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On the cover: Robert H. Ruby, MD, FACS (right), has spent many decades chronicling the histories of Native Americans (see page 14).

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

Spring Meeting
2006 Dallas, TX, April 23-26
2007 Las Vegas, NV, April 21-24
2008 To be announced
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
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From my perspective

Like the rest of the nation, we at the American College of Surgeons were deeply saddened by the human toll that Hurricane Katrina wrought on New Orleans and the surrounding Gulf coast region this summer. In the wake of such enormous tragedy, we simply wouldn’t be human if we didn’t feel a tremendous sense of loss and vulnerability.

These feelings of helplessness are particularly frustrating for members of the medical and surgical professions. We are trained to take control when catastrophe, natural or manmade, strikes. We plunge into the maelstrom and try to salvage as many lives as possible.

It’s not surprising, therefore, that so many physicians, residents, interns, nurses, and even administrative staff stayed at their institutions throughout the hurricane and in its aftermath to ensure that patients were evacuated safely. I’ve heard several surgeons recount instances in which they or their residents dodged gunfire to get patients onto helicopters, worked handheld ventilators to keep children alive, and carried patients down darkened stairwells on their backs. Such heroics warrant our most profound respect and deepest thanks. We will highlight some of these stories in an upcoming issue of the Bulletin.

Despite these individuals’ best efforts, some patients perished. The September 14 New York Times reported that staff at Memorial Medical Center in New Orleans, where 45 bodies were discovered earlier that week, said they could do little more than comfort patients. Charity and University Hospitals, both part of the Louisiana State University system, reportedly did not have the money to hire helicopter companies to evacuate patients. Hence, they were among the last to be evacuated and were forced to rely almost exclusively on the military and federal agencies for rescue activities. The two facilities were unable to evacuate their 28 infant patients (18 in intensive care) until the morning of the Friday after Katrina hit and the levees broke. A total of 20 bodies were left behind at the two facilities; 12 of the patients had died before the storm.

What went wrong?

Whenever an inevitability (such as a hurricane slamming into the southeast portion of the country, an earthquake in California, a tornado ripping though the plains) turns into a calamity, people are driven to point fingers and try to find some rational explanation for how the situation became uncontrollable. Many of the physicians who were on site in New Orleans report that their hospitals were prepared to make it through a typical hurricane, stocked with enough extra food, generators, and supplies to last at least a week. What they weren’t prepared for was the levees breaking and Lake Pontchartrain overflowing into the city. Moreover, the response from federal, local, and state relief agencies was clearly inadequate and too slow. As Simon Winchester noted in the September 8 New York Times, “The last time a great American city was destroyed by a violent caprice of nature, the response was shocking ly different....” Referring to the earthquake that upended San Francisco in 1906, killing 3,000 people and leaving 225,000 homeless, Mr. Winchester noted that the entire nation responded to the disaster with speed and determination. Troops were quickly dispatched into the city to control looters and blast through the city.
some of the wreckage. The mayor requisitioned boats to the Oakland telegraph office to inform the country that San Francisco was in ruins and needed help. Relief trains began arriving that same night. Congress convened and quickly passed legislation to pay all bills.

At the time of the San Francisco earthquake, no government-run agencies, such as the Federal Emergency Management Agency, were in place to declare when disaster had struck and how to respond. The people of San Francisco reported their dire situation, and the state and federal government heard their plea and acted accordingly. It was that simple.

**Emerging from the flood**

Despite the cripplingly slow pace of relief efforts in New Orleans, I believe that this historically significant and unique city will eventually emerge from this tragedy with the same grace as San Francisco did nearly 100 years ago. To help the hurricane survivors—patients and surgeons—the College has been working at several levels.

First, Operation Giving Back was in regular contact with the major federal agencies that coordinated the response and through an electronic alert to our members provided surgeons with regular updates on how they could offer their services. Many of you volunteered your time and skills. The College applauds your generosity and compassion.

In addition, our Job Bank is helping displaced surgeons find positions elsewhere. Equally as important, the surgical boards’ residency review committees are assisting trainees who need to be placed, at least temporarily, in other programs. I would strongly encourage all program directors to embrace these residents. By all accounts, they were key in evacuating patients and deserve the highest respect and consideration. Some of their stories will be told in the upcoming *Bulletin* article that I mentioned earlier.

