbursement for members of the surgical team.

In a report on Medicare fee schedule payments for certified registered nurse first assistants (CRNFAs) at surgery, the commission stopped short of recommending that policies be expanded beyond the currently allowed payments to physicians, physician assistants, and a defined list of advanced practice nurses, such as nurse midwives. However, MedPAC did conclude that any congressional action to add CRNFAs to the list of practitioners eligible for fee schedule payments should include provisions to offset added Medicare program costs so that the policy change will be budget neutral.

A second report focused on cardiothoracic surgeons’ practice expenses and whether Medicare fee schedule payments accurately reflect the costs of surgeon-employed clinical staff who provide patient care services in the hospital setting. While the commission acknowledged the thoracic surgeons’ concerns, MedPAC concluded that current data limitations and methodological problems hinder Medicare’s ability to determine more accurate payment amounts.
A common theme raised in both reports is a concern about duplicate payments for clinical staff who may be employed by either the hospital (and so paid under Medicare Part A) or the physician (and reimbursed under Part B either as a separate payment or as part of the surgeon’s payment). A proposed solution would combine facility and physician payments for hospital-based services and allow hospitals and physicians to divide the total amount according to how clinical staff are supplied and used. A stated advantage of this approach is that it would allow the quality of surgical care to be measured as a whole, with the hospital and the surgeon held jointly accountable.

Both reports can be viewed on MedPAC’s Web site at www.medpac.gov through links found under the heading of “recent products.”

The College submitted comments on January 3 to the Centers for Medicare & Medicaid Services (CMS) in response to the final 2005 Medicare physician fee schedule. The comments focus on the need for CMS to adopt a new methodology and better data collection for calculating professional liability insurance relative value units that would more fairly compensate high-risk surgical specialties. In addition, the College submitted 29 surgical service codes for consideration during the five-year review of relative work values. The five-year review will take place this year, and any resultant changes to the value of these codes will become effective in 2007. In its comments, the College also calls into question the issue of parity with regard to newly established Medicare payment for drug administration codes. To read the text of the College’s comments, go to http://www.facs.org/ahp/views/medicare2005.html.

According to CMS actuaries, health care spending growth slowed in 2003, for the first time in seven years. Total health care spending under private and public programs grew 7.7 percent in 2003 to $1.7 trillion, down from a 9.3 percent growth rate in 2002. On a per capita basis, health spending increased by $353 to $5,670. Health expenditures accounted for 15.3 percent of the gross domestic product, however, outpacing growth in the overall economy by nearly three percentage points.

Of particular interest:
- Hospital spending, which accounts for nearly one-third of total national health expenditures, grew 6.5 percent in 2003, down from 8.5 percent the year before.
- Spending growth for prescription drugs declined from 14.9 percent in 2002 to 10.7 percent in 2003.
- Spending growth for freestanding home health agencies increased by one percentage point to 8.5 percent in 2003.
- Spending growth for physician services increased slightly to 8.5 percent in 2003, compared to 8.2 percent in 2002.

Surgical service at Abu Ghraib: One Fellow’s experience

by Diane S. Schneidman, Senior Editor
Picture this scenario: One day you’re in a state-of-the-art American operating room performing surgery on an infant with gut barrier failure whose anxious parents are awaiting word on the outcome. A few weeks later, you’re inside the now infamous Abu Ghraib prison in Iraq operating on detainees injured during a mortar attack on the facility.

One Fellow of the College need not rely on his imagination to envision this turn of events because he experienced it firsthand. From April to July 2004, Maj. Jeffrey S. Upperman, MD, FACS, was a member of Task Force Oasis, 848th Forward Surgical Team, at Abu Ghraib.

Dr. Upperman, a pediatric surgeon at Children’s Hospital of Pittsburgh, PA, received his orders from the U.S. Department of the Army in February 2004, indicating that he would be attached to Task Force Oasis at Abu Ghraib. The task force was established while revelations about the abuse of Iraqi prisoners in 2003 were just beginning to surface. Its primary purpose was to rebuild goodwill among the Iraqi people—to “reduce the sting of Abu Ghraib”—and to show that not all American military troops are driven by or act on dark impulses, as Dr. Upperman’s Commander, Col. Michael Oddi, MD, FACS, said in his salutatory address to the team. (For more information about the task force’s achievements, see the sidebar on page 10.)

Dr. Upperman arrived at Baghdad Airport to join the task force in carrying out its noble mission on April 13, 2004—his 40th birthday. It was his first deployment since enlisting in the Army Reserves in 1992.

The war zone

Although Dr. Upperman and the other medical personnel at Abu Ghraib were there to provide humanitarian aid and not to engage in combat, they were constantly aware of the fact that they were in the middle of a war zone. “When we left the airport and were headed to Abu Ghraib, we passed the debris and wreckage of a convoy that had been ambushed,” Dr. Upperman said. The sight of the burning tractor-trailer and the carnage served as jarring representations of what they might experience during their deployment. (Surgeons and anesthesiologists generally had three-month tours of duty, while nurses, medics, and so on were deployed for about one year.)

To help protect them from becoming casualties or mortalities, all of the members of Task Force Oasis were armed and ready for battle if necessary. “You needed to be fully engaged and ready to shoot,” Dr. Upperman said.

Under attack

The personnel in Task Force Oasis did, in fact, find themselves directly in harm’s way on several occasions. The most powerful instance that Dr. Upperman recalls occurred soon after his arrival at Abu Ghraib. The prison compound experienced a major shelling from Iraqi insurgents attempting to storm the facility and lead a breakout.

“The mortar attack itself lasted probably 10 or 15 minutes, but it seemed like hours. Twenty-five mortars hit. You just didn’t know how crazy it was going to get,” he said. Medical personnel and some prisoners they were able to help sought refuge within the prison itself, which was constructed from cement, making it relatively resistant to such attacks. Security forces tried to fend off the attackers, while detainees who were housed in outdoor cells and tents became easy prey to the shelling.

“That was definitely the most horrifying experience I had there,” he added. “It was the biggest attack on Abu Ghraib.”

The attack resulted in approximately 100 casualties and 25 mortalities. Once the insurgents ceased fire, Dr. Upperman spent 11 hours straight operating and triaging patients to other facilities. “We performed wound repairs and ‘washouts.’ Some casualties even required amputations,” he said.

Unforgettable case

The most memorable operation that Dr. Upperman performed, however, was not on a victim of the mortar attack. “I had one case that was pretty scary. I don’t know what the guy was doing, but he had really significant gunshot injuries, with multiple holes through his large and small intestines. The American soldiers found him engaged in some suspicious behavior, and he was carrying an AK-47 at the time that he was appre-
hended,” Dr. Upperman said. “I performed an initial two-hour operation to resect about four feet of his intestine and remove debris,” he added. The detainee underwent a total of three operations.

“Some guys who weren’t part of the medical unit would say, ‘How can you take care of that guy when he probably did this or that?’ When you’re part of a medical team, you’re really obligated to take care of everyone and to treat them in a humane way. You don’t know why they’re being detained. You don’t know the circumstances that led up to them being captured. That wasn’t my job. My job was to take care of the injured, regardless of who they were,” Dr. Upperman said.

**Typical day at the office**

Although the sound of gunfire and explosions could almost always be heard in the distance, Dr. Upperman said most of his days at Abu Ghraib were fairly routine. “I literally set up office hours

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### Task Force Oasis’s accomplishments

Following is a list of some of Task Force Oasis’s most notable achievements from February through September 2004.

- Established a viable, full-service, 35-bed hospital within a bombed-out warehouse.
- Developed standard operating procedures for mass casualty incidents.
- Built a protective fence around the hospital and implemented other defensive strategies and procedures.
- Established sanitation measures, including placement of sinks at latrines, the redirection of dumped waste, and the initiation of other public health activities.
- Placed a dietary technician in the kitchen used to prepare meals for detainees to improve food sanitation, preparation, quality, and distribution.
- To help overcome heat-related illness, purchased coolers for detainee tents and educated detainees about the perils of dehydration and symptoms of heat exhaustion.
- Established standard operating procedures for suspected or alleged prisoner abuse.
- Arranged for prosthetic limbs for detainee amputees through an Iraqi prosthetist.
- Provided around-the-clock dental care.
- Established centralized system for distributing medication.
- Purchased clothing, reading glasses, soccer balls, board games, copies of the Koran, and wheelchairs for detainees.

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Dr. Upperman (right) and Dr. Oddi performing a wound closure.
to consult with patients and to arrange elective procedures. I saw patients one or two days a week. I was always on call because I was the only general surgeon, although Dr. Oddi was always available as back-up. I tried to make sure that I had a variety of cases to manage each week. I didn’t want to weigh down the schedule,” he explained.

He performed 40 operations—“the lion’s share”—after the mortar attack. “It was split about 50-50 between emergency operations and elective procedures,” Dr. Upperman said. Typically the elective operations were along the lines of “lumps and bumps,” hernia repair, and other common general surgery procedures. He also recalled performing an emergency appendectomy on one Iraqi detainee with a ruptured appendix. Most of the critical care procedures, however, were done to treat shrapnel injuries.

“All of the operations were on Iraqis. I may have sewn up a couple of open lacerations on American soldiers, but we had a military hospital in nearby Baghdad, which is where they would have gone for any significant care,” Dr. Upperman added.

Operations were performed inside what was essentially a small, double-wide trailer that was redesigned to serve as an operating room (see photo, page 10). “It wasn’t state-of-the-art,” Dr. Upperman said, but it did house all the necessary equipment, including a manual operating room table, an anesthesia machine, and so on.

