Surgical Innovation
Promoting High Standards Through Research, Education, and Philanthropy
FEATURES

Surgical innovation: “Renaissance man” endows award for surgical investigators
Diane S. Schneidman

Surgical innovation: CQI promotes high standards of surgical care through research
Cory Petty

ATLS celebrates 25th anniversary
Paul E. Collicott, MD, FACS

Legislative advocacy and political activity: How surgeons and chapters can get involved
Christian Shalgian and Jon H. Sutton

DEPARTMENTS

From my perspective
Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director

Dateline: Washington
Division of Advocacy and Health Policy

Socioeconomic tips
Medicare computer software changes
Division of Advocacy and Health Policy

On the cover: Encouraging surgical innovation through philanthropy (see page 10) and the CQI program (see page 15).
NEWS

Dr. Reiling runs for AMA Council on Medical Education

Breast implant safety Web site launched

Trauma and critical care course slated for June

Resident Research Scholarships for 2005 awarded

2006 ANZ Travelling Fellow selected

2005 Oweida Scholar named

Faculty Research Fellowships awarded by College

2006 ACS Japan Traveling Fellowship available

Highlights of the ACSPOA Board of Directors and the ACS Board of Regents meetings, February 11-12, 2005

©2005 by the American College of Surgeons, all rights reserved. Contents may not be reproduced, stored in a retrieval system, or transmitted in any form by any means without prior written permission of the publisher.

NTDB™ data points:
Click click—you’re dead?
by Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

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
Our traditional view of license renewal and recertification soon will fade into the hazy past.

Additionally, we are seeing new evidence that medical skills and knowledge often decline over time, a reality made only harsher as technology proliferates.

As a result of these findings, surgeons and other professionals are being held more accountable for their actions and the quality of care they provide. The certifying and licensing boards have stepped in and are implementing the types of requirements they believe will help to ensure that patients receive appropriate care from proven professionals.

ABMS

In response to the mounting public and government concerns, and to avert the imposition of federal regulations, the ABMS determined that all physicians should be trained in six competencies: patient care, interpersonal and communication skills, professionalism, medical knowledge, practice-based learning and improvement, and systems-based practice. To ensure that physicians would continue to sharpen these abilities, the ABMS also determined that all physicians should be trained in six competencies: patient care, interpersonal and communication skills, professionalism, medical knowledge, practice-based learning and improvement, and systems-based practice. To ensure that physicians would continue to sharpen these abilities, the ABMS also determined that all
Member boards should transition from recertification to MOC programs.

Under the traditional recertification process, surgeons’ initial certificates expired six to 10 years after being issued, depending on the issuing specialty board, and successful passage of another exam qualified them for new certification. Under the new MOC process, surgeons will maintain their original certification by periodically meeting board requirements.

The ABMS has organized the MOC process into a four-part framework, which requires that individuals offer evidence of the following: (1) professional standing; (2) lifelong learning and periodic self-assessment; (3) cognitive expertise; and (4) performance in practice.

The ABMS considers verification that a diplomate has maintained basic credentials, such as state licensure, to be evidence of professional standing. Some boards, including the American Board of Surgery (ABS), also ask that diplomates submit reference letters from their chiefs of surgery and the chairs of the credentials committees at the hospitals where they have admitting privileges.

Evidence of commitment to lifelong learning and periodic self-assessment includes verifiable use of an instrument that allows surgeons to test their own knowledge and clinical judgment, such as the College’s Surgical Education and Self-Assessment Program (SESAP). Diplomates also must accumulate a specific number of continuing medical education (CME) credits that are relevant to an individual’s practice emphasis. The boards typically require 50 Category 1 CME credits per year, varying percentages of which must be specialty-specific.

Passing a board-administered exam, one that’s similar to the traditional recertification exam, is considered evidence of cognitive expertise. Diplomates generally will need to take these tests perhaps more frequently than in the past, however.

Finally, surgeons will be expected to participate in programs that will allow them to compare their outcomes to those of other surgeons and to otherwise evaluate their ability to apply the six competencies mentioned previously in their practices. Many of the specialty boards plan to partner with their corresponding specialty societies and umbrella organizations, like the College, to develop feasible assessment methodologies.

This fourth prong of the MOC process poses problems for physicians who cease clinical practice within the scope of the specialty board or who pursue careers in administration, research, education, or public service. Hence, an ABMS task force that has been studying this issue issued a white paper on March 16 recommending that the ABMS member boards develop appropriate methods for evaluating diplomates who do not provide direct or supervised care and for physicians reentering clinical practice after a hiatus.

FSMB

Like the ABMS, the Federation of State Medical Boards has determined that its member boards need to respond to increasing public demands that licensing authorities periodically retest physicians for competence. As the first step in this effort, the FSMB established a special committee on maintenance of licensure in 2003. The following year, the organization issued a policy statement indicating that the 70 state medical boards that are members of the FSMB are responsible for guaranteeing the continuing competence of physicians seeking relicensure. As part of this new relicensure process, some state medical boards are already performing criminal background checks on physicians.

The FSMB is collaborating with the ABMS to determine how the MOC program relates to competence and licensure. The organization also is partnering with the National Board of Medical Examiners, which has a post-licensure assessment system that monitors complaints about level of competence, resumption of practice after a long hiatus, and change in practice emphasis. Additionally, the FSMB is collaborating with the Conjoint Committee on CME to evaluate current CME systems and to dialogue about medical boards’ needs to quantify learning and practice outcomes of physicians participating in CME. Later this year, the FSMB intends to gather relevant stakeholders to discuss “core” issues, such as the definition of “competence,” methods of assessing physician competence, future collaboration, and remediation of physicians identified as deficient.
The College’s role

The College offers a wide range of programs to help surgeons meet the criteria for maintenance of certification and licensure.

With respect to educational programming, the annual Clinical Congress and Spring Meeting offer an ever-expanding array of didactic and hands-on, skills-oriented courses for CME credits. The broadening scope of skills-oriented postgraduate courses are specially designed to address: contemporary topics in surgery; knowledge and skills related to the core competencies, patient safety, and new procedures; and nonclinical topics related to the practice of surgery.

To provide surgeons with more opportunities to participate in CME activities without having to travel away from their practices, we have produced some excellent Internet-based education programs. These Web-based educational vehicles include Web casts of sessions from the 2002, 2003, and 2004 Clinical Congresses, as well as the 2004 and 2005 Spring Meetings. Several of our electronic and other learning programs are aimed at promoting the core competencies that surgeons will need to continually enhance, including professionalism, leadership, and communication skills.

Additionally, we regularly revise SESAP to meet surgeons’ changing self-assessment demands. The fact that the ABS has selected this program as the vehicle of choice as evidence of commitment to self-assessment is testimony to its quality and ongoing utility.

We are becoming increasingly active in efforts to measure outcomes and performance in practice. We anticipate that the ACS National Surgical Quality Improvement Program will prove to be an invaluable instrument for analyzing outcomes in a risk-adjusted way and that the data gathered through it will be useful in the surgical decision-making process. Furthermore, we are upgrading the National Cancer Database and the National Trauma Data Bank™ to improve the relevance and application of the data collected through these repositories. Additionally, we are developing programs centered on evidence-based surgery to accumulate, assimilate, and communicate scientifically sound research of effective and safe treatments. Personal digital assistant and Internet-based programs to help surgeons systematically monitor their outcomes and compare these data with national and regional benchmarks are in production.

As I mentioned in my October 2004 Bulletin column, we anticipate that the College’s Web portal, currently under construction, will eventually support e-learning programs, serve as a repository for surgeons who want to record and track cases, and allow surgeons to share information with the public about their practices and outcomes. We can foresee a time when this device will serve as a central meeting point for surgeons who want to share practice information. We further anticipate that surgeons will be able to enter all the necessary information for MOC in a running personal diary of their activities. For example, case logs, SESAP experiences, and so on, will be entered into this electronic record in “real time” and can then be turned over to the boards when necessary.

Without question, we are entering an era of greater accountability, and the ABMS’s and FSMB’s efforts to strengthen the recertification and relicensure processes are prime examples of what is occurring in this area. Professional organizations such as the American College of Surgeons owe it to our members and to our patients to ensure that surgeons have the resources they need to comply with the maintenance of certification and licensure requirements emanating from the ABMS and FSMB.

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

Thomas R. Russell, MD, FACS
## CME ONLINE

### Web casts of select sessions

The Division of Education of the American College of Surgeons is making sessions from Clinical Congress 2004 available online at:

[www.acs-resource.org](http://www.acs-resource.org)

### Clinical Congress 2004

<table>
<thead>
<tr>
<th>Session</th>
<th>Title</th>
<th>Moderator/Co-Moderators</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR04</td>
<td>Locally Advanced Rectal Cancer: Strategies for Success</td>
<td>Robert D. Fry, MD, FACS, Philadelphia, PA</td>
</tr>
<tr>
<td>GS09</td>
<td>Practice-Based Learning and Improvement: What Every Surgeon Needs to Know</td>
<td>Ajit K. Sachdeva, MD, FACS, FRCSC, Chicago IL</td>
</tr>
<tr>
<td>GS16</td>
<td>Contemporary Management of Benign Breast Diseases</td>
<td>Wiley W. Souba, MD, FACS, Hershey, PA</td>
</tr>
<tr>
<td>GS23</td>
<td>Barrett’s Esophagus/Nissen Fundoplication and Its Role in the Prevention of Cancer</td>
<td>Carlos A. Pellegrini, MD, FACS, Seattle, WA</td>
</tr>
<tr>
<td>GS30</td>
<td>Management of Malignant/Benign Biliary Strictures</td>
<td>Michael G. Sarr, MD, FACS, Rochester, MN</td>
</tr>
<tr>
<td>GS32</td>
<td>Safety in the Operating Room: Lessons Learned from Aviation and Other Systems</td>
<td>Julie Ann Freischlag, MD, FACS, Baltimore, MD</td>
</tr>
<tr>
<td>GS40</td>
<td>Cutting-Edge Trauma Surgery: What's Proven, What's Not</td>
<td>George C. Velmahos, MD, PhD, FACS, Los Angeles, CA</td>
</tr>
<tr>
<td>GS51</td>
<td>Breast Surgery: Has the Knife Lost Its Edge?</td>
<td>Edgar D. Staren, MD, PhD, FACS, Toledo, OH</td>
</tr>
<tr>
<td>PL03</td>
<td>Management of the BRCA-Positive Patient</td>
<td>S. Eva Singletary, MD, FACS, Houston, TX</td>
</tr>
</tbody>
</table>

### Spring Meeting 2004

<table>
<thead>
<tr>
<th>Session</th>
<th>Title</th>
<th>Moderator/Co-Moderators</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS01</td>
<td>Assembly for Surgeons</td>
<td>Shukri F. Khuri, MD, FACS</td>
</tr>
<tr>
<td>GS04</td>
<td>Genetics And Cancer: Implications For Surgeons</td>
<td>Murray F. Brennan, MD, FACS</td>
</tr>
<tr>
<td>GS05</td>
<td>Excelsior Surgical Society/Edward D. Churchill Lecture</td>
<td>Andrew L. Warshaw, MD, FACS</td>
</tr>
</tbody>
</table>

Additional sessions from the 2003 and 2002 Clinical Congresses, and the 2003 Spring Meeting, are also available at [www.asc-resource.org](http://www.asc-resource.org) for details.