In an effort to ensure that our members are prepared for any disasters—natural or man-made—that may occur in this country, we continue to offer educational programs in disaster preparedness. Our Governors’ Committee on Blood-Borne Infection and Environmental Risk monitors these types of situations and develops recommendations on how surgeons can prepare for cataclysmic events. In addition, our Advanced Trauma Life Support® course trains health care professionals in providing prompt and effective care for individuals who are injured or otherwise in need of emergency care.

Finally, I am proud to say that the College still plans to hold its 2007 Clinical Congress in New Orleans. Many of you have fond memories of the city, and we have always had a good experience dealing with the convention center and hotels. By bringing our meeting there, we will be doing our part to help the city of New Orleans rebuild.

To those individuals who lost family, friends, homes, and livelihoods to Hurricane Katrina, we offer our condolences and solemn wishes for better days ahead. To the medical professionals who fought to save lives under the most grueling and primitive of circumstances, we extend our thanks and admiration. All of you exemplify that a disaster may demolish buildings and infrastructures but not the human spirit.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
Soon after Hurricane Katrina ripped through the Gulf coast this summer, the Centers for Medicare & Medicaid Services (CMS) took action to ensure that individuals enrolled in the Medicare, Medicaid, and State Children’s Health Insurance programs would receive emergency care. Many of the programs’ normal operating procedures were relaxed to speed care to the elderly, children, and people with disabilities. For example, because many hurricane victims were evacuated to facilities in neighboring states, CMS waived the normal burden of documentation for patients’ eligibility to receive benefits. In addition, federal officials worked with state Medicaid agencies to coordinate interstate payment agreements. Other forms of relief that the CMS offered, which may be of interest to surgeons, are as follows:

- Normal licensing requirements for physicians, nurses, and other health care professionals who cross state lines to provide emergency care in stricken areas were waived, provided that they had been licensed in their home states.
- Certain privacy requirements were waived so that physicians could speak with family members about a patient’s condition, even if the patient could not grant that permission.
- Hospital emergency departments were not be held liable under the Emergency Medical Treatment and Active Labor Act for transferring patients to other facilities for assessment, if the original facility was in an area where a public health emergency had been declared. For more information about CMS’ hurricane relief activities, go to www.cms.hhs.gov/katrina.

A study by the Agency for Healthcare Research and Quality (AHRQ) published in the August issue of Critical Care Medicine indicates that patients in hospital intensive care units (ICUs) are at significant risk for preventable adverse events and serious medical errors. The Critical Care Safety Study: The Incidence and Nature of Adverse Events and Serious Medical Errors in Intensive Care shows that more than 20 percent of the patients admitted to two ICUs at an academic medical center experienced adverse events. Approximately 45 percent of those adverse events were considered preventable, and more than 90 percent occurred during routine care. AHRQ’s press release about the study may be viewed at http://www.ahrq.gov/news/press/pr2005/icuerrpr.htm. AHRQ also recently released data from the agency’s 2004 Medical Expenditure Panel Survey, indicating that 48.3 million Americans (16.8% of the civilian population) were uninsured in early 2004. The study indicates that young adults aged 19 to 24 years were most likely to be uninsured, and 35 percent lacked coverage. Only 11.7 percent of children younger than age 18 were uninsured, but 29.4 percent had public insurance only. Additional survey data are available at www.meps.ahrq.gov/papers/st83/stat83.pdf.

CMS and the Hospital Quality Alliance have added two measures for preventing postoperative infections, as well as a measure for treatment of pneumonia to the Hospital Compare Web site. The first two measures are part of a larger set of patient safety measures that will...
NIH offers student loan repayments

The National Institutes of Health (NIH) is accepting applications for its five loan repayment programs. The five loan repayment programs that the NIH offers are in clinical research, clinical research for individuals from disadvantaged backgrounds, contraception and infertility, health disparities, and pediatrics. Through these programs, the NIH repays up to $35,000 of the qualified educational debt of health professionals pursuing careers in biomedical and behavioral research. To qualify, applicants must possess a doctoral-level degree, devote 50 percent or more of their time to research funded by a domestic not-for-profit organization or government entity, and have educational debt equal to or exceeding 20 percent of their institutional base salary. Applications must be submitted by December 1. To apply for or to learn more about the loan repayment programs, go to www.lrp.nih.gov.