The medical team comprised the full range of medical professionals, including nurses, emergency care specialists, pharmacists, lab staff, technical support staff, and anesthesiologists.

A bombed-out warehouse located within the prison complex was rebuilt to serve as a hospital. The 35-bed facility was assembled and fully operational within a matter of five to six weeks.

The facility was generally well-stocked with the supplies necessary to care for the detainees. “We had a landing pad for helicopters, and most of the supplies we needed could be flown in quickly. Some things that had to be trucked in were sometimes delayed due to restricted travel, but I never felt like we were squeezed,” Dr. Upperman said.

The members of Task Force Oasis proved themselves in many ways, but one indicator of the quality of care provided despite these makeshift circumstances is the fact that only one patient suffered from a postoperative infection.

**Transferring skills**

One might assume that a pediatric surgeon would feel a little displaced caring for adults wounded in wartime activities. Dr. Upperman, however, found some similarities between his civilian career and what he did at Abu Ghraib.

“I work at one of the largest pediatric trauma centers in the country, and, you know, kids can get into the darnedest things. Granted they’re not getting blown up by mortar, but they can suffer some rather significant injuries if, for instance, they fall off an all-terrain vehicle,” he said. Hence, he was able to apply his trauma experience in treating the wounded detainees.
Dr. Upperman also believes his pediatric background equipped him with the skills needed to communicate with and attain the confidence of Iraqi patients. He noted that very young children, in particular, view him as “this scary guy in a white coat,” who’s going to be performing operations on them for reasons that they don’t fully understand. To gain their trust, he often relies on the parents or guardians to act as intermediaries. To dispel the Iraqi prisoners’ fears, he relied on translators.

“The translators were an integral part of the operation,” Dr. Upperman said. “They really had to try to convince the prisoners that we were there to help and comfort them.” Most of the translators were Iraqi civilians. “A lot of Iraqis who helped the coalition forces were either taken hostage or assassinated for helping the Americans,” he added.

Living conditions

Dr. Upperman describes the living conditions at Abu Ghraib as “very Spartan.” There was no indoor plumbing within the prison, so the members of the task force relied on portable toilets. The crew slept on cots inside the prison cells that had been stripped of their doors.

Mosquitoes were a constant nuisance. “I was there for about three weeks and kept getting torn up by the mosquitoes,” Dr. Upperman said. He ordered some netting to cover himself with at night (see photo, this page), which provided some relief.

The food that was served to the members of Task Force Oasis was better than one might expect, certainly a cut above K rations. “There was always steak or some sort of beef on the menu. Of course, the cooking could be variable,” Dr. Upperman said.

While the desert heat made life uncomfortable, Dr. Upperman left Iraq just before “death month” in August, so named because the severe heat causes massive heart attacks, especially among elderly Iraqis. “When I left highs were starting to creep up to 110 degrees,” he said.

The close confines and the stressful conditions engendered the formation of lifelong friendships, Dr. Upperman said. For example, he and his “cellmate” quickly became comrades. “My buddy Ed Alexander, CRNA, from Akron, OH, and I are on the phone with each other at least once a week. We came in together and made sure we got out alive together. We came in really sort of naive and by the time we left, we were like these war-battered soldiers,” he said.

Managing boredom and fear

Despite the desolate environment, Dr. Upperman said that morale within his unit remained high. “We were quite proud of the professional behavior that our colleagues exhibited when interacting with other military personnel and with the Iraqi prisoners,” he said.

To encourage the comradery and to keep spirits high, the leaders of Task Force Oasis made certain
that the personnel had opportunities and the facilities to work out, play sports, and spend time in organized activities, such as karaoke nights and cookouts. Maintaining morale is a command issue. The top brass need to lead by example and help the troops “manage the boredom,” Dr. Upperman said.

To help manage his own boredom, Dr. Upperman said that he did a lot of bedside teaching and tried to stimulate the young minds around him. “I would go over cases and each step of a procedure with the nurses and medics,” he noted.

He also tried to encourage some of the nonmedical personnel to learn about operative procedures and devices. If he noticed that some of the troops were getting frustrated and spending all their time hanging around the weight room, he would hand them a book or point out a Web site where they could exercise their brains and think about something besides their predicament. “I don’t spend much time around 19- and 20-year olds in my daily life, so it was refreshing to see how excited they would get about learning something new,” Dr. Upperman added.

What he missed

“The biggest frustration, really, was being away from family and loved ones,” said Dr. Upperman, who is married and has three young sons. He was able to correspond with his family mostly through e-mail. The compound housed an Internet café, which contained about a dozen computers for the personnel’s use.
Dr. Upperman also missed his practice. “I really like pediatric surgery. There’s always a lot to do, and the variety of cases is incredible,” he said. Dr. Upperman also relishes the fact that pediatric surgery is “the specialty of the 80-year cure,” affording him the privilege of seeing his patients go on to lead healthy and fulfilling lives.

Apparently some of his patients missed him as well. “In a surgical practice there are some patients you have a relationship with, and some of them sent me care packages while I was in Iraq. For people to go through that much effort is really something,” Dr. Upperman noted.

Readjustment

Although he was anxious to return to his family and practice, leaving Abu Ghraib behind was more difficult than Dr. Upperman had anticipated. “I thought the transition was going to be a lot smoother than it was,” he said, noting that the constant stress of not knowing when the next attack would occur does change people, at least during their time of deployment. “You go from not understanding why anyone would want a gun, to not understanding why you wouldn’t have one,” he said.

Soon after leaving Abu Ghraib and upon his arrival in Kuwait (his first stop on his trek back to the U.S.), Dr. Upperman said he felt “100 percent de-stressed.” Nonetheless, his experience has had some long-term effects on how he views certain aspects of life and work.

“You just come to realize what security really means,” he said. “You find yourself questioning whether where you work and where you live would really be prepared for a catastrophic incident.”

Dr. Upperman also said, “I think we could all do a better job of being civil toward each other and being appreciative of our neighbors. A lot of people are taking advantage of the ‘detachedness’ of our society.” He believes that when disaster strikes, they will have a hard time turning to others for help because they haven’t connected with members of their communities.

Advice

Dr. Upperman advised anyone who is interested in joining a branch of the military full-time or as a reservist to do so only out of a sense of patriotism and not solely for financial reasons. “You have to go in wanting to uphold the Constitution. We’ve gone through the ‘me, me, me’ generation. What happened on 9/11 brought it home to people that we need to focus on more than ourselves,” he said.

For those surgeons and other military personnel who will be going to war at some point he said, “You have to be prepared. You’ve got to be prepared to die, and that means making sure you have everything in order for your family before you leave.” Once you’re there, “have an opinion and speak with your commanders about your concerns. And stay motivated,” Dr. Upperman added.

Proud of accomplishments

Despite any hardships or hard lessons that his deployment may have incited, Dr. Upperman takes great pride in knowing that the members of Task Force Oasis accomplished their mission of serving as “ambassadors of hope” to the Iraqi people. The entire company received high commendations for their efforts.

In his salutary address to the members of the team, Dr. Oddi noted that many individuals at the staff level did not believe the project would succeed and were reluctant or unable to supply the hospital with personnel and equipment. However, the members of the task force “showed them they were wrong,” Dr. Oddi said. Indeed, the members of the task force, composed of eight different units, “accomplished a mission that has humanitarian significance and international repercussions,” he added.

Dr. Upperman and other military personnel who were involved in or aware of the work that the members of the task force carried out freely and unconditionally believe their efforts may pave the way toward better U.S. relations with the international community and methods of managing detainees. “But those stories just aren’t on the 6:00 news,” he added.
Three Fellows elected to Congress

by Julie Lewis, Legislative Assistant, Division of Advocacy and Health Policy

On January 4, 2005, three Fellows of the American College of Surgeons were sworn in as new members of the U.S. House of Representatives. This article presents brief biographical information about each of these surgeons.

Rep. Joe Schwarz, MD FACS (R-MI)

Joe Schwarz, MD, FACS, is the new congressman from Michigan’s seventh district. Born in Battle Creek, MI, Representative Schwarz received his medical degree from Wayne State University in Detroit and has been in private practice since 1974.

Throughout his life, Representative Schwarz has served his country, his state, and his community. He was a naval officer in Vietnam and worked as an assistant naval attaché at the U.S. Embassy in Djakarta, Indonesia, from 1966 to 1967. Following his naval career, he went to work for the Central Intelligence Agency, stationed in Southeast Asia from 1968-1970.

As a Michigan state senator for 16 years, mayor of Battle Creek for two years, and city commissioner of Battle Creek for six years, Representative Schwarz has enjoyed a distinguished political career.

During his years in the Michigan Senate, Representative Schwarz was a member of the Appropriations Committee and chaired the Subcommittee on Higher Education and the Subcommittee on General Government. His reputation for being plain spoken has garnered him the support of both his colleagues and constituents. He was elected president pro tempore of the Michigan senate in 1993.

As a member of various boards, including the one at Detroit Receiving Hospital, Representative Schwarz has remained actively involved in the Battle Creek community and greater Michigan. He has one daughter, Brennan Louise.

Rep. Tom Price, MD, FACS (R-GA)

In the 109th Congress, four health care professionals (two physicians and two dentists) will represent the state of Georgia in the U.S. House. The newest member of the Georgia delegation is orthopaedic surgeon Tom Price, MD, FACS, of the state’s sixth district. Congressman Price has had...
a long history of public service in Georgia as a practicing surgeon and as a member of the state senate.