For more information, contact Dawn Pagels, MBA, at dpagels@facs.org.

---

*Try the online CME program:  
Take 2002: GS10, Patient Safety, and 2003: GS08, GS21, and GS37 FREE OF CHARGE*  

- Each session is offered separately.  
- Printable written course transcripts.  
- Audio of sessions.  
- Video of introduction of session.  
- Post-test and evaluation.  
- Printable CME certificate upon successful completion.

---
On March 1, the Medicare Payment Advisory Commission (MedPAC) issued its 2005 annual report to Congress containing recommendations on Medicare payment policies pertaining to physicians, hospitals, skilled nursing facilities, and other providers. With respect to physician payments, the report contains the following recommendations:

- Medicare reimbursement to physicians should increase by 2.7 percent in 2006, as opposed to the 5.2 percent payment reduction that the sustainable growth rate formula is expected to yield next year.
- Several changes should be made in policies pertaining to diagnostic imaging, including improved coding edits to detect unbundled services and reduced technical component payments for multiple imaging services provided in a single patient encounter. It is also suggested that the Secretary of the U.S. Department of Health and Human Services (HHS) set standards for physicians and other providers who bill Medicare for interpreting or performing diagnostic imaging studies.
- Congress should establish a quality incentive payment policy for physicians in Medicare. This process could start with quality-enhancing functions and outcomes associated with information technology use and claims-based, condition-specific process measures.


MedPAC issued a second report in March on physician-owned specialty hospitals, which recommends that Congress extend the current 18-month moratorium on development of these facilities until January 1, 2007. In the meantime, the commission recommends that the Secretary of HHS refine the current hospital diagnosis-related groups (DRGs) to fully capture differences in severity of illness among patients so that payments can be better balanced between specialty and full-service community hospitals. MedPAC also recommends that the Secretary be authorized to permit gain-sharing arrangements between physicians and hospitals.

Congress first acknowledged the controversy over specialty hospitals when it included a provision in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (commonly referred to as the MMA) establishing the 18-month moratorium only on the development of physician-owned facilities, as requested by the hospital industry. (Interestingly, no bans on specialty hospitals owned by other investors have ever been proposed or endorsed.)

The Centers for Medicare & Medicaid Services (CMS) has announced plans to adjust Medicare payments to hospitals in a manner similar to the one recommended by MedPAC. Although the exact changes CMS will propose were unknown at press time, they will affect reimbursement for both specialty and full-service hospitals. It appears unlikely that CMS can complete the work in time to implement changes by October 1, 2005—the deadline for implementing next year’s hospital
payment policies. However, the agency is scheduled to release a report on the issue shortly.

On March 8, the Senate Committee on Finance and the House Ways and Means Subcommittee on Health held hearings on this issue. The College submitted a written statement for the hearing record supporting CMS’s efforts to refine the DRG system to provide more equitable reimbursement for procedures that are performed in hospital settings. That statement is posted on the College’s Web site, at http://www.facs.org/ahp/testimony/specialtyhospitals.html.

ACS testifies on medical liability reform

Congress began its 2005 session by holding hearings on medical liability reform. On February 17, Chad Rubin, MD, FACS, from Columbia, SC, testified on behalf of the College before the House Small Business Committee. His testimony was presented at a hearing on Medical Liability Reform: Stopping the Skyrocketing Costs of Health Care. Dr. Rubin described how the rising cost of medical liability insurance is dramatically affecting his group practice in South Carolina. He also told the committee how the crisis pushed his mother’s physicians out of southern Illinois, forcing her to travel across state lines for her medical care. Congress will be considering medical liability reform legislation in the coming months. Dr. Rubin’s testimony can be found on the College’s Web site at http://www.facs.org/ahp/testimony/medical liability.html.

ACS publishes patient safety manual

The American College of Surgeons has announced publication of its new manual Surgical Patient Safety: Essential Information for Surgeons in Today’s Environment. Edited by Barry M. Manuel, MD, FACS, and Paul F. Nora, MD, FACS, this 200-page publication is intended to provide guidance and leadership in evolving areas of patient safety. Chapters in the book describe a variety of practical resources and provide a broad overview of key issues. For example, the first two chapters address the scientific basis of surgical patient safety, specifically human factors and systems analyses. Other chapters evaluate the processes affecting surgical patient safety, such as decision support, electronic prescribing, and error detection, analysis, and reporting. Legal challenges for surgeon participation in patient safety activities are reviewed.

Strategies for preventing wrong-site surgery, safe implementation of blood and blood components, and patient safety in trauma care are addressed, as are broader error prevention methods, including the use of surgical simulation, educational interventions, and quality improvement initiatives.

Individual copies of this publication are available to members of the College for $20. The price for nonmembers is $25. The publication order number is 05PS-0001. Orders can be placed online through the College’s Publications and Services Catalog (Patient Safety and Professional Liability section) at http://www.facs.org/commerce/2004/catsplash.html.
"Renaissance man" endows award for surgical investigators

by Diane S. Schneidman, Senior Editor
Beginning this year, the College will offer two awards that are endowed by Julius H. Jacobson II, MD, FACS, and his wife Joan. They are the Jacobson Innovation Award, which has been presented annually since 1994, and the newly established Joan L. and Julius H. Jacobson II Promising Investigator Award, which will be given for the first time this year. The two honors rightfully bear the Jacobson name not merely because the couple provides the funding for them, but because they aptly describe this surgeon’s legacy as well.

The legacy

Dr. Jacobson says his greatest contribution to surgery was introducing the microscope to the general surgery operating room. Indeed, he is widely renowned as the “father” of microsurgery, the technique that now accounts for approximately one-half of all neurosurgery procedures performed in the U.S. and that ultimately enabled surgeons to perform coronary artery bypass, limb reimplantation, and many other procedures.

According to Dr. Jacobson, the concept of using the microscope during operations came to him in one of those “aha!” moments that inspire many creative minds. In 1960, Dr. Jacobson had newly arrived as associate professor and director of surgical research at the University of Vermont, Burlington. “The teaching of the time was that you could not reconstruct blood vessels smaller than 7 mm in diameter,” Dr. Jacobson said. Meanwhile, pharmacologists at the center were studying the effects of denervating the carotid artery on the action of drugs. They found that they could not reliably denervate the small carotids on the experimental animals and asked for help.

“Thus, my very first project was to denervate the carotid artery in a dog. It became apparent that the only way to be certain of complete denervation was to divide the vessel and rejoin it,” he said. Dr. Jacobson realized that one of the failures of operating on arteries so small in size was that “the eye could not see to tell the hand what to do.”

It soon became apparent that a two-person surgical microscope was needed so that both the surgeon and his or her assistant would have the same view of the operation in process. This diploscope (the first of which is now in the Smithsonian Institution in Washington, DC) was developed with the Zeiss Company, along with a cadre of miniaturized instruments and suture materials. These instruments and techniques were subsequently applied at the Cleveland (OH) Clinic, where Donald Effler, MD, FACS, with the assistance of University of Vermont laboratory fellow Ernesto Suarez, MD, “put coronary artery bypass on the world’s surgical map,” Dr. Jacobson said.

Twists of fate

Dr. Jacobson attributes his epiphany to bring the microscope into the OR to the year he spent in the lab “all day, every day” at the University of Pennsylvania, Philadelphia, as a surgical investigator, using a microscope to research cell physiology, an
experience that was both the product and progenitor of chance. He had completed high school by the age of 15. He then went on to complete three years of undergraduate study at the University of Toledo, OH. At age 17 he enlisted in the U.S. Navy, where he served as pharmacist mate for a year. Just before he was scheduled to ship out with the fleet marines, the U.S. dropped the atom bomb and ended World War II. “I felt that my life was saved that day,” Dr. Jacobson said.

Upon his return to civilian life, Dr. Jacobson applied to 23 medical schools and was rejected by each one, largely because so many veterans were applying. He finished up his undergraduate studies at the University of Toledo. “One of my professors had a great deal of faith in me and sent me to a friend at the University of Pennsylvania who had written the definitive book on cell physiology to begin work on a master’s degree,” Dr. Jacobson said. He believes to this day that had he been accepted to medical school on the first attempt and not spent the year in the research lab, microvascular surgery would have arisen elsewhere.

With encouragement from his mentor at the University of Pennsylvania, Dr. Jacobson reapplied to the medical schools and was accepted at each one. He chose to go to Johns Hopkins, Baltimore, MD, where he received his medical degree in 1952. He then spent seven years as a resident at Columbia-Presbyterian Hospital, in New York, NY. Within two months of starting his practice in general and thoracic surgery at that institution, he “got the offer you can’t refuse,” Dr. Jacobson said. He was asked to accept the position at the University of Vermont where he blazed the trail for microsurgery.