HIPAA contingency plan for claims submissions ends

As of October 1, CMS is no longer processing electronic Medicare claims for payment that do not conform to the standards required in the Health Insurance Portability and Accountability Act (HIPAA). HIPAA required CMS to adopt standards for health care claims and other financial and administrative transactions in order to streamline claims processing, decrease paperwork, and reduce the cost of health care administration. The effective date for the claims submission standards was October 16, 2003, but CMS implemented a contingency plan to allow continued payment of claims that are not HIPAA-compliant until providers had sufficient time to become fully compliant.

As of June 2005, fewer than 1 percent of Medicare fee-for-service providers has submitted electronic claims that are not HIPAA-compliant, demonstrating that all providers can become compliant. CMS has made software available at little or no cost through Medicare carriers and intermediaries to enable providers to submit HIPAA-compliant claims. To find out more about the HIPAA claims submission requirements, go to the CMS “Medlearn Matters” article at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3956.pdf.
PAYING FOR QUALITY:
Making policy and practice work for patients

by Shawn Friesen, Government Affairs Associate,
Division of Advocacy and Health Policy

Since the Institute of Medicine (IOM) published *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001)\(^1\) and *Leadership by Example: Coordinating Government Roles in Improving Healthcare Quality* (2002),\(^2\) the conversation among health care policymakers has shifted. Whereas the focus previously was on patient safety efforts, prevention of errors, and their application to public health programs, the emphasis now includes the implementation of quality improvement (QI) processes and outcome measures across the health care system. Following the route established by these IOM reports—as well as through efforts at the National Quality Forum (NQF) and private sector entities such as the Leapfrog Group—the QI conversation has progressed beyond the theoretical academic applications of the late 1990s and early 2000s to the practical, more tangible world of health policy and health care delivery through the work of the Medicare Payment Advisory Commission (MedPAC), the Centers for Medicare & Medicaid Services (CMS), and, most noticeably, the U.S. Congress.
In his testimony before the U.S. Senate Committee on Finance in July, Mark Miller, executive director of MedPAC, stated, “MedPAC has concluded that Medicare is ready to implement pay for performance [P4P] as a national program and that differentiating among providers based on quality is an important first step toward purchasing the best care for beneficiaries and assuring the future of the program.” Miller was restating the broad recommendations of the March 2005 MedPAC Report to the Congress, in which the commission specifically recommended that Congress establish quality incentive payment policies for physicians and other providers. In light of these recommendations, Congress has responded by holding hearings on how such a payment system might be implemented. Furthermore, given the challenges posed by the sustainable growth rate (SGR) methodology for calculating Medicare physician payments (which, left in its current form, will cut physician payments between 4 and 5% per year for the next six years), congressional discussions have focused largely on how the SGR might be replaced by a physician P4P system.

Congress moves ahead on legislation
Following the issuance of MedPAC’s March report, conversations between policymakers and physician stakeholders, such as the College, began to focus in earnest on possible forms of legislation that would establish a comprehensive P4P system under Medicare. On June 30, Sens. Charles Grassley (R-IA) and Max Baucus (D-MT)—Chair and Ranking Member of the Senate Finance Committee, respectively—were the first to introduce legislation, the Medicare Value Purchasing Act of 2005 (S. 1356).6 Similarly, Rep. Nancy Johnson (R-CT), Chair of the House Ways and Means Subcommittee on Health, introduced the Medicare Value-Based Purchasing for Physicians’ Services Act of 2005 (H.R. 3617) on July 29.7 Both bills would establish a process for setting quality measures and both would create financial incentives for physicians to report on particular measures effective in 2007.

According to their authors, both S. 1356 and H.R. 3617 envision a consultative process between the physician community and CMS in establishing those measures; however, H.R. 3617 more clearly establishes a process for physician organizations and specialty societies to submit specific measures each year to a consensus-based entity, such as the NQF. That entity, in turn, would make recommendations to CMS regarding specific quality measures for inclusion in the P4P system, and CMS would then publish its proposed measures for review and comment before final implementation each year. H.R. 3617 would establish a phased approach to P4P, starting with the required reporting of particular processes in 2007 and phasing into full P4P in 2009. Under H.R. 3617, those physicians who report required data in 2007 and 2008, and those who meet the measure requirements in 2009 and future years, would receive a payment increase equivalent to the Medicare Economic Index (MEI), which measures the annual increase in physicians’ practice costs. Physicians who do not meet the requirements will receive a payment increase of MEI less 1 percent.