Congressman Price received his medical degree at the University of Michigan, Ann Arbor, and completed his orthopaedic residency at Emory University in Atlanta, GA. He established an orthopaedic clinic north of Atlanta and was in private practice for 20 years. He was also an assistant professor at Emory University School of Medicine. In order to have an impact on legislation affecting physicians, he ran for the state senate in 1996 and won.

Representative Price was a member of the Georgia state senate for eight years. His colleagues twice elected him as their minority leader, and in 2002, Congressman Price was elected to serve as the first Republican majority leader in the history of Georgia. As a leader in the state senate, Dr. Price was an advocate for medical liability reform, increased patient choice in a more flexible health care system, enactment of medical savings accounts, and Medicaid reform.

He now intends to bring his expertise and passion for the issues to the U.S. Congress. Representative Price has stated that his goals will be reforming the tax system, strengthening health care, securing the future of Medicare, and bringing common sense to the country’s litigation system. House leaders spotted Representative Price’s potential early, naming him Deputy Whip as a freshman congressman. In this role, he will aid Majority Whip Roy Blunt (R-MO) in gathering votes for important legislation, such as medical liability and Medicare reform.

Representative Price and his wife Elizabeth have a son, Robert.

Rep. Charles W. Boustany, Jr., MD, FACS (R-LA)

Rep. Charles W. Boustany, Jr., MD, FACS, is the new congressman from Louisiana’s seventh district. He is the first Republican ever elected from that district.

Representative Boustany was raised in Lafayette, LA, and in 1978 received his undergraduate degree from his hometown school, the University of Southwestern Louisiana. He received his medical degree in 1982 from Louisiana State University (LSU) School of Medicine, New Orleans. Representative Boustany was a general surgery resident at the LSU Division Charity Hospital in New Orleans and then moved on to become chief resident in thoracic and cardiovascular surgery at the University of Rochester, New York. Upon completing his residency in 1990, Representative Boustany returned home.

Representative Boustany has served on the Louisiana Organ Procurement Agency tissue advisory board, as well as the board of directors and as the vice-president for government affairs for the Greater Lafayette Chamber of Commerce. In 2000, he also served as president of the Lafayette Parish Medical Society. He was an at-large member of the Lafayette Parish Republican executive committee from 1996 to 2001 and was named the vice-chairman of the Bush/Cheney Victory 2000 Campaign for Lafayette Parish. Representative Boustany currently sits on the board of directors for Lafayette General Medical Center.

Representative Boustany and his wife Bridget have a son, Erik, and a daughter, Ashley.
Roger Salisbury, MD FACS, has been an artist since childhood and a surgeon and an educator for 35 years. Colleagues invariably tease him that he will always have another interest to make retirement a productive time. But, Dr. Salisbury is not yet contemplating retirement and enjoys the full life of working as both an artist and a surgeon. The dual vocations have always brought him personal fulfillment.

Merging two loves

His parents were both educators. His father, a dentist and an artist, encouraged him to attend the Philadelphia Museum of Art School for classes while in grammar school. When he went to New York, NY, for medical school, he participated in the art student’s league.

The love of the creative life ultimately led him to plastic surgery. “I know that it was somewhat naïve, but the thought of daily doing for people what we accomplished in art school seemed the absolute best,” Dr. Salisbury said.

A general surgery residency, hand surgery fellowship, three years at the Army burn center during the Vietnam War, and a subsequent plastic surgery fellowship led to his current practice in the area of cosmetic surgery.

Creativity and commitment to excellence are constants

by Lynne Ames, White Plains, NY

Above: Dr. Salisbury (inset), and his painting “Spring in the Parks, #2.”
surgery residency forced him to put the art career on hold. He subsequently taught plastic surgery at the University of North Carolina, Chapel Hill, and directed the burn center there. He found that the portrait classes he had taken helped him enormously in performing facial reconstruction. For example, “if someone has a severely burnt face and microstomia, there is nothing in residency or the medical textbooks that tells us how large to make the mouth. If you overcorrect the mouth in the horizontal direction, if it is too long, the patient looks like a guppy. Portrait classes teach that the dropping of verticals from the center of the eye identifies the location of the oral commissure,” Dr. Salisbury said. This type of background helped him to write the first atlas on burn reconstruction.

Since 1981, he has been professor of surgery and chief of plastic surgery at New York Medical College in New York, NY, as well as director of the Westchester Burn Center in Valhalla, NY. He has an artist’s studio in his home and a retreat in Gloucester, MA, home of one of the nation’s first artist colonies.

Dr. Salisbury always takes his art materials along on medical trips. He extends meeting travels with side trips to paint on-site. For example, when he presided over a burn symposium in China several years ago, he detoured to spend a week painting Hong Kong’s busy harbor and the boat people.

His wife Judith, a nuclear cardiologist, usually accompanies him. She is also creative, being an award-winning professional photographer, member of several photography honor societies, and represented in galleries in the northeast.

Because of a very full surgery and teaching schedule, Dr. Salisbury can only paint on weekends, vacations, and trips. “I can’t turn creative energy on and off like a light switch. Painting suffers and becomes ordinary,” he explained.

**Devotion to excellence**

Dr. Salisbury’s artistic resume mirrors his academic curriculum vitae with respect to excellence. He was elected to The Pastel Society of America, the American Society of Marine Artists, the Rockport and North Shore Artist Association, and the New York Salmagundi Club. His paintings are sold in galleries in Massachusetts, Connecticut, and New York, his prints are sold nationally, and some of his paintings have been shown in multiple museums.

In terms of his professional society memberships, Dr. Salisbury is active in the American College of Surgeons, the American Association of Plastic Surgeons, the Society of University of Surgeons, and the American Society for Surgery of the Hand. He is past-president of the American Burn Association, one of only two plastic surgeons to have achieved that honor.

“My general surgery lineage is extremely important to me, and we strive to imbue our residents and students with the wonder of being able to perform total patient care. Sadly, medicine has become so fragmented that the media perception of plastic surgeons is that we only do aesthetic surgery. While we teach that part, we emphasize critical care, wound healing, and reconstruction,” Dr. Salisbury said.

Dr. Salisbury said both art and surgery require commitment and intensity. “Art could be a wonderful hobby but it is much more for me. If you want to go to the highest level you must attempt to paint well enough to be accepted in national shows, galleries, and honor societies. My artist friends struggle through economic uncertainty, fickle critics, and rejection that is humbling. The thrill of plastic surgery is the quest for excellence, to explore one’s human potential, in giving the very best to our patients. I push my residents to be bet-

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

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

This issue of the Bulletin contains reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Plastic Surgery, and the American Board of Urology.

The April issue of the Bulletin will feature the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Orthopaedic Surgery, the American Board of Surgery, and the American Board of Thoracic Surgery.
Resident numbers and neurosurgical match
During the 2003-2004 academic year, there were 94 accredited neurosurgical residency training programs in the U.S. Eight hundred fourteen residents were in training, and 142 graduated in June. In January 2004, 363 individuals registered for the neurological surgery matching program. Two hundred eighty-two rank lists were submitted—an increase of 12 percent from the previous year. Two hundred thirty-seven were ranked and 149 matched. The percentage of U.S. seniors and international medical graduates (IMGs) matching has steadily fallen over the past four years, indicating a more competitive selective process.

Primary examination
The American Board of Neurological Surgery (ABNS) written primary examination is administered annually to neurosurgical trainees. The multiple-choice examination covers the breadth of neurosurgery’s clinical and basic science curriculum. It may be taken for self-assessment but must be taken and passed for credit prior to applying for oral examination and certification. For residents entering training after June 30, 1998, the residency review committee (RRC) for neurological surgery and ABNS training requirements specify that it must be passed during training in order to successfully complete the residency program. Many programs now require trainees to pass the examination before progressing to chief resident.

In March 2004, the primary written examination was administered to 475 examinees. One hundred ninety-three took it for credit and had a 23 percent fail rate; 282 took the exam for self-assessment.

Oral examination
Oral examinations are the final step in the initial certification process. They are administered by the ABNS each spring and fall to neurosurgical practitioners who have applied for certification. Candidates must meet the requirements of graduation from accredited training programs, hold unencumbered licenses and hospital privileges, demonstrate good professional standing as assessed by mentors and peers, and show satisfactory practice performance through review of a minimum of one year’s consecutive cases.

In November 2003, 89 candidates sat for oral examination with a 22 percent failure rate. In May 2004, 72 candidates were examined with a 14 percent failure rate. Candidate performance is scored numerically by six examiners. Their grades are used to determine pass/fail status by computer program to maximize objectivity in the process. Standardized questions are now being used for a portion of the examination.

Maintenance of certification (MOC)
The ABNS issued its first time-limited certificate in May 1999. Since then it has developed all of the components for the MOC program in order to meet the requirements of the American Board of Medical Specialties. Letters outlining the MOC program to the diplomates were mailed in March 2004. The ABNS has largely completed its work in outlining its requirements for MOC. We anticipate that the practice evaluation component will be developed further. The components of lifelong learning and self-assessment consist of a requirement for 150 hours over three years of specific neurosurgical continuing medical education (CME) content and a Web-based self-assessment program, which has been developed by the Congress of Neurological Surgeons. Further CME offerings to be developed by the American Association of Neurological Surgeons are in preparation.