The award

Dr. Jacobson, Distinguished Service Professor of Surgery and director emeritus of vascular surgery at the Mount Sinai Medical Center in New York, NY, believes that many surgeons today are making equally significant discoveries. He and his wife have endowed the newest ACS award carrying the Jacobson name to give young surgeons who are conducting research the same sort of encouragement that Dr. Jacobson received. They are confident that these promising surgical investigators will advance the art and science of surgery.

The $30,000 award will be presented at least once every two years, with Dr. Jacobson providing all of the funding. The Jacobson Promising Investigator Award is administered by the College’s Surgical Research Committee, which is currently reviewing nominations for the potential 2005 recipient. Candidates for the award must demonstrate that their research shows the promise of leading to a significant contribution to the practice of surgery and patient safety. Nominations for the award are accepted at any time. For more information about the criteria and selection process for the award, go to www.facs.org/cqi/src/jacobson.html.

Philanthropist

The Promising Investigator Award is just one of many educational activities and honors that Dr. Jacobson and his wife Joan have funded. By donating so much of his financial resources to surgery, Dr. Jacobson said he hopes he is leading by example. “We surgeons, all of us, should feel obliged and privileged to give back,” he added.

The other award that the ACS presents through his generosity, the Jacobson Innovation Award of the American College of Surgeons, honors living surgeons or surgical teams who have developed a novel surgical technique.

The College is not the only entity to benefit from the magnanimity of Dr. and Mrs. Jacobson. They have provided funding for professorships in vascular surgery at Johns Hopkins University School of Medicine, Mount Sinai School of Medicine, and the Hadassah-Hebrew University School of Medicine, Jerusalem, Israel—all institutions where Dr. Jacobson has spent time. These endowments call for vascular surgeons at each institution to participate in monthly shared “rounds” over the Internet. During each session, a surgeon describes a challenging case, and the participants discuss alternative treatment methods. Dr. Jacobson said he started this program to bring the medical centers together and to foster the sort of collaboration that will advance surgical outcomes, research, and education.

The Jacobsons also have endowed a professorship in molecular biology at the University of Toledo and a chair at the Harvard School of Public Health, Cambridge, MA. The latter is currently held by the dean and is intended to promote leadership, teaching, and research for the prevention of disease and
protection of health with an emphasis on these needs in underdeveloped countries.

Furthermore, they have established a program supporting an annual conference on research initiatives in vascular disease sponsored by the Lifeline Foundation of the Society of Vascular Surgery.

Additionally, Mrs. Jacobson has established The Joan Leiman Jacobson Fund for Learning, Writing, and Teaching at her alma mater of Smith College. Founded because of her concern for the quality of expository writing, the program trains both Smith students and teachers throughout the U.S. She believes that the program will also benefit surgery. “If our brilliant investigators, surgeons, physicians, and medical writers can present papers that say what they mean, their advances will be more readily understood and take effect more quickly,” she said.

Inventor

Besides being a dedicated surgical educator and philanthropist, Dr. Jacobson continues to have his fair share of “aha!” moments that lead to the development of new products and devices. Currently, he is working on a new principle in shoe design for people with diabetes and other conditions that affect sensation in their feet. The shoe will contain “what amounts to a waterbed,” which will help to distribute the weight in the foot and eliminate pressure points resulting in gangrene and amputation, Dr. Jacobson said.

He also is working with a computer company to develop a system that will allow physicians to monitor patients in the intensive care unit (ICU) when they are away from the hospital. An audiovisual unit would be set up next to every bed in the ICU. If a nurse noticed that a patient was experiencing difficulties, he or she could contact the physician, who would be able to check the patient’s vital signs and medications and actually see the patient through a monitor, thereby avoiding the uncertainty of making mad dashes to the hospital in the middle of the night.

Another invention that Dr. Jacobson is working on is aimed at helping athletes to avoid heat stroke. The athletes would swallow a “capsule” that telemeters out the core body temperature, which is monitored by a central computer on the Internet. This computer would then signal the athletic field when a player is approaching a dangerous temperature level.

His inspirations

Dr. Jacobson found his early inspiration in his paternal grandparents. “I was named after my grandfather, who was a surgeon. I never met him. He died before I was born, but I had heard a lot about him and his work,” Dr. Jacobson said. His grandmother was the first female graduate of the McGill University Medical School, and she went on to become a prominent member of the medical community in Edinburgh, Scotland. “I come from a great medical family,” he noted.
Dr. Jacobson said he continues to find sources of inspiration, mostly in his patients. “If I could give one piece of advice to a young surgeon, it would be to be a humanist. Become friends with your patients. We in medicine have so many opportunities to become friends with really interesting people,” he said.

Music lover
When he’s not busy sponsoring a new program or coming up with his latest invention, Dr. Jacobson can be found attending performances of classical music. Recently, he decided to share his love of classical music with those individuals who are not particularly familiar with the art form.


Perhaps not surprisingly, Dr. Jacobson not only shares biographical information about the composers and his beliefs about why certain compositions are noteworthy, but some medical stories as well. In fact, in the introduction, Dr. Jacobson explains in layperson’s terms how hearing can be damaged by listening to overamplified music, resulting in Boilermakers’ disease.

Dr. Jacobson was stimulated to publish the book after a conversation with a woman who had indicated an interest in learning about classical music, and he was unable to find an appropriate book for her to explore. Additionally, “a patient of mine who is a musicologist and I went to the symphony one night, and they performed a new piece of music. As we were leaving, my friend ran into another musicologist,” Dr. Jacobson said. The two learned men discussed the composition and, out of politeness, asked Dr. Jacobson for his opinion. When he offered a dissenting opinion, his friend (a former patient) suggested that he write a book offering his perspective on music—“that is to say, the view of someone who knows nothing about music,” Dr. Jacobson said jokingly.

In selecting which artists to include in the book, “I just picked composers that I like,” Dr. Jacobson said.
When the American College of Surgeons’ strategic planning process was initiated in 2000, one end result was the reorganization of the College into four divisions: Advocacy and Health Policy, Education, Member Services, and Research and Optimal Patient Care. This article looks at some of the work carried out through the Division of Research and Optimal Patient Care, specifically at its program focused on evidence-based surgery.

In 2001, the College established the Office of Evidence-Based Surgery within the Division of Research and Optimal Patient Care to help surgeons apply the current verifiable research to surgical practice. Last year, the name of this section changed to Continuous Quality Improvement (CQI). The CQI program promotes the highest standards of surgical care through the evaluation of surgical outcomes in clinical practice. Charged with providing assistance to health services, clinical, and laboratory research, CQI promotes the undertaking of systematic reviews, clinical trials, and outcome studies. It also provides practicing surgeons with easy access to scientifically sound evidence available to support best practices.

The following information is drawn from an interview that the author conducted with R. Scott Jones, MD, FACS, Director, Division of Research and Optimal Patient Care, and Karen Richards, Administrative Director, Continuous Quality Improvement.

What is the focus of Continuous Quality Improvement?

The focus for CQI and for the College’s entire Division of Research and Optimal Patient Care is continuous improvement of the quality of surgical care. As such, CQI works toward creating a foundation for: applying of the best scientific evidence to the clinical practice of surgery; documenting outcomes with unquestionable data; identifying new knowledge and techniques; and assisting the conduction of careful clinical trials to establish the safety and efficiency of new techniques before they are used in patient care.

How does CQI’s work fit into the College’s efforts to further surgical patient care?

The College’s mission entails improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment. CQI’s work is perfectly aligned with that objective. By accumulating, assimilating, and communicating best evidence and practices as they relate to surgery, CQI is working to meet the goal of providing optimal patient care.

How does CQI’s work benefit surgeons?

Overall, CQI’s efforts will provide support to research efforts that will arm surgeons with information they need to give the best patient care pos-
sible. More specifically, there has been a lack of surgeon access to the best evidence. One of CQI’s goals is to increase surgeons’ ability to get the information they need with the establishment and maintenance of a repository—assembled through literature searches and data from ongoing research—for best evidence. Additionally, there has been a lack of solid clinical trials on conditions that require surgical intervention. For various reasons, there are not a lot of surgeons who are able to run high-quality, well-designed, well-conducted prospective randomized clinical trials. Additionally, not all surgical conditions call for such clinical trials. Part of CQI’s work will be to assist with the running of trials and to identify the surgical conditions that need to be studied in such trials.

**Does CQI collaborate with other College divisions?**

Yes. We collaborate with the Division of Education to provide educational programs and with the Division of Advocacy and Health Policy to promote public policy initiatives in clinical research. CQI also forms partnerships with outside groups and organizations involved in evaluating surgical outcomes.

**What other societies or outside groups will CQI be collaborating with on various activities?**

CQI has been and will continue to collaborate with a wide range of medical societies and other groups to improve the quality of surgical care. Groups we are currently collaborating with include: the Centers for Medicare & Medicaid Services, the Joint Commission on Accreditation of Healthcare Organizations, the Physician Consortium group of the American Medical Association, the University Health System Consortium, the Centers for Disease Control, and the Society of Thoracic Surgeons—to name just a few.

**What programs are being orchestrated by CQI?**

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) is a major initiative that CQI has implemented. ACS NSQIP is a national, validated, outcomes-based, risk-adjusted program created to measure and enhance surgical care. Believing that the ACS NSQIP is one of the best ways to benchmark and improve surgical care, the ultimate goal of the program is to reduce surgical morbidity and mortality.