Similar to H.R. 3617, S. 1356 would set up a phased approach to P4P, starting with the reporting of data in 2007; but unlike the House bill, S. 1356 would implement full P4P in 2008. The penalties for failure to report data or to meet performance thresholds also would be greater under S. 1356: Physicians not submitting data in 2007 would receive the payment update provided under law less 2 percent, and starting in 2008, physicians not meeting quality thresholds would receive the payment update less 1 percent. The amount subtracted for physicians who do not reach thresholds would increase incrementally each year to a full 2 percent reduction in 2012.

Although all of these differences are significant, the most marked difference between the bills is that H.R. 3617 would repeal the SGR and replace it with payment updates that guarantee increases for all physicians in 2006 and almost certainly would guarantee increases regardless of their quality measure status for all physicians in 2007 and beyond. Because S. 1356 leaves the SGR in place, it would merely add P4P to the already broken physician payment structure.

CMS sets the stage
Although much attention is currently (and rightfully) being paid to these congressional efforts, it is important to note that CMS has been setting the stage for P4P for several years. In November 2001, Tommy Thompson, then-Secretary
of the U.S. Department of Health and Human Services, announced the CMS Quality Initiative, which began with the Nursing Home Quality Initiative (NHQI). Through a collaborative effort with NQF and nursing home stakeholders, CMS developed quality measures for the facilities that were included in a pilot project that commenced in April 2002. In November 2002, the NHQI was launched in nursing homes nationally. In 2003, this initiative was extended to include home health agencies through the Home Health Quality Initiative and hospitals through the Hospital Quality Initiative (HQI); in 2004, it was extended to dialysis facilities that treat end-stage renal disease patients and the Physician Focused Quality Initiative, which at present is focused largely on primary care demonstration projects.8

Consistent with the logical progression of the NHQI, CMS has turned its focus this year toward quality measures for physicians. Although CMS’ authority for development of these broad quality measures is uncertain, and no formal physician P4P measures have been proposed as of press time, CMS has forged ahead in communications with the physician community about possible measures for inclusion in a physician P4P program; whether the program would be of national scope or initially limited to a pilot program remains to be determined.

With respect to surgery, draft measures circulated by CMS staff are based largely on the College’s collaboration with CMS, the Centers for Disease Control and Prevention, and other partners through the Surgical Care Improvement Project (SCIP),9 and include measures to prevent postoperative complications, such as surgical site infection, adverse cardiac events, and postoperative pneumonia. However, while the College has been closely involved in the development of the SCIP criteria, to date these measures have been largely hospital-based. Concerns have been raised within the profession about the application of hospital-based surgical measures to surgeons, who see a more narrow scope of patients. In response, the College and the surgical specialties are working to ensure that any surgical measures, whether implemented in a demonstration project or more broadly, appropriately account for the risk associated with particular patients and particular conditions.

Hospitals: A model for surgical P4P?

Beyond the College’s efforts within SCIP, the HQI approach taken by CMS—and, to a lesser extent, Congress—should serve as a helpful guide for surgery and the physician community as a whole when considering the possibilities of physician P4P—partly because of the considerable interaction that physicians and hospitals have in caring for patients, and partly because of similar political realities that hospitals faced when quality reporting requirements were first linked to their payment under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).10

Over the past year, the course adopted by the HQI, which provided for a collaborative process between CMS and the Hospital Quality Alliance (HQA), is one that CMS and congressional policymakers and physician stakeholders have used as a model for developing a physician P4P program. The HQA is a public/private effort that includes a wide range of organizations and supporters, including the American Hospital Association, the Federation of American Hospitals, the American Medical Association, the Agency for Healthcare Research and Quality (AHRQ), CMS, NQF, the Joint Commission on the Accreditation of Healthcare Organizations, consumer groups, and labor representatives. Through HQA, a starter set of 10 basic quality measures were developed, and under the MMA, those hospitals that report on the starter set measures are guaranteed a full inflationary update for fiscal years 2005, 2006, and 2007; for those same years, those hospitals not reporting data have their payment update reduced by 0.4 percent. In addition, the public is able to compare various hospitals on up to 17 measures via the CMS Hospital Compare Web site (http://www.hospitalcompare.hhs.gov/); similar quality comparison Web sites exist for the nursing home and home health efforts.