Evidence of performance in practice will be evaluated by the submission every three years of 10 consecutive “key cases” selected from a list of procedures that cover the subspecialties of neurosurgery. In addition, candidates will submit a surgical case log, submitted once every 10-year cycle, in which six months of practice data are submitted on our Internet-based data accrual program, NeuroLog. Finally, the communication assessment tool will be performed to measure patient perceptions of physician performance in the areas of interpersonal
communication skills. The MOC program of the ABNS will be rolled out in 2005.

**NeuroLog**

NeuroLog is an Internet-based data collection tool developed by the ABNS to facilitate the gathering of information necessary for primary certification and MOC, as well as RRC resident case log accumulation and residency site reviews. The system is highly secure and Health Insurance Portability and Accountability Act-compliant.

Applicants for certification now use NeuroLog to record all inpatients during a 12-month period. NeuroLog then compiles these data and creates a summary report of inpatients, which is one of the requirements of the application. NeuroLog provides all of the necessary data fields to complete this requirement and an efficient online mechanism for review of the data by the professional practice data committee.

Program directors use NeuroLog to accumulate the data required for RRC accreditation. It tracks the necessary elements for residents and attending physicians to meet current documentation standards. The cataloging of operative data is streamlined and yields both Current Procedural Terminology codes and appropriate ABNS/RRC procedural categories.

The ABNS anticipates that NeuroLog will be the vehicle for Web-based data accrual for the lifelong learning and self-assessment and practice evaluation components of the MOC process.

**Revocation of certification**

At the board’s meeting in May 2004, a hearing was held on revocation of three certificates; all three certificates were revoked.

**Resident duty hours**

The ABNS continues to be committed to the welfare of our residents and the safe delivery of care to neurosurgical patients. Neurosurgical program directors have rapidly come into compliance with the new Accreditation Council for Graduate Medical Education guidelines and a variety of strategies have been implemented to accomplish the objectives of training in neurosurgical training programs, including the use of physician assistants and nurse practitioners in the delivery of care and the use of “night-float” systems to ensure compliance with duty-hour requirements.

There is a widespread perception among neurosurgical educators that we run the risk of developing a “shift-work” mentality among our residents, leading to a commitment to excellent patient care over the course of the patient’s illness that is less keenly sensed than in the past. The board is concerned about this trend because it has the potential to change standards of neurosurgical practice, which have been developed over decades.

**ABNS directors**

At its spring 2004 meeting in New Orleans, LA, Volker K. Sonntag, MD, FACS, and Arthur L. Day, MD, FACS, completed their six years of contributions and leadership on the ABNS. Newly elected directors are Paul C. McCormick, MD, FACS, and Warren R. Selman, MD, FACS. New officers are Ralph G. Dacey, Jr., MD, FACS, chairman; Hal L. Hankinson, MD, vice-chairman; Marc R. Mayberg, MD, FACS, treasurer; and M. Sean Grady, MD, FACS, secretary.

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**The American Board of Ophthalmology**

by Charles P. Wilkinson, MD, Baltimore, MD

**Certification examinations**

The fall oral examination and meeting of the American Board of Ophthalmology (ABO) was held October 24-26, 2003, in Cambridge, MA. The annual meeting took place November 12, 2004, in San Francisco, CA.

The future dates for examinations are as follows: Written qualifying examination, April 15,

The total number of diplomates certified at the October 2003 Cambridge and May 2004 San Francisco oral examinations was 410 (205 in Cambridge, 205 in San Francisco). Eighty-three failed the examination and must repeat all six subjects.

The 2004 written qualifying examination was held Friday, April 16, at three sites in the U.S. The questions on this examination were prepared by the written examination committee of the ABO and the ophthalmic knowledge assessment program committee of the American Academy of Ophthalmology. It is the responsibility of the written examination committee to review and approve the final questions.

Of the 738 individuals registered for the 2004 written qualifying examination, 636 took the examination, 202 failed (31.76%), and 434 passed. Of the individuals who failed, 119 (58.91%) had failed previously. Of the 636 candidates who took the examination, 189 (29.72%) were repeaters, and of these individuals 119 (62.96%) failed again.

International medical graduates constituted 11.32 percent (72) of the individuals who took the examination, and 35 failed (48.61%). U.S./Canadian graduates constituted 88.68 percent (564) of the candidates, and 167 (29.61%) failed.

Of the 189 candidates repeating the written qualifying exam, 31 (16.40%) were international medical graduates and 158 (83.6%) were U.S./Canadian graduates.

The candidates who passed the 2004 written qualifying examination, 636 took the examination, 202 failed (31.76%), and 434 passed. Of the individuals who failed, 119 (58.91%) had failed previously. Of the 636 candidates who took the examination, 189 (29.72%) were repeaters, and of these individuals 119 (62.96%) failed again.

International medical graduates constituted 11.32 percent (72) of the individuals who took the examination, and 35 failed (48.61%). U.S./Canadian graduates constituted 88.68 percent (564) of the candidates, and 167 (29.61%) failed.

Of the 189 candidates repeating the written qualifying exam, 31 (16.40%) were international medical graduates and 158 (83.6%) were U.S./Canadian graduates.

The candidates who passed the 2004 written qualifying exam plus the repeaters from previous oral examinations provided a potential pool of 253 candidates for the November 2004 San Francisco oral examination and 253 potential candidates for the June 2005 Philadelphia oral examination.

Recertification examinations

The future dates for examinations are as follows: Certificate renewal examination, written (CREW), February 1 through March 31, 2005 (this is a take-home examination with two months to complete); office record review (ORR), January 1-31, 2005, and July 1-31, 2005 (given twice a year with one month to complete).

The 2004 CREW examination was administered as a take-home examination from February 1 through March 31, 2004. Of the 477 registered for this examination, 473 completed the examination, with 470 passing (99.4%) and three failing (0.6%).

The ORR was administered July 1-31, 2003, and January 1-31, 2004. Of the 141 registered for the July 2003 examination, 139 passed the review and two were incomplete. At the January 2004 examination, 320 were registered, with 312 passing and eight incomplete.

Representation

The representative to the American College of Surgeons for 2004 was David T. Tse, MD, FACS, Miami, FL. The board’s representatives to the residency review committee for the year 2004 were: Susan H. Day, MD, San Francisco, CA; Richard P. Mills, MD, FACS, Seattle, WA; and James S. Tiedeman, MD, Charlottesville, VA.

In December 2003 and June 2004, the residency review committee for ophthalmology reviewed 34 of 121 accredited ophthalmology residencies. With few exceptions most programs continued to receive full accreditation with three-to-five-year cycles assigned on the strength of the program’s review.

The following directors became officers of the board for 2004: chairman, Charles P. Wilkinson, MD, Baltimore, MD, and vice-chairman, William F. Mieler, MD, FACS, Chicago, IL.

The two new board directors who took office January 1, 2004, are Marilyn B. Mets, Chicago, IL, and James C. Orcutt, MD, Seattle, WA.

The voting representatives to the American Board of Medical Specialties (ABMS) for 2004 are: Edward G. Buckley, MD, FACS, Durham, NC; Richard P. Mills, MD, FACS, Seattle, WA; William F. Mieler, MD, Chicago, IL; and Charles P. Wilkinson, MD, Baltimore, MD. The term of Denis M. O’Day, MD, FACS, Nashville, TN, on the executive committee of the ABMS was completed in March 2004.

The board welcomes Suzanne T. Anderson as a public member. She is the vice-president of Meaghan Jared Partners, Inc., a management-consulting firm for physicians, hospitals, and other health care entities, in Bellevue, WA. Ms. Anderson has served as a public member for the ABMS and has published and written extensively on health care management issues and recertification. She also serves on the board of directors of the
Foundation of Anesthesia and Education and Research, as a trustee of the Educational Commission for Foreign Medical Graduates, and as a reviewer for the *Healthcare Financial Management Journal.*

The ABO honored the following directors at the November board meeting and expressed appreciation for their contributions: M. Bruce Shields, MD, FACS, director (1996-2003), chair (2003); and Richard L. Abbott, MD, director (1996-2003).

**General Information**

The American Board of Ophthalmology continues to develop various pathways for the maintenance of certification (MOC). Key among these is the evidence of cognitive expertise. The current take-home, open-book written examination will change in 2006 to a secure, proctored examination administered at more than 250 computerized testing centers. The curriculum from which the cognitive examination will be based is being developed by the American Academy of Ophthalmology and is being referred to as the practicing ophthalmologist curriculum.

**Qualifying/certifying examinations**

The 2004 written qualifying exam was administered to 291 candidates April 23 in Chicago, IL. All candidates then participated in the oral certifying exam, which was conducted April 24 and 25 by 98 individuals, including American Board of Otolaryngology (ABO) directors, senior examiners, and guest examiners. Individuals who did not achieve the qualifying score on the written exam had their oral scores invalidated. Of those achieving the qualifying score, 274 passed the exam and were certified (95%) and 14 failed (5%).

**Otolaryngology training exam**

The otolaryngology training exam was conducted March 6, 2004, in more than 100 locations. It was the seventh year that the exam had been prepared and conducted by the ABO. More than 1,100 residents and practitioners participated in the exam. The next otolaryngology training exam is scheduled for Saturday, March 5, 2005.

**Board of directors**

The following individuals were elected to serve as officers in 2004: Harold C. Pillsbury III, MD, FACS, president; Jesus E. Medina, MD, FACS, president-elect; and Paul A. Levine, MD, FACS, treasurer.