The original National Surgical Quality Improvement Program was initiated 11 years ago by the Veterans Health Administration (VHA) to measure the incidence of operative morbidity and mortality in VA hospitals. After the program was implemented in 128 VA hospitals, surgical mortality decreased by 27 percent and morbidity decreased 45 percent. In 2001, a grant from the Agency for Healthcare Research and Quality was awarded to the VA and the American College of Surgeons for the collaborative implementation of the NSQIP in private sector hospitals. After gathering more than three years worth of study data, nearly 100,000 surgical cases have been collected from 18 private hospitals. The results of the study have shown that the program has been successfully implemented in these hospitals and that the NSQIP methodology works well in the private sector.

In response to the program’s success in the VA and the private sector, the College developed a busi-
ness plan to offer the program to all interested and qualified hospitals, beginning with the general and vascular surgery departments. All private sector hospitals that meet the minimum participation requirements, complete a hospital agreement, and pay an annual fee are now being offered the ACS NSQIP.

Furthermore, CQI has several grant-funded clinical trials and research projects, including projects dealing with inguinal hernia management, palliative care, patient safety, and working conditions of surgery residents.

Is CQI involved with the American College of Surgeons Oncology Group (ACOSOG)?

CQI was actively involved in the grant renewal application process that ACOSOG recently completed. CQI and other areas of the College will continue to provide resources and support to ACOSOG in order to further its mission of conducting high-quality surgical oncological clinical trials.

Why was the name of this area changed from the Office of Evidence-Based Surgery?

The new name, Continuous Quality Improvement, better represents the activities our area is currently undertaking to improve the quality of surgical care in this country. While the new name includes the idea of evidence-based surgery, it’s much broader and encompasses other areas, such as the documentation of outcomes through our databases, well-designed and carefully implemented clinical trials, and the identification of new knowledge and techniques.

What are the long-range plans for CQI?

While medical research continues to aggressively take place in the U.S.—much of which is supported by the National Institutes of Health (NIH)—physicians practicing in medical disciplines other than surgery lead the way in obtaining funding for research, in participating in NIH peer-review processes, and overall research productivity. The surgical profession should work to correct that deficiency in the interest of the public.

The work of CQI and the Division of Research and Optimal Patient Care as a whole, can play an important role in closing the research gap. As such, CQI’s plans and goals for the next five years entail becoming a more comprehensive unit that houses: an Office of Best Evidence to accumulate, assimilate, and communicate best evidence; an Office of Outcomes that steers the ACS NSQIP and collaborates with both the NCDB and NTDB; an Office of Surgical Innovation that will herald new technology, techniques, knowledge, and programs; and an Office of Clinical Trials that will develop an infrastructure for research grant acquisition and management, as well as develop and sustain scholarly inquiry and research proposal writing.

Additionally, a Surgical Research Promotion Unit will be established. This unit will create an avenue for informing the surgical profession of today’s research and the role of that research in promoting the quality of tomorrow’s care. Furthermore, the unit will have a role in setting standards, establishing curricula, providing organization, structure, and general oversight for research, education, and training, enhancing career development in research, defining and maintaining an optimal surgical research workforce, and establishing better communications with leaders of NIH.

As a great deal of evidence shows, changes are needed in the quality and safety of the health care provided in this country. For myriad reasons, the quality of health care falls short, perhaps in part because of the massive stream of new knowledge and new technology that is available to health care workers. Furthermore, there is a lack of uniformity in the systems and standards available for translating the best scientific evidence into tangible methods of delivering patient care and a failure to systematically observe and measure the effectiveness of disease prevention and treatment efforts. Through CQI, the American College of Surgeons will be one step closer to addressing the major issues of safe and effective surgical patient care.
Since its introduction 25 years ago, the Advanced Trauma Life Support® (ATLS®) program has been the most successful educational course that the American College of Surgeons offers, and it has served as the international standard for the initial evaluation and management of the trauma patient.

**History**

At the invitation of C.T. Thompson, MD, FACS, then-Chair of the ACS Committee on Trauma (ACSCOT), I agreed to introduce the concept to the committee at their 1979 annual meeting in Houston, TX. The ACSCOT enthusiastically endorsed the concept and called upon its Region Chiefs to meet in Lincoln, NE, for an introduction to the course.

It was a cold, snowy January in 1980 that the College initiated the promulgation of ATLS as an educational program to teach physicians about the initial care of the injured patient (See Figure 1, page 19).

This course was not the first one ever presented. The true pilot course was given to a group of family physicians in the small southeastern Nebraska town of Auburn in 1978. This course was presented at the request of several Lincoln, NE, physicians and nurses following the 1976 crash of a private airplane piloted by J.K. Styner, MD. Dr. Styner’s wife was killed and his children were injured in the tragedy. This incident, which also occurred in southeast Nebraska, was the catalyst for developing the course we know today as ATLS.

It was a quirk of fate and a set of unusual circumstances that caused Lincoln to be the test site for ATLS. The community had previously established an area health educational consortium called the Lincoln Medical Education Foun-
of Medicine, through Brent E. Krantz, MD, FACS, and the ACS Nebraska Committee on Trauma, through Joel T. Johnson, MD, FACS, became involved. Because all of the people and institutions involved were striving to improve the care of the injured patient, no one claimed “ownership” of the project, and, as a result, the course was further refined.

Expansion

Initially, everyone involved believed that this would be a “Nebraska course.” However, the then Immediate Past-Chair of ACSCOT, R. W. Gillespie, MD, FACS, and the president of the American College of Emergency Physicians, Harris Graves, MD, FACEP, were both Nebraskans and convinced the group to think more broadly. Another course was then presented to representatives of both groups and the then
ACSCOT chair suggested that because trauma is a surgical disease, this course should be run under the auspices of the College. This decision was a bold departure from ACS tradition because, in the past, its educational programs had been intended exclusively for surgeons.

In 1980, the promulgation of ATLS in the U.S. began with regional courses in Denver, CO, Dallas, TX, San Diego, CA, Washington, DC, Philadelphia, PA, Newark, NJ, Opelika, AL, and Milwaukee, WI. An administrative plan was developed and additional courses in the U.S. ACSCOT regions occurred.

Canada introduced ATLS in 1981, with courses in Toronto and Vancouver and subsequent promulgation. By this time, a committee within the ACSCOT was formed and charged with oversight, refinement, and further advancement of the course. In the span of two years, ATLS rapidly was accepted and became the standard of the initial evaluation and management of the trauma patient in the U.S. and Canada. For the next six years, ACSCOT members made a concerted effort to ensure the course’s availability to all physicians who participated in the care of the injured patient. ATLS gave meaning and purpose to the regional and state structure of the ACSCOT.

In 1986, ATLS was introduced to the international community, primarily in Latin America. The first course outside of the American continents was presented at the...
Royal College of Surgeons of England in London (see Figure 2, page 20).

The Royal Australasian College of Surgeons in Melbourne hosted an ATLS course two weeks later (See Figure 3, page 20).

Between 1986 and 1992, a total of 13 countries, including Israel, Ireland, Singapore, Saudi Arabia, and South Africa introduced ATLS. The course is now taught in 43 countries; 25,637 courses have been conducted in which 600,000 physicians, 7,500 physician extenders, and 24,000 auditors have been trained.

Ongoing refinement

Since the introduction of the course, the manual has been revised on multiple occasions with the seventh edition introduced this year to celebrate the 25th anniversary. Today the manual’s content is based on input from all countries that teach the program. The manual has been translated into several different languages, and the testing methodologies have been standardized. All additions and deletions to the manual must be evidence-based. Representatives of each country teaching the ATLS principles meet annually at the Clinical Congress to share ideas and experiences. Indeed, ATLS has become the international standard for the initial evaluation and management of the trauma patient with multiple injuries.

Several ancillary “educational products” have been produced in conjunction with ATLS: Trauma Evaluation and Management for medical students; Pre-Hospital Advanced Trauma Life Support; the Advanced Trauma Course for Nurses; and several other courses using the precepts of ATLS. The number of “copycat” courses today points to the success of ATLS.

The course continues with almost an exclusive student/teacher interaction approach to the learning process and the digitization of the slides and roentgenograms. Students and instructors must refresh every four years and physicians working in ACS-verified trauma centers must be ATLS qualified.

Commitment

The resounding success of ATLS cannot be ascribed to one person or organization but, rather, to the unrelenting commitment of those individuals who care for the injured patient. The single identifiable link in this entire process is Ms. Irvene K. Hughes, RN, the coordinator and administrator of the program.

The ACS thanks the entire volunteer faculty for their unceasing dedication to this program. Countless lives have been and will continue to be saved because of the ATLS principles and the dedicated individuals who develop them.

Bibliography


Dr. Collicott

Director of the ACS Division of Member Services and one of the founders of ATLS.
LEGISLATIVE ADVOCACY
AND POLITICAL ACTIVITY:

How surgeons and chapters can get involved

by Christian Shalgian,
Manager of Legislative Affairs,

and Jon H. Sutton,
Manager of State Affairs,
Division of Advocacy and Health Policy

Over the course of the past few years, the American College of Surgeons (ACS) has significantly increased its legislative advocacy activities at the federal and state levels. Surgeons and ACS chapters have been playing a more active role in encouraging Congress to address important legislative issues, such as medical liability reform, physician reimbursement, trauma system funding and development, patient safety, and so on. Similar issues have come before state legislatures as well, with many surgeons contacting their state legislators through the Surgery State Legislative Action Center, personal telephone calls, and participation in events at the state capital.
A bedrock of American democracy is the right of individual citizens to interact with their elected officials and to come together and form organizations, such as the College, to represent their collective concerns. An example of how this system works can be found in efforts to achieve medical liability reform, through which the views of various medical specialists are represented by their respective associations in addition to individual letters and telephone calls to legislators.

To avert potential abuses, Congress and state legislatures have enacted restrictions on lobbying activity by organizations and individuals. The federal tax code and election laws affect the types of political advocacy in which not-for-profit organizations may engage. Sometimes determining what is and is not permissible under these regulations can be a confusing task, and chapters and surgeons have periodically asked for guidance on these matters. This article is intended to clarify the lobbying activities that can be carried out by both chapters and individual surgeons. A considerable amount of the material is contained in the American College of Surgeons’ Chapter Guidebook.