Under the HQI, CMS has also been exploring P4P in the hospital setting through the Premier Hospital Quality Incentive Demonstration,11 a three-year study that began in October 2003. It includes 274 hospitals nationwide and studies linking hospital payments with quality measures in the following five clinical areas: (1) acute myocardial infarction, (2) congestive heart failure, (3) coronary artery bypass graft, (4) hip and
knee replacement, and (5) community-acquired pneumonia. Hospitals performing in the top 10 percent for a given diagnosis receive a 2 percent bonus for payments for the measured condition, and hospitals in the second 10 percent receive a 1 percent bonus. In the third year of the demonstration, hospitals not reaching baseline thresholds for performance improvement will have adjusted payments; the baseline will be set by hospitals performing in the ninth and tenth deciles in the first year. Specifically, in year three, hospitals performing below the ninth decile threshold from the first year for a given condition will receive a 1 percent reduction of payments for the diagnosis; those below the tenth decile will receive a 2 percent reduction in payments. Although these established baselines would set penalties for hospitals not meeting these thresholds, CMS and Premier have stated their belief that all participating hospitals will exceed these thresholds and not be financially penalized.\(^{12}\)

In May of this year, CMS and Premier released data regarding hospital quality under the demonstration’s first year, during which the median composite performance scores for all participating hospitals increased by 7.5 percent.\(^{12}\) Although there was improvement in all five clinical areas, the most significant improvements were realized in care provided to heart failure and pneumonia patients. In addition, an initial finding of particular interest that should be no surprise to the surgical community is that a key component to hospital QI is actively engaging the staff physicians in the QI effort. In the case of several measures—for example, the administration of prophylactic antibiotics, which is consistent with SCIP measures supported by the College and circulated by CMS staff for possible inclusion in surgical P4P—the surgeon is ultimately responsible for ensuring that care is delivered to the patient. So long as physician QI efforts remain consistent with the HQI model and the Premier demonstration, surgeons can be encouraged about policymakers’ desire to establish a consultative process, which uses process measures that surgery has helped develop and that most surgeons are already implementing on behalf of their patients.

From a political perspective, there are similarities between the situation facing the physician community today and the one the hospital community was experiencing at the time of the MMA’s enactment. In light of the March 2003 MedPAC Report to the Congress,\(^{13}\) hospitals were recommended to receive less than a full inflationary update for inpatient services in 2004; instead of the full inflationary increase of 3.5 percent, MedPAC recommended that inpatient payments to hospitals increase by 3.1 percent. With Congress prepared to act on MedPAC’s recommendations, the hospital community, in exchange for a full inflationary update, agreed to initial data reporting on quality measures. As mentioned previously, those hospitals not reporting data receive an inflationary update minus 0.4 percent. As in the case of hospitals two years ago, policymakers are again using Medicare payment formulas to enact their QI goals. However, whereas hospitals stood to receive lower payment increases than previously expected, physicians stand to have their Medicare payments actually cut in January 2006. In spite of this notable difference, though, by engaging policymakers now, the physician community is laying a foundation for physician P4P under Medicare that can be based on a consultative partnership between CMS and the physician community, much like the process in place for hospitals. For surgery, this means building on the success of SCIP and applying its lessons to the surgeon as well as the hospital, in addition to building on broader QI efforts such as the College’s leadership in the National Surgical Quality Improvement Program (NSQIP).\(^{14}\)

**Physician P4P efforts under way**

Beyond hospital P4P efforts, it is also important for surgery to look at other efforts to link payment to quality of physician services that are already under way. In 2004, CMS launched the Physician Focused Quality Initiative. Under the initiative, initial efforts to establish payment incentives for improved quality have included multiple demonstration projects, such as the following:

- **Doctor’s Office Quality (DOQ) Project:** DOQ is a one-year demonstration administered by Medicare quality improvement organizations (QIOs) in Iowa, California, and New York; DOQ includes clinical measures on chronic disease and preventive care services and an evaluation survey of patient experiences.

- **DOQ Information Technology (IT):** DOQ-IT
is a two-year demonstration led by the California QIO, Lumetra, which will include up to five states and is designed to promote the use of electronic health records in small- to medium-sized physicians’ offices in the delivery of the chronic care and preventive services measured by DOQ.