Roger L. Crumley, MD, FACS; Gerald B. Healy, MD, FACS; and Robert H. Miller, MD, FACS, completed their terms on the board of directors at the conclusion of the 2003 annual meeting in April af-
After many years of dedicated service to the ABO, Dr. Healy had served as executive vice-president of the board for the past six years. The executive vice-president position has now been eliminated. Dr. Miller has assumed the newly created, full-time position of executive director.

Ellen M. Friedman, MD, FACS (Houston, TX); James A. Hadley, MD, FACS (Rochester, NY); and Peter A. Hilgerm, MD, FACS (Edina, MN), were elected to the board of directors. All had served for many years as guest or senior examiners.

Maintenance of certification

In 2002, the ABO issued its first 10-year, time-limited certificates. Maintenance of certification (MOC) is the program by which diplomates maintain/renew their certification as required by the American Board of Medical Specialties (ABMS). Diplomates certified before 2002 are not required to participate in the MOC program, but may do so if they wish. As a member of the ABMS, the ABO must comply with certain ABMS requirements. More importantly, MOC is a process that promotes lifelong learning and the ongoing provision for up-to-date, high-quality patient care.

The four components of the ABO MOC process include documentation of professional standing, documentation of lifelong learning and self-assessment, evidence of cognitive expertise, and evaluation of performance in practice. The ABO has instituted Part I of MOC and is in the process of developing the other three components.

Neurotology

The ABO conducted its first neurotology exam April 26, 2004. Twenty-six examiners and 52 candidates participated. Fifty (96%) passed the exam; two (4%) failed.

The most compelling reason for instituting the neurotology exam was to ensure that individuals who complete neurotology subspecialty training programs approved by the Accreditation Council for Graduate Medical Education (ACGME) are, in fact, qualified to diagnose and treat neurotologic and lateral skull base diseases and disorders. In addition, the basic ABO certificate does not test the body of knowledge defining medical and surgical neurotology. As a public trust, the ABO is obligated to assess and certify that those trained in neurotology are qualified to practice the subspecialty, just as it is obligated to examine candidates and issue primary certificates in otolaryngology.

Two pathways have been established to permit individuals to take the neurotology exam: one for those who have completed ACGME residency training in neurotology, and one for those who have not completed such training but limit their practice to neurotology. The alternate pathway will close after 2011.

Additional information

Information on ABO policy and examinations, as well as information on the scope of knowledge study (which defines the content of ABO exams and requisite otolaryngology training), may be found online at www.aboto.org.

The American Board of Plastic Surgery

by Lawrence L. Ketch, MD, Denver, CO

Examinations

A total of 206 candidates sat for the oral examination November 13-15, 2003. One hundred seventy-three candidates passed and 33 failed, resulting in a failure rate of 16 percent. The oral examination was offered in combination with the American Board of Plastic Surgery’s (ABPS’s) semianual meeting for the first time since 1997. In September 2002, 222 candidates took the oral examination. One hundred ninety-two candidates passed in 2002 and 30 failed, with a failure rate of 13.5 percent. The usual failure rate range has been 17 percent to 25 percent. At the time this report was prepared, the board anticipated 220 candidates for
the 2004 oral examination. As of November 15, 2003, the ABPS has certified 6,672 plastic surgeons.

The second computer-based test (CBT) format for the written or qualifying examination was held October 20, 2003, for 230 candidates. Results of the 2003 written examination were distributed on December 22, 2003. One hundred seventy-seven of the total of 230 candidates passed the written examination, with a failure rate of 23 percent. In 2002, 186 of a total of 242 candidates passed the written examination, with a failure rate of 23.1 percent, which was consistent with prior years. The 2004 examination was offered again as a CBT October 19, 2004, at test centers across the country. Approximately 230 candidates were expected to sit for the 2004 written examination.

ABPS administered the 2003 subspecialty certification in surgery of the hand examination (formerly the certificate of added qualification in surgery of the hand) to 41 ABPS diplomates, 28 who were recertifying. Eleven of 13 diplomates passed the hand surgery examination. The total failure rate for all 65 examinees was 6.2 percent. A total of 28 diplomates sat for the 2003 hand surgery recertification examination; 21 passed, and the overall failure rate for 148 was 10.1 percent. The 2004 certification examination in surgery of the hand was administered as a CBT from August 6 through September 4, 2004. The board expected 68 candidates, 46 of whom were recertifying. Results were scheduled to be announced in November.

**Recertification**

The second recertification examination was given during April 2004. One hundred twenty-two diplomates took the examination; 118 passed and four failed, for a 96.7 percent passing rate. One hundred thirteen of those individuals participating possessed time-dated certificates that would expire in 2005 or 2006. Nine were lifetime certificate holders. The cognitive examination was offered as a CBT in four modules: comprehensive plastic surgery, cosmetic/breast surgery, craniomaxillofacial surgery, and hand surgery. A subspecialty certificate in surgery of the hand was accepted in lieu of the hand surgery module cognitive examination component of the recertification program. The four key components of professionalism, knowledge, lifelong learning, and performance in practice are incorporated into the recertification program. Diplomates are collecting an operative log for six months for assignment to an examination module in the areas of their practice profile. Maintenance of certification is currently planned to phase in during 2006/2007.

**Prerequisite training years**

A task force for the evaluation of training pathways is currently evaluating the duration and content of the prerequisite years in training.

**Revocation of certification**

The board is using the Federation of State Medical Boards DANS Alert System through the American Board of Medical Specialties to identify diplomates with state medical license sanctions. Plastic surgeons with revoked state medical licenses are referred to the ethics committee for revocation of certification. To date, the board has revoked certification for 39 diplomates. This information was also published in the board’s annual newsletter to diplomates.

**ABPS code of ethics**

The board developed and adopted its own code of ethics in November 2001. Reporting and enforcing issues regarding advertising and expert witness testimony has resulted. The ABPS code of ethics is supplied to every candidate and is available on the board’s Web site.

**Subspecialty issues**

The ABPS continues to be committed to the engagement, development, and recognition of subspecialty interests for the purpose of advancing the core of the entire specialty. The board’s four advisory councils have been working since May 2000, contributing to the work of the recertification process and maintenance of certification program. The advisory councils reflect the four identified subspecialty modules for the recertification program: comprehensive plastic surgery, cosmetic plastic surgery, craniomaxillofacial surgery, and hand surgery. The members include board directors and nominees
from plastic surgery subspecialty organizations. The board currently uses subspecialty expertise to develop journal review questions for self-learning for the *Plastic and Reconstructive Surgery* Journal.

**In appreciation**

The ABPS honored the following directors at the May board meeting and expressed appreciation for their work: Bruce L. Cunningham, MD, FACS, director (1997-2003), chair (2003-2004); James G. Hoehn, MD, FACS, director (1998-2004); Carolyn L. Kerrigan, MD, FACS, director (1997-2004); and Luis O. Vasconez, MD, FACS, director (1998-2004).

**New officers/directors**

The new directors elected to the ABPS are: John W. Canady, MD, FACS, Iowa City, IA; Jack A. Friedland, MD, FACS, Phoenix, AZ; and Nicholas B. Vedder, MD, FACS, Seattle, WA.

ABPS officers for 2004-2005 are: Lawrence L. Ketch, MD, FACS, Denver, CO, chair; John A. Persing, MD, FACS, New Haven, CT, chair-elect; Thomas R. Stevenson, MD, FACS, Sacramento, CA, vice-chair; and Ronald E. Iverson, MD, FACS, Pleasanton, CA, secretary-treasurer.

A new appointee to the Cosmetic Advisory Council to the board is William P. Adams, Jr., MD, FACS.

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**The American Board of Urology**

*by Joseph A. Smith, Jr., MD, FACS, Nashville, TN*

**Exams**

The certification process of the American Board of Urology (ABU) incorporates a qualifying examination (Part 1) and a subsequent certifying examination (Part 2). Admissibility to the qualifying examination requires that the applicants have completed or are within six months of satisfactorily completing an Accreditation Council on Graduate Medical Education (ACGME)-approved urology residency program. Admissibility to the certifying examination requires that the candidates have passed the qualifying (Part 1) examination, have 18 months of clinical practice experience in a single community, submit an acceptable practice log, and receive satisfactory peer reviews.

On August 6, 2004, 317 candidates completed the qualifying (Part 1) examination. The examination was administered for the first time as a computer-based test and was a cognitive, multiple-choice examination. The computer-based testing allows candidates to enter their responses directly into the computer and to view enhanced images on the screen. Of the 317 candidates who sat for the qualifying examination, 263 passed and 54 failed. As has been true in other years, practitioners—U.S. or foreign-educated—who have previously failed the examination had a high failure rate on reexamination.

Since 1987, the scoring of the qualifying examination has used the principles of criterion-referenced testing, whereby the pass level is equated to a previous benchmark test, using the Rasch model. The passing score will vary according to the difficulty of the examination for any year. Thus, although an examination may vary in difficulty from year to year, the probability of passing (pass rate) is based solely on the ability of the candidate pool in any given year. This methodology is fair and defensible because it does not impose an arbitrary pass/fail point.

The 2004 certifying (Part 2) examination is a standardized oral examination that consists of six protocols on which the candidate is tested. In February 2004, 280 candidates took the certifying (Part 2) examination; 255 (91%) passed and were certified; 25 (9%) failed. The board uses a modified Rasch model for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. Consistent with the board’s commitment to continually improving its evaluation processes, in 1995 the board applied a dual scoring system for the oral examination protocols.
Separate grades are used for information gathering and diagnosis, and for problem solving and patient management. This change has resulted in a significant increase in statistical reliability. The board is pleased with this scoring technique for the oral examination.