Lobbying and political action

The Internal Revenue Service (IRS) does not clearly define the term, but generally, the agency considers lobbying to be any contact with legislators and their staff members (either by phone, in writing, or in person) to talk about pending or proposed legislation and regulations. The IRS’s broad definition of lobbying also has been extended to newsletters and other types of membership communications that contain information about current or pending legislation or regulations, especially if members are encouraged to contact their elected officials.

Permissible chapter activities

ACS chapters generally are categorized as either 501(c)(3) or 501(c)(6) organizations under the tax code. Both are tax-exempt, not-for-profit entities, but 501(c)(3) groups are more restricted because their primary focus is supposed to be education. Nonetheless, these organizations lobby in support of or in opposition to federal and state legislation. The dollar amount of lobbying expenditures that 501(c)(3) organizations may spend varies and is limited to a percentage of their total budgets. Most tax advisors agree that lobbying expenditures are insubstantial if they are less than 5 percent of the 501(c)(3) organization’s budget. Alternatively, the chapter may make a special election under 501(h) of the U.S. Tax Code to spend an amount based on a sliding scale up to 20 percent of its total budget on lobbying. The maximum percentage, regardless of the size of a 501(c)(3) organization’s budget, is $1 million.

Most of the College’s U.S. chapters are 501(c)(6) organizations, and the rules and regulations governing their lobbying activities are more lenient than those for 501(c)(3) organizations. For example, 501(c)(6) tax-exempt organizations may spend an unlimited amount of their money on lobbying. In other words, a chapter with this tax-exempt status could spend as much as 100 percent of its total budget on lobbying activities, although it is highly unlikely that a chapter would devote its entire budget to political action.

Chapter involvement

Chapters that are 501(c)(3) organizations are prohibited from undertaking activities on behalf of or in opposition to any candidate for public office, whether federal, state, or local. This prohibition includes amounts paid to candidates for speeches, travel, polls, publicity, or any other activity that serves to promote the individual’s candidacy. Violations may result in loss of tax-exempt status and tax penalties.

In contrast, a 501(c)(6) organization may engage in some legal political activity, although lobbying cannot be its primary function. Any direct political expenditures such an organization makes are subject to a special tax. More importantly, federal election law prohibits all corporations, including incorporated associations, from making campaign contributions to candidates for federal office. According to the Federal Election Commission (FEC), contributions include direct and indirect payments or gifts of money, services, or anything of value.

501(c)(6) organizations can sidestep many of these prohibitions by forming a separate political action committee (PAC) to finance advocacy activities, including contributions to candidates.
Segregated funds must file periodic reports, maintain books and records, and ensure that the fund receives and makes only legal contributions.

Even if no separate PAC fund is created, certain political activities are permitted. More specifically, a 501(c)(6) organization may communicate with its members about any matter, including a partisan one. Additionally, 501(c)(6) organizations may encourage their members to register, vote, or otherwise participate in the political process by making personal campaign contributions to the candidates of their choice or volunteering for campaign work. These organizations may also solicit their members on behalf of an individual candidate. For example, the executive director or officer could ask an individual member of the 501(c)(6) organization to make a personal contribution to a candidate, attend a political fund-raising event hosted by others, or individually host such an event. However, a 501(c)(6) organization cannot buy a table with its own treasury funds at a federal fund-raising event, although its members could individually purchase tickets.

Furthermore, 501(c)(6) organizations are prohibited from facilitating political contributions by their members (for example, they may provide the address of a candidate’s campaign office, but they cannot provide an envelope addressed to the campaign). In addition, if the costs of partisan communications on behalf of an individual candidate reach $2,000 for any single election, the association must file a report with the FEC.

Although 501(c)(6) organizations may encourage political involvement by the general public, any information they disseminate must be nonpartisan in nature. In other words, such information may not indicate any political affiliation or favor any specific candidates. The FEC provides relatively detailed guidance about the characteristics of nonpartisan communications, including voter guides and congressional voting records. 501(c)(6) organizations may invite a candidate, a candidate’s representative, or party representative to address its members about a campaign. During such an event, the candidate or representative may even solicit contributions to a campaign, and the organization’s leaders may encourage such contributions. Such an event could be viewed as a political fund-raiser, but attendance must be carefully restricted to the organization’s members and executives (in FEC parlance, it’s a restricted class and, as such, cannot be open to the general public). A 501(c)(6) organization may also issue a press release to its usual media contacts endorsing particular candidates.

ACS chapters with 501(c)(6) status may use congressional elections as an opportunity for meeting candidates and their campaign staff and educating them about issues of concern to their members.

**Contributions from individuals**

Under federal election law, an individual may contribute up to $2,100 to any one candidate per election (primary, general, or special). In the aggregate, an individual’s political contributions, including those made to PACs, are limited to $101,400 biannually. An individual may offer the use of his or her home for candidate and political party-related activities. The cost of related invitations, food, and beverages voluntarily provided by the individual host are considered in-kind political contributions and are included in their annual giving limits.

**State lobbying activities**

State election laws also restrict the amount of money an individual surgeon state-level PAC may contribute to a state or local campaign. Because of the variation from state to state, it is important to know a specific state’s spending limit before making a contribution. The best way to acquire this information would be to call a candidate’s office and ask the campaign manager about the legal limits. This individual, no doubt, would be more than happy to provide this information and help to coordinate any fund-raising activity.

**Collective action for liability reform**

Over the past few years, surgeons have become very involved in lobbying and political action activities relating to medical liability reform. Whether it be for federal or state legislation, surgeons have risen to the occasion and have provided their patients with informational issue
brochures, hung posters in their waiting rooms, and contacted their elected officials multiple times in person, by letter, or by telephone.

Some surgeons have raised questions about the types of activities that are allowable under federal and state laws. Following are some examples of appropriate activities for surgeons and state chapters. However, before a chapter engages in any of these activities it’s best to check with the state’s ethics office about any limitations.

• Advocacy events at the capital. ACS chapters and state medical societies often organize annual advocacy days at their state capitals, which provide their members with opportunities to meet with state legislators to discuss issues of concern and help to build relationships with those officials. Some chapters have arranged these advocacy days to coincide with their annual meetings. Typically, Fellows who have participated in these events say they had very positive experiences and often look forward to the following year’s meeting.

• Regular visits with legislators. During the state legislative session, progress on a “hot” issue like medical liability reform may require more than one visit to the capital. It is appropriate for individual surgeons to regularly meet with their elected officials, attend committee hearings on proposed legislation, and gather for visible rallies in the capital rotunda or other generally accepted meeting points for public events. In these instances, it is likely that physician offices will be closed for the day, so it is important that arrangements for emergency care be made in the same way a surgeon would if they were leaving town to attend an educational conference or specialty society meeting.

• Patient education. This has been a very effective tool in advocating for medical liability reform, as patient brochures can be given to each patient and posters hung on waiting room walls. Take a minute or two during patient visits, if appropriate, to talk about the issue and encourage the patient to contact their state legislators. Some physicians wear liability reform buttons on their coats to initiate a dialogue with their patients.

• Take advantage of ACS advocacy resources. The College’s Division of Advocacy and Health Policy is responsible for federal and state legislative affairs. The staff in the Washington Office is available to help schedule chapter visits to Capitol Hill and can brief surgeons planning to meet with their federal legislators in DC or their home districts. In the Chicago office, the state affairs staff is available to assist chapters in developing and implementing state advocacy efforts, including contacting state legislators or other officials through the Surgery State Legislative Action Center. In addition, the division’s Web site (http://www.facs.org/ahp/index.html) contains useful information on medical liability reform (the Medical Liability Reform Action Guide), Medicare and physician reimbursement, and other issues.

Important reminders

One very important point to remember when chapters or surgeons are considering advocacy activities is that if there is any doubt about whether an activity is legal, consult an attorney.

Finally, as mentioned previously, a good resource on chapter activities is the Chapter Guidebook. Published by the Division of Member Services, this publication contains very useful information on a host of organizational, administrative, and legal issues facing chapters. A complete copy is available online at www.facs.org/about/chapters/guidebook.html.
Socioeconomic tips

Medicare computer software changes

by the Division of Advocacy and Health Policy

This month’s column centers on changes to Medicare’s computer software that either already have been made or will be made later this year.

Check the card
The Centers for Medicare & Medicaid Services (CMS) changed its claims processing software to require an exact match on the beneficiary’s first initial, surname, and health insurance claim number. This modification was made to avoid payments on behalf of the wrong beneficiary. To avoid having a claim denied, always submit the claim with the name and number exactly as they appear on the beneficiary’s Medicare card because that is the information that matches CMS’s files. If a beneficiary says the Medicare card is incorrect, refer him or her to the local Social Security field office, where the staff can change the name in Medicare’s records and send the patient a new card with the correct name. For more information, go to http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0516.pdf.

Remittance advice codes
The remittance advice codes are updated three times a year. On April 4, an especially large number of codes were added to replace existing codes. A number of the changes occurred because codes with multiple meanings were split so that there are separate codes for each meaning. For example, code M45, “Missing/incomplete/invalid occurrence codes or dates,” has been restricted to mean “Missing/incomplete/invalid occurrence code(s)” and code N299 has been added to mean “Missing/incomplete/invalid date(s).” A complete list of codes is available at http://www.wpc-edi.com/codes. For more information, go to http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3636.pdf.

Processing crossover claims
For many years individual carriers have sent claim information automatically to certain secondary insurers. CMS is now consolidating the Medicare claims crossover process for automatic crossovers under a single coordination of benefits contractor (COBC).

Under the new process, surgeons will file a Medicare claim with their local carrier, which pays Medicare claims. If the claim is to be automatically transferred to the secondary payor, the claim and Medicare payment information is sent to the COBC. The COBC then transmits the claim and Medicare payment information to the secondary payor. CMS has been testing the consolidated crossover process with approximately 10 supplemental insurers and is now ready to move the remaining secondary insurers to the single COBC during the next few months.