- **VistA—office electronic health records:** CMS is working with the Veterans Health Administration (VHA) to configure VistA, the VHA’s electronic health records technology, to promote adoption of this program in private physician office settings across the U.S. Among its applications, VistA’s technology will assist in disease management and in interfacing practice management and billing systems.

- **Medicare Physician Group Practice Demonstration:** This three-year demonstration includes 10 large group physician practices and evaluates them on the care management they provide to chronically ill, high-risk Medicare beneficiaries by measuring the effectiveness of the disease management and preventive services they provide. Payment awards to practices will be based on their success in improving quality and avoiding high-cost complications.

- **Medicare Care Management Performance Demonstration:** This three-year demonstration, which is limited to four sites, promotes the use of IT by physicians in managing the care of chronically ill patients. Those physicians meeting certain standards for quality improvement set by CMS will be eligible for bonus payments. The demonstration must be budget neutral.

In addition to these efforts, which were highlighted in the September *Bulletin*, the Ambulatory Care Quality Alliance (AQA) released a proposed starter set of 26 measures for use in the primary care setting earlier this year.

Surgery’s efforts have not gone unnoticed by CMS and the College receives frequent mention by CMS leaders, such as Mark McClellan, MD, PhD, CMS Administrator, and Herb Kuhn, Director of the Center for Medicare Management, when discussing the success of SCIP. In addition, as mentioned previously, surgery, along with a wider range of specialties, appears to be likely to be included in some type of CMS-led P4P effort in the near future. Even though CMS’ authority to implement measures to link payment to quality for all physician payments under Medicare is questionable, the agency, under Section 646 of the MMA, was mandated to establish a five-year, budget-neutral demonstration program to examine factors that lead to QI in patient care. From recent conversations with CMS staff, barring congressional action, the most likely scenario would be a demonstration project under Section 646 for a broad range of physician services, including surgery. Although the details of any such effort remain to be determined, it is likely that any demonstration for surgery would bear similarities to some of the examples highlighted, in which payments are linked to particular processes and best practices, improved quality outcomes, and actual savings to the Medicare program.

**Surgery’s leadership in QI**

As the prospect of linking payment to quality for physician services moves increasingly closer to reality, surgery must determine what role it will play. Although the clearly defined efforts of CMS have focused on QI in primary care, the College has arguably been a pioneer in the QI effort, essentially setting the stage for surgical P4P through its efforts with SCIP and NSQIP. Likewise, health policy leaders in Congress are preparing to expand CMS authority so that commitment might be realized.

In addition to the partnership at SCIP and NSQIP, the College, along with the surgical specialties, continues to be an active participant in the Physician Consortium for Performance Improvement, which has served a vital role in the review and approval of evidence-based quality measures that recognize the best clinical practices across physician services. In the near future, the consortium is expected to complete its work on measures for perioperative cardiac risk assessment. As Congress and CMS consider how to pay for quality, the College will continue its history of commitment to QI through its collaborations with the physician community, CMS, VHA, and quality organizations, such as AHRQ and NQF, and through its internal efforts in the Division of Research and Optimal Care. Through these ongoing efforts, and through the Division of Advocacy and Health Policy, the College is working to ensure that any quality measures for surgery are based on such efforts and are linked.
to better outcomes for patients.

While paying for quality performance may be a relatively new concept to Medicare, for more than 90 years the College and its Fellows have set the standard for quality outcomes and improvement in surgery. Since the College’s founding in 1913, its chief mission has been to ensure the highest quality in surgical care for patients. Practically, this mission has been most noticeably realized in the educational, professional, and ethical standards associated with College Fellowship. Consistent with the requirements of Fellowship, the College has also realized that promoting the highest-quality surgical care means educating Fellows about advances in practice and technology that stand to improve the quality of surgical outcomes for patients. In linking reimbursement to quality, policymakers’ success or failure will ultimately be determined by their ability to align payments with such advances rather than hindering them. While we proceed cautiously, the College sees hope in paying for quality—hope for better outcomes for patients and hope for the recognition that Fellows deserve.