Certification

The board requires completion of certification within five years of completion of an ACGME-approved residency program; extensions are granted for approved fellowship training. Failure to complete certification within the time allotted requires reentry into the certification process at the qualifying examination (Part 1) level after first passing a preliminary examination.

In 1992, the board began its mandatory recertification process for all diplomates with 10-year time-limited certificates, which have been issued since 1985. Currently, all trustees of the ABU recertify during their tenure on the board unless, because they were originally certified after 1985, they have already recertified to retain their certification. The process consists of multiple components. These various components provide the diplomate with different opportunities and ways to document his or her competence. A modular, written, open-book examination consists of five subject areas from which the diplomate will choose three with which he or she is most comfortable. Each module has 20 questions, for an individual examination of 60 questions. Other components include peer review, a surgical log review, and a continuing medical education requirement.

In addition, at the board’s discretion, hospital/office chart reviews, an oral interview or examination, and/or a site visit may be required. Diplomates may enter the recertification process up to three years before expiration of the primary certificate. Upon successful recertification, the diplomate is issued a certificate valid for 10 years from the date of expiration of the original certificate. The 2002 recertification process was the first year that included diplomates recertifying for their second time.

In November 2003, 432 diplomates sat for recertification; 411 diplomates (95%) successfully completed the recertification process. The pass rate was consistent with previous years.

Many of the ABMS member boards are developing a maintenance of certification process that would supersede their existing recertification processes. Maintenance of certification would entail, among other things, ongoing monitoring of physicians by the certifying boards. The ABU is actively discussing and developing a maintenance of certification model. However, the trustees have significant concerns regarding the implementation of the process and are proceeding cautiously after much consideration and deliberation.

Officers and trustees

Current officers and trustees are: Joseph A. Smith, Jr., MD, FACS, president; Michael J. Droller, MD, FACS, vice-president; Robert C. Flanigan, MD, FACS, president-elect; Linda M. Shortliffe, MD, FACS, secretary-treasurer; Peter C. Albertsen, MD, FACS; David A. Bloom, MD, FACS; Peter R. Carroll, MD, FACS; Michael O. Koch, MD, FACS; Paul H. Lange, MD, FACS; Mani Menon, MD, FACS; Howard M. Snyder III, MD, FACS; and W. Bedford Waters, MD, FACS.
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Brickhouse Professor and chair, department of surgery, Eastern Virginia Medical School
Norfolk, VA

Bruce Douglas Browner
Orthopaedic surgery
Gray-Gossling Professor and chairman, department of orthopaedic surgery, University of Connecticut Health Center, Farmington, CT, and director of orthopaedics, Hartford Hospital, Hartford, CT

Martin B. Camins
Neurological surgery
Clinical professor of neurological surgery, Mount Sinai Hospital and Medical School
New York, NY

A. Brent Eastman
General surgery
Chief medical officer, Scripps Health, and N. Paul Whittier Chair of Trauma, Scripps Memorial Hospital, La Jolla, CA, and clinical professor of surgery, University of California, San Diego
San Diego, CA
Richard J. Finley  
*General surgery*
C. N. Woodward Chair in Surgery and professor and head, division of thoracic surgery, University of British Columbia Faculty of Medicine
*Vancouver, BC*

Josef E. Fischer  
*General surgery*
Professor of surgery, Harvard Medical School, and chairman of surgery, Beth Israel Deaconess Medical Center
*Boston, MA*

Barrett G. Haik  
*Ophthalmic surgery*
Chair, department of ophthalmology, University of Tennessee Health Science Center, College of Medicine
*Memphis, TN*

Alden H. Harken  
*Cardiothoracic surgery*
Professor and chairman, department of surgery, University of California-San Francisco, East Bay
*Oakland, CA*

Charles D. Mabry  
*General surgery*
Private practice
*Pine Bluff, AR,* and assistant professor of surgery, practice management advisor to the chairman, department of surgery, University of Arkansas for Medical Sciences
*Little Rock, AR*

Jack W. McAninch  
*Urology*
Professor of urology, University of California-San Francisco, and chief of urology, San Francisco General Hospital
*San Francisco, CA*

Mary H. McGrath  
*Plastic surgery*
Professor of surgery, division of plastic surgery, University of California
*San Francisco, CA*

Robin S. McLeod  
*Colon and rectal surgery*
Professor of surgery and health policy, management and evaluation, University of Toronto, and head, division of general surgery, Mt. Sinai Hospital
*Toronto, ON*
Carlos A. Pellegrini  
*General surgery*  
Henry N. Harkins Professor and chairman, department of surgery, University of Washington  
*Seattle, WA*

Karl C. Podratz  
*Gynecology (oncology)*  
Joseph I. and Barbara Ashkins Professor of Surgery, and professor of obstetrics and gynecology, Mayo Clinic  
*Rochester, MN*

John T. Preskitt  
*General surgery*  
Attending surgeon, Baylor University Medical Center  
*Dallas, TX*

J. David Richardson  
*Vascular surgery*  
Professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine  
*Louisville, KY*

Thomas V. Whalen  
*Pediatric surgery*  
Professor of surgery and pediatrics, and chief of pediatric surgery, Robert Wood Johnson School of Medicine  
*New Brunswick, NJ*
In compliance...

...with the security rule under HIPAA

by the Division of Advocacy and Health Policy

On April 20, the security standards under the Health Insurance Portability and Accountability Act (HIPAA) will go into effect. So now is a good time to review how this rule and the privacy rule work together and to examine what surgical practices need to do to comply with the rules.

Privacy and security rules

The privacy rule under HIPAA, which became effective in its present form April 14, 2003, applies to all protected health information (PHI) for patients, whether it is in oral, written, or electronic form. The rule restricts the availability of that information to only those individuals who need to know the content of the records and reduces the inadvertent release of information.

On the other hand, the security rule applies only to those records that contain electronic protected health information (EPHI). EPHI is information that is created, received, maintained, or stored on a computer or any storage device that is hooked up to a computer (such as a magnetic disk, flash drive, or compact disc) or that is transmitted via the Internet. The purpose of the security rule is to protect the integrity of the electronic record.

While it is possible to imagine a physician’s practice that is subject only to the privacy rule, as a practical matter, virtually all practices are subject to both rules. Both the privacy and security rules contain administrative, physical, and technical safeguards that the practice must meet, and the rules have been structured so that, wherever possible, a practice that meets the privacy standards will already be well along in compliance with the security rules.

Similarities and differences

Both rules require the practice to have written policies regarding a range of activities. In fact, the privacy rule is much more comprehensive, touching everyone in a practice. On the other hand, the security rule affects only individuals responsible for electronic systems, either working on a computer in the practice or overseeing related work done under contract to the practice.

Both rules also require the practice to have written policies covering a range of items, and both are very flexible in terms of exactly what will satisfy a requirement. However, the two rules differ with respect to what practices must document to satisfy the two rules.

The security rule is built around 18 standards that are general statements of security needs. Each security standard is then followed by implementation specifications designated as either “required” or “addressable.” Required specifications must be implemented and documented in the practice’s policies. Addressable specifications must be assessed in terms of whether they are reasonable and appropriate safeguards in the practice’s environment; if the conclusion is that they are not, the practice must consider whether other safeguards could be substituted. For addressable specifications, the documentation in the final policy must outline the entire process of considering the original implementation specification and, if that is rejected, of considering any substitute actions.

Example of the two rules working together

The privacy rule requires that the practice “have and apply appropriate sanctions” against those who violate its privacy policies and procedures (45 C.F.R. § 164.530 (e)). The security rule requires that the practice “apply appropriate sanctions against those who fail to comply” with their security policies and procedures (45 C.F.R. § 164.308 (a)(1)).
The privacy rule simply says a practice must have policies to prevent disclosures of information in violation of the regulation. While the rule makes it clear which disclosures are permitted or prohibited, the practice must decide exactly which policies it will have. A practice simply documents its policies and does not have to document the rationale for the final policy.

Reassessment of policies
Both the privacy and security rules require that practices periodically reassess their policies. Because of the way these two rules fit together, it is probably best to review policies under the two rules together. In addition to annual or other periodic reassessments of policies, the need for further review may be triggered by certain events, such as a change in the data system or a change in the workflow in the office. Reassessment could be needed for less obvious reasons as well, such as if new furniture for staff results in a rearrangement of workstations, perhaps necessitating a number of changes in privacy procedures.

Organizational approaches
Each rule requires the practice to designate a person to be responsible for the development of policies and procedures under the respective regulation. Of course, the practice manager will bear the ultimate responsibility for the development of policies under both rules. However, it is possible to split the responsibility for developing the policies among people. For example, a practice may find it useful to give responsibility for the portions of both the privacy and security rule that relate to systems to one person and responsibility for the remainder of the privacy rule to another person. This method has the advantage of assigning very technical “bits and bytes” work to a specialist in the field. If responsibility for developing the policies for the rules is split, however, the people responsible for developing the policies will need to work closely, and the policies will have to be integrated after they are completed.