There are a few pointers to remember when dealing with the new automatic crossover process, including the following:

- The claims will be passed to the secondary insurer only after the Medicare claim has been paid or, to put it another way, the claims will be passed to the secondary insurer only after the Medicare claims processing floor has been reached.
- Although the claim may pass to multiple insurers, only one will be named on the remit-
The College has nominated Richard B. Reiling, MD, FACS, one of the College’s representatives in the American Medical Association’s (AMA’s) House of Delegates (HOD), to serve on the AMA’s Council on Medical Education. The North Carolina Medical Society, the American Society of Plastic Surgeons, and the American Academy of Orthopaedic Surgeons also have endorsed Dr. Reiling’s campaign for a seat on the council.

The AMA’s Council on Medical Education promotes quality medical education and health care through the development of accreditation and licensing systems and is responsible for generating and coordinating AMA policies that affect medical education and training.

“I believe that I am in a unique position to serve on the Council of Medical Education because of my extensive background in teaching, surgical practice, program administration, and active participation in organized medicine,” Dr. Reiling said.

Indeed, Dr. Reiling has been a proponent of surgical education throughout his professional career. After completing his general surgery training at Harvard in Boston, MA, Dr. Reiling served for two years in the U.S. Air Force as chief of general surgery and director of medical education. He then entered clinical and academic practice in Dayton, OH, where he became a founding member of the department of surgery at Wright State University. He currently is a clinical professor of surgery at that institution. He also served for a number of years as the associate program director and director of surgical education at Kettering Medical Center, Kettering, OH.

Furthermore, Dr. Reiling has developed an estimable reputation for his dedication to the American College of Surgeons and other medical organizations. He served for several years in the Ohio State Medical Association’s house of delegates as a representative of the ACS. In recognition of his allegiance to the ACS, in 2004 he received the College’s highest honor, the Distinguished Service Award. He joined the AMA’s House of Delegates in 1994 as an alternate College delegate and has been a delegate since 1996.

Recently, he served on the AMA’s Special Advisory Group Extraordinaire (SAGE) and Committee on Organization of Organizations. Additionally, he represents the AMA on the College’s Commission on Cancer.

Dr. Reiling believes that the Council on Medical Education carries out a particularly important function at this time because of ongoing concerns about financing for medical education. “Medical education is at a critical juncture today. Mounting problems of financing and increasing tuition costs of medical education require that we find other means of medical school funding,” he said.

Furthermore, because some medical school graduates are turning away from certain specialties, patients are likely to have difficulty accessing appropriate care. “Many popular specialties of the past are now facing critical shortages, creating emergency service coverage and access to care problems,” Dr. Reiling said.

“Residency review committees have new challenges to ensure quality education and support resident needs in an era of much external oversight and diminished training time,” he added. Furthermore, the continuing
medical education (CME) requirements for practicing physicians are changing in light of increasing demands for improved patient safety. “Maintenance of certification is now a reality, and it is imperative that we as physicians determine what this means and how it is implemented,” Dr. Reiling said. “There is also a pressing need for significant educational resources in a rapidly evolving technological arena,” he added.

Throughout his years of membership in the ACS and the AMA, Dr. Reiling has participated in activities for resident training and CME for the practicing surgeon. He has worked within the HOD process to bridge gaps and form coalitions to tackle areas that lack clear physician competency standards and patient safety protections.

The College’s leadership believes that Dr. Reiling’s background and experience in the educational arena, coupled with his intimate knowledge of the HOD process, make him an excellent candidate to serve on the AMA Council on Medical Education. Fellows who are involved in the AMA HOD are encouraged to promote his candidacy and work with their state or specialty delegation to gather support.

Breast implant safety Web site launched

The American Society for Aesthetic Plastic Surgery and the American Society of Plastic Surgeons recently launched a new Web site targeted at women who are interested in getting breast implants. The Web site, www.breastimplantsafety.org, is intended to serve as a resource for educating patients about the implants, offering objective and clinically verifiable information on the topic.

The site depicts the pros and cons of saline implants—currently the only devices approved by the U.S. Food and Drug Administration (FDA) for all uses—and silicone implants. In 1992, the FDA restricted the use of silicone implants to reconstructive and breast revision procedures. The site also provides information regarding the history of implants, medical research, patient safety, clinical trials, and links to related Web sites.

Trauma and critical care course slated for June

The Eastern States Committees on Trauma will present Trauma and Critical Care 2005—Point/Counterpoint XXIV, in Atlantic City, NJ, June 6-8, 2005. The Hilton Casino Resort will be the site for the program, which will examine the latest developments in the care of the injured patient.

Course topics include: Recent Advances in the Care of Injured Children; Trauma Systems, The Good, the Bad, and the Ugly; Challenging Case Presentation in Pediatric Trauma; Caring for the Injured; Fiscal Failure and How to Avoid It; Tips from the Experts on Addressing Difficult Clinical Problems; Bleeding and Clotting—Is There a Happy Medium?; The Cutting Edge—How Do I Do It; Contemporary Trauma Care—The Survivor Game; Issues in Resuscitation; and The Injured Elderly—What We’ve Learned.

The Scientific Program Committee consists of Kimball I. Maull, MD, FACS, Course Chair; Charles C. Wolferth, MD, FACS; L. D. Britt, MD, MPH, FACS; David V. Feliciano, MD, FACS; Rao R. Ivatury, MD, FACS; Lenworth M. Jacobs, Jr., MD, MPH, FACS; and Michael Rhodes, MD, FACS.

Complete course information may be viewed online at http://www.traumapointcounterpoint.com. For further information about the course, contact the Trauma Office at 312/202-5342.
Space sold by Elsevier
Six American College of Surgeons Resident Research Scholarships for 2005 were awarded by the Board of Regents in February. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of $30,000 for each of two years, beginning July 1, 2005. Unless otherwise noted, scholarships are sponsored by the Scholarship Endowment Fund of the College. The 2005 recipients are:

**Prashanth Vallabhajosyula, MD**, resident in surgery, Johns Hopkins Hospital, Baltimore, MD. Research to be performed at Massachusetts General Hospital. Research project: Characterization of regulatory cells mediating tolerance of kidney allografts in a miniature swine model.

**Andrea Badillo, MD**, resident in surgery, George Washington University Medical Center, Washington, DC. Research to be performed at The Children’s Hospital of Philadelphia. Research project: Direct and indirect effects of mesenchymal stem cells in accelerating impaired wound healing. The scholarship is sponsored by Ethicon, Inc.

**Geetha Jeyabalan, MD**, resident in surgery, University of Pittsburgh (PA). Research project: Protective role of carbon monoxide in liver ischemia/reperfusion injury.

**Reza Yassari, MD**, resident in neurosurgery, University of
MAY 2005 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS

Kevin P. Mollen, MD, resident in surgery, University of Pittsburgh (PA). Research project: The role of toll-like receptors (TLR) in hemorrhage initiated danger signaling. The scholarship is sponsored by Wyeth Pharmaceuticals.

Raghuveer Vallabhaneni, MD, resident in surgery, University of Pittsburgh (PA). Research project: Regulation of Fas-associating death domain protein in hepatocyte apoptosis.

Further information regarding the research-oriented scholarships, fellowships, and awards offered by the College for 2006 will be published in the June edition of the Bulletin. This information also appears on the College’s Web site at www.facs.org.

2006 ANZ Travelling Fellow selected

Robert R. Cima, MD, FACS, assistant professor of surgery, division of colon, rectal, and general surgery, Mayo Clinic, Rochester, MN, has been selected as the 2006 Australia and New Zealand (ANZ) Chapter of the ACS Travelling Fellow. As the Travelling Fellow, Dr. Cima will participate in the Annual Scientific Congress of the Royal Australasian College of Surgeons in Sydney, Australia, May 15-19, 2006. He will attend the ANZ Chapter meeting during that congress, and will travel to several surgical centers in Australia and New Zealand.

The application deadline for the Year 2007 ANZ Travelling Fellowship is November 15, 2005. The requirements for the Year 2007 Travelling Fellowship will appear later this year in the Bulletin and will also be posted on the College’s Web site, www.facs.org.

2005 Oweida Scholar named

Darrin Antonelli, MD, a young general surgeon from Black River Falls, WI, was selected to receive the 2005 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons.

The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylvania. The $5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees. The purpose of the Oweida Scholarship is to help young surgeons practicing in rural communities attend the Clinical Congress and benefit from the educational experiences it provides.

The Oweida Scholarship is awarded each year by the Executive Committee of the Board of Governors.
Claims coding reference and education database

ACS CodingToday features:

- Complete CPT, HCPCS Level II, and ICD-9 codes.
- Current Medicare Correct Coding Initiative bundling edits, national and local fee schedules, and Medicare policy information.
- Medicare information on global fee days and modifier usage.
- Automatic calculation of fees by geographic locality.
- Full text Local Medical Review Policies, fall 2003.

The only coding database that contains ACS billing and coding tips!

Special discount pricing: Only $199 for the first user, $50 for each additional user—a $590 value!
Faculty Research Fellowships awarded by College

Ten American College of Surgeons Faculty Research Fellowships for 2005 were awarded by the ACS Board of Regents in February. These two-year fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty and carry grants of $40,000 per year from July 1, 2005, through June 30, 2007. Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the College. The recipients are:

Kenneth W. Liechty, MD, assistant professor, University of Pennsylvania School of Medicine, Philadelphia, PA. Research project: Interleukin-10 inhibition of inflammation in fetal tissues. Dr. Goldstein’s fellowship—the Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons—is named to honor Dr. Martin, founder of the College.

Adam W. Bingaman, MD, assistant professor, Medical College of Georgia, Augusta, GA. Research project: Memory T-cells and their relationship to transplantation tolerance.

Melina R. Kibbe, MD, assistant professor, Northwestern University, Chicago, IL. Research project: Regulation of the ubiquitin-proteasome pathway by nitric oxide.