Addressable implementation specifications
In the security rule, an addressable implementation specification does not mean it is automatically optional. The practice must consider whether the specification is reasonable and appropriate given the environment and, if not, whether other safeguards could be substituted. Cost is certainly a factor that should be included in the analysis. The rationale for the final decision must be documented in the final security policy.
The 2004 interim meeting of the American Medical Association (AMA) House of Delegates (HOD) was held December 4-7, 2004, in Atlanta, GA. This meeting offered delegates from national and state medical societies the opportunity to discuss and vote on policy matters of concern to the house of medicine. The College was well represented at the meeting by the following surgeons: LaMar S. McGinnis, Jr., MD, FACS (Atlanta), delegation chair; delegates Charles Logan, MD, FACS (Little Rock, AR), Richard Reiling, MD, FACS (Charlotte, NC), and Amilu Rothhammer, MD, FACS (Colorado Springs, CO); alternate delegate Thomas Whalen, MD, FACS (New Brunswick, NJ); and Young Physicians Section delegate Patricia Turner, MD (Washington, DC).

The HOD addressed a number of issues of interest to surgeons that came about due to resolutions submitted at previous meetings by the College. These pertained to expert witness qualifications, specialty hospitals, and uncompensated care.

Expert witness report

At the 2004 annual meeting of the HOD, which took place last June in Chicago, a College resolution was adopted, which called attention to the need for stronger AMA policy regarding expert witness testimony in medical liability trials. It requested that the AMA implement an expert witness affirmation for AMA members similar to those adopted by a number of national specialty societies. In addition, a College resolution was adopted at the December 2003 interim meeting asking for development of policy on expert witness qualifications and behavior. As a result of these two resolutions, a comprehensive expert witness report was submitted by the AMA Board of Trustees, and after considerable debate, the HOD adopted it with few modifications.

The report included recommended statutory qualifications for expert witnesses. It also contained an expert witness affirmation statement for dissemination to AMA members. The statement reflects requirements that have been adopted by the College, the American College of Obstetricians and Gynecologists, and other specialty societies. (See box, below.)

Specialty hospitals

In response to a College resolution adopted at the 2004 annual meeting of the HOD, the Board of Trustees submitted Report 15-I-04 with a series of recommendations to address various aspects of the specialty hospital issue. Considerable debate and discussion resulted in refinement of some of the recommendations, which, in turn, enhanced the HOD’s support and led to the report’s adoption. Of particular interest is inclusion of a policy that the AMA will oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in

Minimum requirements for expert witnesses

- Comparable education, training, and occupational experience in the same field as the defendant or specialty expertise in the disease process or procedure performed in the case.
- Professional experience that includes active medical practice or teaching experience in the same field as the defendant.
- Active medical practice or teaching experience within five years of the date of the occurrence giving rise to the claim.
- Certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or a board with equivalent standards.
which they have ownership interests.

Regarding certificate of need (CON) laws, a policy was adopted indicating that the AMA will oppose federal efforts to institute CON. The AMA also will fight state efforts to implement CON laws where none currently exist or to expand existing CON laws to physician-owned ambulatory facilities.

Uncompensated care

A number of surgical specialty societies joined the College in sponsoring Resolution 918-I-04, Cost of Providing Uncompensated Care. This resolution asked the AMA to work with specialties affected by the costs of providing uncompensated care to develop legislative and regulatory proposals to help offset such costs for those physicians who provide care in emergency departments, trauma centers, and other settings. It directed that these proposals include expanding to other specialties the methodology currently used by the Centers for Medicare & Medicaid Services to account for uncompensated care provided to the specialty of emergency medicine. As anticipated, this resolution was discussed at length. In the end, the resolution was referred to the AMA Board of Trustees due to the complexity of the issue with a report back at the 2005 annual meeting in June.

Maintenance of certification

This meeting was the first where the College had full administrative and management responsibility for the Surgical Caucus program. Under Dr. McGinnis’ leadership, the educational portion of the program focused on professionalism, competency, and surgical practice as they relate to maintenance of certification. Speakers at this session included the following surgeons: Stephen Miller, MD, MPH, FACS, president, American Board of Medical Specialties (ABMS); Frank Lewis, Jr., MD, FACS, executive director, American Board of Surgery (ABS); and Ajit Sachdeva, MD, FACS, FRCS, Director, ACS Division of Education. Many surgeons commented on the level of expertise of the speakers and the value of hearing about those maintenance of certification activities being offered through the ACS, ABS, and ABMS.

Campaign for leadership role

The College has nominated Dr. Reiling for a position on the AMA Council on Medical Education. He has received the endorsement of the North Carolina Medical Society, and the delegation is in the process of seeking additional backing from other groups represented at the HOD. Dr. Reiling stands an excellent chance of being elected to this council. Fellows who are involved in the AMA HOD are encouraged to promote his candidacy and work with their state or specialty delegations to gather support.

For further information about these or other issues from the AMA House of Delegates, contact Jon Sutton, Manager of State Affairs, by telephone at 312/202-5358, or by e-mail at jsutton@facs.org.
ACS Archives joins research community through Library of Congress database

by Susan Rishworth, ACS Archivist

For more than three years, the American College of Surgeons’ historical archival records have been undergoing what archivists call preservation treatment. This process involves arranging and describing the items to make the archives accessible to members of the College and other researchers and to ensure the longevity of the archived materials.

In the summer of 2004, in order to increase their visibility, a description of the ACS Archives was submitted to the National Union Catalog of Manuscript Collections (NUCMC) to be entered into the NUCMC database of nearly 2,000 archival repositories holding as many as 90,000 separate archival collections. NUCMC is a section of the Special Materials Cataloging Division of the U.S. Library of Congress.

The Library of Congress, through NUCMC, provides listings in its database free of charge as part of a cooperative cataloging program to make archival repository collections available to researchers throughout the U.S. and around the world. Archives-at-large, which are well-endowed archival repositories, are often able to enter their own manuscript cataloging into one of the large Library of Congress databases and pay an annual fee for such access.

Smaller archives—such as the College’s—cannot afford to belong to the large groups; thus, their holdings may be totally obscure except to the archive’s parent body, such as the staff of the American College of Surgeons. It was for the purpose of giving these smaller, much less well-known archival repositories a chance to be seen by a wider audience that the NUCMC Section of the Special Materials Cataloging Division of the Library of Congress was created.

The ACS Archives is now listed on NUCMC/RLG Web site: http://lcweb.loc.gov/coll/nucmc. As a result, it is anticipated that the number of researchers using the ACS collections will grow due to the increased exposure through the databases.

Even though the ACS Archives staff still has many records to process, and will have many more records to process as more areas of the College transfer their inactive records to the Archives, the inclusion of the ACS in the NUCMC databases constitutes a significant achievement for the College toward enhancing the meaning and value of “FACS” for surgeons and the public.

Additional information regarding the College’s Archives may be obtained by contacting Susan Rishworth at 312/202-5270, or via e-mail at srishworth@facs.org.

SURGICAL LIFESTYLES, from page 18

ter than me. If I can’t do that one of us has failed,” Dr. Salisbury said.

While Dr. Salisbury enjoys both his careers, he notes that surgery offers less room for imperfect performance. “Many people can paint, and no one would mistake me for Monet. Our brotherhood of surgery is so unique that few can do what we have chosen. Is there another profession in which less than a 100 percent success is regarded as failure? Failure in my art gets painted over, erased, or torn up. These options don’t exist in surgery, and therein lies the ultimate challenge,” he said.
Space sold by Elsevier
American College of Surgeons Insurance Program: Update

by Gay L. Vincent, CPA, Comptroller

The Trustees of the American College of Surgeons Insurance Program met in December 2004. All program plans were performing well except the medical/hospital plans. While the combined claim experience for the medical/hospital plans has recently shown signs of improvement, financial results continue to produce a deficit to the insurance program.

The response to the new 10-Year Level Term Life Insurance product has been favorable. The product is priced very competitively with approximately 62 percent of policies written in the super preferred (best health) risk classification.

The Trustees also approved a 20-Year Level Term Life Insurance product that will be introduced to U.S. (currently unavailable in Florida, Texas, Vermont, and Washington) and Canadian members under age 55 in the near future.

The response from our other new products was encouraging as well. These insurance products include auto, homeowners, and long-term care. A significant number of ACS members were existing customers of its long-term care provider.

Contact information is as follows:
- Auto, homeowners: 1-800/524-9400 (U.S. only).

Additional information regarding the ACS Insurance Program may be found on the College’s Web site, www.acs-insurance.com, or by contacting Gay Vincent, Trustee, at 312/202-5449.

South Africa to host International Surgical Week

Surgeons from around the world are invited to attend International Surgical Week (ISW), the 41st World Congress of Surgery, which will be held August 21-25, 2005, in Durban, South Africa. Sponsored by the International Society of Surgery and the Societe Internationale de Chirurgie, and co-hosted by the Association of Surgeons of South Africa, the meeting’s most important task is to build bridges between general surgeons in the developing countries and specialists in the developed countries.

Creating the right blend for specialists and general surgeons is the goal that has been set for this year’s ISW program. Major panel discussions will be featured, during which specialists will describe and explain the most recent developments in their particular fields and provide information on their relevance for the general surgeon. What is essential for the general surgeon to know these days, and how much does he or she have to be able to put into practice? And what is still in the clinical research phase and of a more speculative nature?

For additional information on the program and to register for this exciting international meeting, visit www.isw2005.org.za.

Trauma meetings calendar

The following Continuing Medical Education Courses in Trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:
- **Trauma and Critical Care—2005**, March 21-23, 2005, Las Vegas, NV.
- **Trauma and Critical Care—2005: Point/Counterpoint XIV**, June 6-8, 2005, Atlantic City, NJ.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
“The College represents multiple surgical disciplines. In our daily practice of surgery, we gravitate toward the things with which we are most comfortable. Almost unconsciously we may specialize within our specialty. A strong organization like the ACS is capable of representing broad as well as specific specialty interests. Thus my contribution to the College rather than to a specific surgical specialty.

“I prefer to give to a profession dedicated to healing. Through local, state, and federal taxation we support the community as a whole (and not always as we might choose). A gift to the ACS can be directed to your cherished interests.

“The major College benefit, to me, has been continuing surgical education. I joined the College more than 50 years ago upon completing my surgical residency. A secondary benefit has been the development of social contacts nationwide that would simply not have happened otherwise.”

Dr. Kridelbaugh supports the College financially through active membership in the Fellows Leadership Society.

For information about joining the Fellows Leadership Society, please contact the College’s Development Office via telephone at 312/202-5376, via e-mail at fholzrichter@facs.org, or by visiting the ACS Web site at www.facs.org.
The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Germany.

Purpose
The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Germany, and a German Traveling Fellow will visit North America.

Basic requirements
The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:
- Has a major interest and accomplishment in clinical and basic science related to surgery.
- Holds a current full-time academic appointment in Canada or the U.S.
- Is under 45 years of age on the date the application is filed.
- Is enthusiastic and personable and possesses good communication skills.

Activities
The Fellow is required to spend a minimum of two weeks in Germany:
- To attend and participate in the annual meeting of the German Surgical Society, which will be held in Berlin, Germany, May 2–5, 2006.
- To attend the German ACS Chapter meeting during that congress.
- To visit at least two medical centers (other than the annual meeting city) in Germany before or after the annual meeting of the German Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons.

The academic and geographic aspects of the itinerary will be finalized in consultation and mutual agreement between the Fellow and designated representatives of the German Surgical Society and the German ACS Chapter. The surgical centers to be visited will depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Germany.

His or her spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction in addition to professional activities.

Financial support
The College will provide the sum of $6,000 U.S. to the successful applicant, who will also be exempted from registration fees for the annual meeting of the German Surgical Society.

He must meet all travel and living expenses. Senior German Surgical Society and ACS German Chapter representatives will consult with the Fellow about the centers to be visited in Germany, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his own travel arrangements in North America, because doing so will allow him to take advantage of reduced fares and travel packages for travel in Germany.

The American College of Surgeons International Relations Committee will select the Fellow after review and evaluation of the applications. A personal interview may be requested prior to the final selection.

Applications for this traveling fellowship may be obtained on the College’s Web site at http://www.facs.org/memberservices/research.html, or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is April 1, 2005. The successful applicant and an alternate will be selected and notified by July 31, 2005.
The American College of Surgeons Division of Education presents the **Personal Financial Planning and Management Course for Residents and Young Surgeons**, which uses an interactive/lecture format to arm surgeons with basic financial management skills. The course is designed to educate and equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children) and proper planning for financial stresses related to their surgical practice.

**Objectives**

At the end of the course, the participants will be able to describe:

- The essentials of personal financial management as they relate to young surgeons in practice and residents and their families.
- The impact of interest rates and time upon loans, compound interest, and the implications for debt management.
- The building blocks necessary for the surgeons to invest successfully.
- The importance of time in reducing the risk of investing.
- The basics of mutual funds, stocks, bonds, and other investment vehicles.
- How to evaluate and choose a financial advisor.

**Intended Audience:**

- Surgical residents and surgeons recently in practice.

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**Now available on CD-ROM**

Fellows of the American College of Surgeons: $120  
Non-Fellow: $215  
RAS member: $75  
Surgical Resident, not a RAS member*: $95  
*Non-RAS residents must supply a letter confirming status as a resident from a program director or administrator, and are limited to one CD-ROM. (Additional $16 for shipping and handling of international orders.)

Orders may be placed through ACS Customer Service at 312/202-5474 or via the College’s Web site at: www.acs-resource.org  
For more information contact Dawn Pagels, MBA, at dpagels@facs.org, or tel. 312/202-5185.
The seventh annual Connecticut Trauma Conference will take place April 7-8, at the Foxwoods Conference Center, Ledyard, CT. The conference—Issues, Trends, and Management in Trauma Care—is sponsored by the ACS Connecticut Committee on Trauma.

The conference is a forum in which complex and controversial issues affecting the care of the trauma patient will be presented and discussed by nationally recognized experts in all aspects of trauma care. The conference’s goal is to provide insight into issues and problems related to the optimal care of the trauma patient.

The program will focus on ethical and sociological issues in trauma care, as well as on perplexing management problems in orthopaedic, vascular, and pediatric trauma care. Participants will be provided with a comprehensive overview of current concepts in areas of resuscitative trauma care, as well as new techniques and technologies available to providers responsible for caring for the trauma patient.

For additional information, contact Ronald I. Gross, MD, FACS, Hartford Hospital, 80 Seymour St., CB 101, Hartford, CT 06102; tel. 860/545-4187, e-mail rgross@harthosp.org.

New from the American College of Surgeons

Announcing a NEW Member Benefit for Residents...FREE* ONLINE ACCESS!!
I was kindly given the opportunity to attend the 2004 Clinical Congress of the American College of Surgeons with the support of the College’s Nizar N. Oweida, MD, FACS, Scholarship. This was actually the second Clinical Congress that I have attended. My first experience was in 2001, when I was a chief resident at MCP/Hahneman University Hospital, Philadelphia, PA. At that time, I mostly was interested in sessions that were centered on technological innovations and laparoscopic surgery.

After having worked at a rural hospital for a little more than two years, my preferences this time were quite different. I attended those sessions that would have a direct impact on my practice. Some of the sessions that I found very helpful for rural surgeons were those that addressed legal issues, gastroesophageal reflux disease, fluid resuscitation, wound care, surgical infections, and the College’s development of a Web portal and other electronic learning tools.

Additionally, the 2004 Clinical Congress featured an important forum for rural surgeons from all over the country to openly discuss problems they or their families are facing. The biggest drawback to rural surgery is the lack of opportunities for continuing education and professional growth. Several options for addressing this problem were discussed. One possible solution would be to integrate rural practices with nearby academic institutions where rural surgeons could participate in any educational programs, including case presentations and workshops.

The majority of participants at the meeting also agreed that the faculty at those academic institutions should be involved in the educational growth of rural surgeons in the surrounding area. This activity might involve visits of the faculty to these rural areas or mentoring rural surgeons.

All the rural surgeons greatly appreciated the steps the College is taking toward recognizing the concerns of rural surgeons and resolving them.

One rather depressing moment for me occurred during the research articles presentation part of the Scholarships Committee meeting. I realized that, despite my love for academic medicine, I was unable to contribute my knowledge or skills to this forum because so few opportunities in this area are available to rural surgeons. I strongly recommend that interested rural surgeons be offered alternatives that allow them to participate in teaching and research activities.

*Editor’s note:* The Oweida Scholarship provides an award of $5,000 to subsidize the participation of a young rural surgeon in the annual Clinical Congress. For more information about this and other scholarships, contact the Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or visit the College’s Web site at www.facs.org.

**Dr. Siddiqui** is in private practice in Jonesville, VA. Previously, he was assistant professor of surgery, Baqai University Hospital, Karachi, Pakistan.
NTDB™ data points

Winter wonderland

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

Spring is just around the corner, but not long ago the ground was covered with snow in the midwestern and northern states. Picture the landscape dotted with green fir trees and covered with a peaceful and pure white blanket. A chill is in the air and a wintry silence abounds—a silence that is rapidly disrupted by the loud roar of motorized recreational snow craft.

Snowmobiles are gas-powered, high-performance, motorized sleds designed for traveling across snow-covered terrain. Some models are capable of traveling at speeds approaching 110 miles per hour and weigh more than 600 pounds. There are more than 1.6 million registered snowmobiles in the U.S. and over half of these are located in Michigan, Minnesota, New York, and Wisconsin. Four million snowmobilers reside in North America, and in the U.S., snowmobiling accounts for an estimated 9 billion dollars in revenue as well as more than 10,000 hospital visits annually.

In the previously mentioned states, when last call is over at the local bars, snowmobiles are the mode of transportation waiting to take home the revelers in this winter wonderland.

This behavior has the potential to transform the picturesque landscape into a winter nightmare. The mixture of alcohol, cold temperatures, high speed, and risk-taking behavior is a formula for disaster. The once soft winter blanket becomes a rock-hard reality as the snowmobiler flips and crashes. There are close to 2,000 records of snowmobile injuries contained in the National Trauma Data Bank™ Annual Report 2004. It is apparent in examining the data on these injuries that almost half of the records where testing occurred indicated the presence of alcohol (see figure, above).

Evidence is lacking demonstrating the effectiveness of injury prevention strategies for snowmobile-related injuries and fatalities. However, recommendations of the committee on injury and poison prevention of the American Academy of Pediatrics, when modified to be generally applied, imply that snowmobile-related injury could be prevented. Prevention strategies are needed in order to stop the yearly increase in snowmobile injuries and fatalities.

For more information on snowmobile injuries and their prevention, visit the Committee on Trauma’s Injury Prevention and Control Subcommittee at http://www.facs.org/trauma/snowmobile.html and http://www.facs.org/trauma/atv.html.

Throughout the year, we will highlight these data through brief reports in the Bulletin. The full NTDB report is available on the ACS Web site as a PDF file and as a PowerPoint presentation at http://www.ntdb.org. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mmeal@facs.org.