Terence M. Myckatyn, MD, instructor, Washington University, St. Louis, MO. Research project: Effects of centrally and peripherally expressed glial-derived neurotrophic factor on nerve regeneration in a novel transgenic mouse model. Dr. Myckatyn’s fellowship—the C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care—honors the late Dr. Carrico, a former President-Elect of the College.

Gerald S. Lipshutz, MD, assistant professor in residence, University of California, Los Angeles, CA. Research project: Indoleamine 2, 3-dioxygenase: A novel immunosuppressant for liver transplantation.
John Phay, MD, assistant professor, Vanderbilt University School of Medicine, Nashville, TN. Research project: Abnormal hexokinase expression and function in malignancy.

Shu S. Lin, MD, PhD, assistant professor, Duke University Medical Center, Durham, NC. Research project: The role of gastroesophageal reflux in pulmonary allograft dysfunction.

Eric K. Nakakura, MD, PhD, assistant professor, University of California, San Francisco, CA. Research project: Elucidation of genetic pathways critical for the development and differentiation of gut endocrine cells and gastrointestinal carcinoid tumors.

Bakhtiar Yamini, MD, assistant professor, University of Chicago (IL). Research project: Investigation of the role of NF kappa beta in the treatment of malignant glioma with temozolomide and tumor necrosis factor alpha.


The Scholarship Endowment Fund of the American College of Surgeons was established in 1965 to provide income to fund scholarship and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are invited. Fellows interested in making gifts to fund these vital programs are encouraged to contact the Development Office at 312/202-5376.
ACS Career Opportunities

The American College of Surgeons’ online job bank

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

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

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

Employers:
• Nationwide market of qualified surgical candidates.
• Resume Alert automatically e-mails notices of potential candidate postings.
• Exceptional customer service and consultation.
• Online tracking.

Questions?
Contact HealtheCareers Network at 888/884-8242 or candidates@healthecareers.com for more information.
2006 ACS Japan Traveling Fellowship available

The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Japan. The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese 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, personable, and possesses good communication skills.

**Activities**

The Fellow is required to spend a minimum of two weeks in Japan.

- To attend and participate in the annual meeting of the Japan Surgical Society, which will be held in Tokyo, Japan (March 29-31, 2006).
- To attend the Japan ACS Chapter meeting during that congress.
- To visit at least two medical centers (other than the annual meeting city) in Japan before or after the annual meeting of the Japan Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons.

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

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 $7,500 (U.S.) to the successful applicant, who will also be exempted from registration fees for the annual meeting of the Japan Surgical Society. He or she must meet all travel and living expenses. Senior Japan Surgical Society and ACS Japan Chapter representatives will consult with the Fellow about the centers to be visited in Japan, 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, as this makes available to him reduced fares and travel packages in Japan.

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

Applications for this traveling fellowship may be obtained from the College’s Web site (www.facs.org) or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211. The closing date for receipt of completed applications is June 1, 2005. The successful applicant and an alternate will be selected and notified by November 1, 2005.
tance advice. If a Medigap insurer is involved, that is the one that will be named.

- Certain situations may prevent the automatic crossover from occurring even though you have been notified of an apparently successful crossover.
- CMS advises that physicians wait at least 15 working days after receiving the Medicare claims payment before inquiring about the secondary insurer’s payment. They also suggest using the self-service tools of the secondary insurer to see if they have received the claim before submitting another one. Self-service tools include a Web site or telephone “hotline.”
- Only the Medicare remittance advice (whether paper or electronic) should be used for supplemental billing.
- A list of secondary insurers who are using the COBC is posted at http://www.cms.hhs.gov/medicare/cob/coba.coba.asp.

The ACSPA Board of Directors approved the 2005 organizational membership dues payment for Doctors for Medical Liability Reform (DMLR). The Board of Directors voted to join DMLR in August of 2003. The ACSPA made a monetary commitment to the organization, which entitled it to a position on the DMLR’s steering committee. Current first-tier members of the steering committee are the American Association of Orthopaedic Surgeons, the American College of Obstetricians and Gynecologists, the American College of Emergency Physicians, the Society of Thoracic Surgeons, and the ACSPA. The ACSPA is the largest organization in the coalition, and its representative, F. Dean Griffen, MD, FACS, holds office as secretary of the DMLR.

During 2004, the organization’s political action committee (ACSPA-SurgeonsPAC) raised $596,000 through its presence at the Clinical Congress and at chapter meetings, telephone calls, and annual mailings. The PAC’s telephone fund-raising program began April 28 and yielded $350,000 in pledges. The ACSPA-SurgeonsPAC donated to more than 112 individual candidates, political party committees, and leadership PACs.

Three ACSPA members were successful last year in their first election campaigns for Congress. On January 12, the ACSPA co-hosted a reception for these new representatives.

In 2005, the ACSPA-SurgeonsPAC will continue to back congressional leaders and other members of Congress who support surgery’s legislative agenda. The first fundraising activity to be hosted by the ACSPA-SurgeonsPAC on behalf of the physician organizations was held February 2.

American College of Surgeons

ACS Statements
The Board of Regents approved a new statement developed by the Committee on Ethics. The new Statement on Principles of Palliative...
Care will be published in an upcoming edition of the *Bulletin* and then posted on the College’s Web site. This statement replaces a previous statement entitled Principles Guiding Care at the End of Life.

The Board of Regents also approved a Statement on Service Volume and Quality developed by the College’s Health Policy Steering Committee. It will be published in a future edition of the *Bulletin* and subsequently posted on the College’s Web site.

**Board of Governors**

The Board of Regents approved a number of recommendations from the Board of Governors. At its October 10, 2004, meeting, the Board of Governors heard reports from its committees.

Several committees offered recommendations that were approved by the Board of Governors. In turn, the Board of Governors presented these recommendations to the Board of Regents for approval.

**Scholarships**

The Board of Regents approved a new health policy scholarship jointly sponsored with the American Academy of Otolaryngology-Head and Neck Surgery Foundation. The College awards approximately $1.5 million annually in scholarships.

**Bylaws**

The Board of Regents approved a change in the College’s *Bylaws*. Article VII, Section 1 (f), will be revised to read “Unprofessional conduct.”

**ACS Foundation**

The Board of Regents approved the *Bylaws* for the American College of Surgeons Foundation, as well as the members of the foundation’s Board of Directors and its slate of Officers. At its October 2004 meeting, the Board of Regents finalized a business plan to establish an American College of Surgeons Foundation. The sole purpose of the foundation is to raise money to support the education, research, and patient safety programs of the College.

Members of the foundation’s Board of Directors are as follows: Oliver H. Beahrs, MD, FACS; John L. Cameron, MD, FACS; Edward R. Laws, MD, FACS; Richard B. Reiling, MD, FACS; and ACS Executive Director, Thomas R. Russell, MD FACS. The foundation’s Officers are as follows: Dr. Laws as President; Dr. Reiling as Secretary; Dr. Cameron as Treasurer; Dr. Russell as MD Director of Development; Gay L. Vincent, CPA, as Comptroller; and Fred W. Holzrichter, CFRE, as Chief Development Officer.

**Development**

In 2004, the College received gifts and pledges totaling $1,984,872. This amount compares favorably to the previous calendar year’s gifts and pledges of $1,418,705. The Development Committee is working to increase awareness of the benefits of using planned gifts and with financial experts to offer personal planned giving advice upon request. The Development Office continues to communicate regularly with pharmaceutical and medical device companies in an ongoing effort to explore opportunities for funding.

**Advocacy and Health Policy**

The Board of Regents approved funds to complete an analysis of closed liability claims to generate data that will help guide relevant ACS educational efforts and the development of resource material for ACS members. The ACS Patient Safety and Professional Liability Committee is conducting a pilot project to analyze closed claims to see if surgery can replicate the success that anesthesiology realized after implementing a claims-review process. This system has resulted in programs that have reduced the number and severity of lawsuits for that specialty. The committee was intrigued with implementing a similar program because of its potential to reduce patient injuries and improve patient care, while stabilizing the liability premiums.
paid by surgeons. Furthermore, the process could be used to identify and prioritize patient safety issues, and such a program would demonstrate that the profession of surgery is taking steps to eliminate those “malocurrences” that are, in fact, preventable. At the conclusion of the project, the committee believes it will be able to report on the most common events leading to malpractice claims, as well as the causes of the most severe injuries.

In comments submitted to the Centers for Medicare & Medicaid Services (CMS), the College focused on the need for CMS to adopt a new methodology and better data collection for calculating malpractice RVUs that would more fairly compensate high-risk surgical specialties. The College submitted codes that surgeons believe are undervalued, for consideration during the five-year review of relative work values. The review will take place this year, and any resulting changes to the value of these codes will become effective in 2007. The College also questioned the issue of parity with regard to newly established Medicare payment for drug administration codes.

Also with respect to payment issues, in December 2004, Frank Opelka, MD, FACS, represented the College at a meeting to discuss the geographic adjustments that are made to Medicare physician payments in rural areas. The meeting was hosted by the Urban Institute, operating under contract to CMS to complete a congressionally mandated study of the adequacy of Medicare payments to rural physicians. Dr. Opelka suggested that add-on adjustments to rural payments and improved administration of “bonus” programs would be the preferred means of addressing rural area concerns.

CMS recently published a new proposed list of procedures that it will cover in ambulatory surgical centers (ASCs). The CMS proposed to add 25 procedures and delete 100. The College submitted comments on the proposed list, which included the ACS’s views on specific procedures included on and excluded from the list and urged CMS to re-evaluate its methods for approving procedures for Medicare reimbursement in ASC settings and for setting payment rates for individual procedures.

In a rule that took effect June 1, CMS set new associated principles for informed consent and operative notes. Paul Friedmann, MD, FACS, and ACS staff met with CMS officials on December 13 to review the informed consent guidelines and discuss their implication for teaching programs. Agency representatives agreed to review suggested changes in the guideline language.

The Senate and the House passed patient safety bills in 2003 and 2004, but they were unable to negotiate the differences between the two bills before adjourning last year. As an active member of the Patient Safety Coalition, the College will continue to work with congressional staff and other health care organizations to promote passage of patient safety legislation in 2005.

Talks are under way with key legislators on the reintroduction of legislation to reauthorize the trauma-emergency medical services program. The College is collaborating with other specialty societies in an effort to find compromise language for another reauthorization bill in 2005.

The College has collaborated with the surgical specialty societies to update the *Physicians As Assistants at Surgery* study. The fifth edition should be published early this spring.

The 2005 series of basic and advanced CPT and ICD-9-CM coding workshops has been scheduled for May, July, and September in Baltimore, MD, Chicago, IL, and Dallas, TX, respectively. The 2005 practice management course, Charting a Sound Course for Surgical Practices, will only be presented at the Spring Meeting and the Clinical Congress.

**Certification/accreditation**

The Board of Regents approved funding for the infrastructure to support verification, certification, and accreditation activities
within the Division of Education. National trends affecting surgical practice and surgical education include intense focus on surgical competence, surgical outcomes, and patient safety. The need to verify, certify, and accredit individuals, educational programs, and educational systems is an integral component of these trends.

Initial planning for an ACS Accreditation Center is under way. Noting that this endeavor is one of the College’s major priorities, the Executive Committee of the Board of Regents discussed and approved the formation of a task force to develop an ACS Accreditation Process.

E-learning
The Board of Regents approved funding for a demonstration project involving development of an e-learning module to support practice-based learning and improvement. The purpose of the project will be to define the characteristics and standards in e-learning important for authoring modules, to evaluate the educational impact and use of the module, and to create a framework for designing multiple e-learning modules and integrating them with other e-learning resources.

Education
A new interactive CD-ROM, Personal Financial Planning and Management for Residents and Young Surgeons, was released during the 2004 Clinical Congress. A set of two CD-ROMs, Practice Management Course for Residents and Young Surgeons, should be ready for release in the coming months.

Three sessions from the 2004 Spring Meeting are available as Web casts on the Internet and offer opportunities to earn online Category 1 continuing medical education (CME) credits. Nine sessions from the Clinical Congress will be available in early 2005. Audio recordings of sessions from the 2004 Spring Meeting and Clinical Congress also are available on CD-ROM or in MP3 format.

SESAP 12 was unveiled at the 2004 Clinical Congress. Initial sales have been brisk. The program includes new features: content categories were changed to make them congruent with the content categories of the recertification examination of the American Board of Surgery, the CME verification process was streamlined, and an audio companion was added. A SESAP Sampler will be launched in the spring.

An Editorial Board has been appointed to review the tapes housed in the ACS Video Library. The Board will review and arrange the tapes thematically in order to produce new video-based education products.

The first Resident Award for Exemplary Teaching was presented at the 2004 Annual Meeting of Fellows. The award recognizes excellence in teaching by a resident, and highlights the importance of teaching in the daily lives of residents.

A one-day program for surgical residents, Life After Residency, was scheduled to take place Friday, April 15, just before the start of the 2005 Spring Meeting. Three special sessions for residents have been planned for the Spring Meeting in collaboration with the Resident and Associate Society of the College. They were slated for Sunday, April 17, and include Spectacular Cases for Residents, Surgical Jeopardy, and a new clinical abstract presentation session.

Journal of the American College of Surgeons (JACS)
JACS began its observance of the publication’s 100th anniversary. Each issue of JACS during 2005 will contain a retrospective editorial about a specific topic from early issues of JACS. January 2005 marked another milestone, as JACS and the Bulletin are now packaged together for mailing through Elsevier.

As of December 2004, the JACS Online CME-1 Program had logged 59,600 CME-1 credits at no cost to Fellows of the College. At all times, JACS Online maintains two full years of material, or 48 possible credits.
Communications

Members of the Public Profile and Visibility Steering Committee initiated the final recruitment and selection process for the members of the College’s Public Outreach Television Team. Letters, along with a videotape outlining the concept of the program, were sent to individual Fellows who had expressed an interest in the project. The response to that letter and one from Dr. Russell resulted in a total slate of 25 candidates for review and consideration. Ten of those candidates accepted and will attend a training session, which is intended to introduce the farm team members to all of the players at television stations and to provide in-depth insight into how the business works, how to establish a working relationship with a TV station, and how surgeons can optimize their interactions with their local stations.

The ACS Web portal prototype demonstrated last October has been transferred into a full production level software and hardware environment, and the graphic design is being revised to improve ease-of-use for members of the College. Dialog continues with parties that are interested in partnering with the College to fund the portal project. A media kit describing the purpose and intended content of the portal has been prepared for distribution to a large number of companies representing various commercial activities.

Continuous Quality Improvement (CQI)

CQI, formerly the Office of Evidence-Based Surgery, presented a new course entitled Outcomes Research. The course focused on designing observational studies, assessing validity, working with large databases, conducting basic statistical analysis, and adjusting for risk. Feedback from faculty and participants was very positive, and the multi-day course will be offered again in 2006.

Work continues on the Web site for the ACS National Surgical Quality Improvement Program (ACS NSQIP). The Web site http://www.acsnsqip.org/ will be a primary source of information regarding the program. A PowerPoint™ presentation about the ACS NSQIP is now available for downloading.

Cancer

As of December 31, 2004, almost 1,270 Commission on Cancer (CoC)-approved cancer program registries had responded to the National Cancer Data Base (NCDB) request for case submissions. Approximately 92 percent of CoC-approved cancer programs have submitted data in response to the 2003 call for data. Additionally, the American Cancer Society has recruited Intel Solution Services to conduct an assessment of the NCDB, the goal of which is to position the NCDB to better support cancer prevention, early detection, and quality of care initiatives.

Trauma

The following is an update on trauma activities.

- The Committee on Trauma (COT) will again work with other organizations on the reauthorization of the trauma systems development and funding bill, and COT members were invited to visit their Congressmen while in Washington, DC, for the 2005 annual COT meeting in March.
- The COT Education Subcommittee is developing a surgical skills course.
- The COT Publications Subcommittee continues to develop trauma guidelines and an interactive CD-ROM project in trauma and critical care.
- The COT Injury Prevention and Control Subcommittee’s educational program in prevention is being beta-tested in 10 trauma centers.
- Advanced Trauma Life Support® revision materials were released this past fall, and the course has been disseminated in Hungary.
- The National Trauma Date Bank™ (NTDB™) Annual Report 2004 was distributed in October, and a grant from Health Resources and Services Administration will fund work to analyze each of the 93 data elements in the NTDB.
• Work continues on the revision of the Web-based *Trauma Performance Improvement: A Reference Manual*, and the updated version will include information on patient safety.

• Revisions continue on the *Resources for the Optimal Care of the Injured Patient*, and a final draft is expected to be completed by the end of the year.

• A Rural Trauma Team Development Course continues to be popular in the U.S. and Canada.

**Member Services**

The Board of Regents approved waiving the application fee, or first year’s dues, for all first-year surgical residents. In subsequent years residents will be billed at the dues rate relative to their category of membership.

The Rural Surgeons Subcommittee of the Advisory Council for General Surgery continues to meet regularly. In addition to a third Rural Surgery Forum, a general session is planned for the 2005 Clinical Congress.

As of January 11, 2005, the Job Bank had 488 positions listed, and 57 job seekers had posted their resumes. The site averaged 500 hits per week.

Representatives of the ACS Committee on Young Surgeons asked the Board of Regents to consider, as one of its future policy and planning initiatives, providing child care for families attending the ACS meetings. The Board suggested that the Convention and Meetings support area explore the possibility of providing such services.
We are tired of hearing the anecdotal story about a driver in a motor vehicle crash whose life was spared because they were not wearing their seat belt. The force of the impact caused them to be thrown from the vehicle, thus escaping major injuries. In that one individual’s mind, if they had been restrained with a seat belt they surely would have died. If they would have listened to the “click it or ticket” campaign, it would have been “click click—you’re dead.”

Unfortunately, some motorists, especially younger ones, listen to these urban legends and tall tales. They look for any reason to rationalize their risk-taking behavior. This age group of teenage drivers has a higher crash risk than any other age group, as measured by miles driven or by population. The last thing they need is an excuse to dispense with a proven safety device that is known to mitigate the severity of the injuries in the event of a motor vehicle crash. In fact, seat belt use among teenagers is lower than among older drivers, as reported in the National Safety Council’s 2002 white paper on teenage seat belt use. The report found seat belt use to be 36 percent among fatally injured teenage drivers. This report also mentions that states with a primary seat belt law have a higher incidence of seat belt use.

The records in the National Trauma Data Bank** Annual Report 2004** contain close to 200,000 records of motor vehicle-related injuries. The overall incidence of seat belt use in these injured motorists is a rousing 42 percent. When focusing on teenage seat belt use, the percentage drops to 31 percent, and of those teenage drivers who are fatally injured, only one in five used a seat belt. These data are depicted in the graph on this page.

Over the past several years, there has been a steady increase in overall seat belt use among motorists. According to federal highway safety officials, in 2004 seat belt use increased in 37 states and the national seat belt use rate was at an all time high of 80 percent. States with a primary seat belt law are seeing a steady increase in seat belt use. Since the records in the NTDB 2004 report come from a five-year sliding window (see last month’s *Bulletin* article, page 52), one can only hope that the yearly increase in motorist seat belt use will translate to an increased use among teenagers. It is up to all of us as responsible adults and parents to take every opportunity to instruct teenage drivers in the proper use of safety restraints. Teenage driving behavior starts with observing their parents and instructors, so please do not forget that click click—you’re alive!

Throughout the year, we will be highlighting these data through brief monthly reports in the *Bulletin*. The full National Trauma Data Bank Annual Report Version 4.0 is available on the ACS Web site as a PDF file and a PowerPoint® presentation at [http://www.ntdb.org](http://www.ntdb.org). If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.