References


Surgeon chronicles Native American history

by Karen Sandrick, Chicago, IL
Wisps of fog swirled outside the mission to the Cayuse Indians at Wailatpu in Walla Walla Valley, WA, muffling the sounds of indigenous wildlife on the morning of November 29, 1847. But the stillness amplified the cacophony of violence within: the harsh bursts of angry accusations, the thwack of a tomahawk on the skull, and then the rapid retorts of gunfire as five Cayuse Indians, led by Tilaukait and Tomahas, killed 14 of the local mission’s 72 residents, including physician and Presbyterian elder Marcus Whitman and his wife, Narcissa.1,2

Vagabonding from tribal area to tribal area for the next three years, hardly welcome even in Cayuse or Nez Perce Indian communities while white settlers clamored for retribution, the band of five finally surrendered to Oregon Territory authorities in April 1850. Indicted on May 21, 1850, these Cayuse Indians went to trial for murder under the first Oregon Territory justice, Orville C. Pratt. After listening to testimony from several women who saw the five kill the Whitmans and other missionaries as well as a Cayuse Indian named Stickus and a white missionary to the Nez Perce tribe who had warned the Whitmans about the murder plot, the jury on May 24 returned a verdict of guilty, and the five Cayuse were sentenced to death, hanged on June 3, 1850, and buried in the Oregon Territory.3

But as retired general surgeon Robert H. Ruby, MD, FACS, Moses Lake, WA, argued in a 2004 letter to Sens. Ron Wyden (D-OR), Maria Cantwell (D-WA), and Rep. Doc Hastings (R-WA), the attack was not a rampant crime spree but the first salvo in a two-year war between the Cayuse nation and American troops that ended with the loss of independence of the Cayuse people.2 The five Cayuse were not wanton murderers but victims of terrorism fomented by what Dr. Ruby calls mixed-blood bullies who claimed white settlers were insurgents, usurping the ownership and farming of Cayuse land, and that Dr. Whitman was spreading poison, not medicine, to the Cayuse from bottles containing measles.

This is one of many stories chronicled by Dr. Ruby since he began writing histories of American Indians in 1955. His first book, The Oglala Sioux, Warriors in Transition, was written while he was chief of the department of surgery at the hospital on the Pine Ridge Reservation in South Dakota. After serving as a member of the Army Air Corps during the occupation of Japan in the late 1940s, Dr. Ruby completed a fellowship in cancer surgery at the Sugarbaker Cancer Clinic in Jefferson City, MO, a year of postgraduate work at the Washington University School of Medicine in St. Louis, MO, and a four-year residency in pathology and surgery at the St. Louis County Hospital.

**How Dr. Ruby began his second career**

In July 1953, Dr. Ruby joined the U.S. Public Health Service (PHS) and was assigned to the Indian Service. Reigniting a boyhood interest in the lifestyle and lore of Native Americans, Dr. Ruby befriended members of the Sioux, attended their traditional ceremonies of worship,
witnessed their rituals, and became one of the first authors to report on the use of peyote by American Indians.

After completing his service in the PHS, Dr. Ruby and his wife, Lelia Jeanne Henderson, moved to Moses Lake, WA, a semi-arid basin that had recently been transformed into a fertile agricultural area through irrigation. Dr. Ruby set up a private practice in general surgery, which concentrated on orthopaedics and abdominal surgery, and continued his research into the past and present lives of Native Americans, beginning a more than 40-year collaboration with John A. Brown, former professor of history at Wenatchee Valley College, Wenatchee, WA.

Independently scavenging depositories in state and university libraries and ordering documents about the same topic—Chief Moses of the Salish Tribe, who refused to lead 200 warriors onto the Yakima Reservation in 1878—Dr. Ruby and Mr. Brown were brought together by a librarian in Olympia, WA, in 1958. Until Mr. Brown’s illness in 2003 and subsequent death in 2004, theirs “was a perfect cooperative arrangement,” says Dr. Ruby. “What I couldn’t do, he did; what he couldn’t do, I did. We meshed. That is the reason we produced so much.” The two authored 13 books on the American Indians of the Pacific Northwest, contributed to biographical sketches of North American Indians, and wrote more than two dozen articles and book reviews on Native Americans for academic journals.

Their hunt for primary sources of information about Native American history took Dr. Ruby and Mr. Brown to depositories along the West Coast—at the University of Washington, Washington State University, and in British Columbia, which was part of Indian tribal lands until the northwestern lines of the U.S. were drawn—as well as to sailors’ and fur traders’ logs in libraries on the East Coast. Dr. Ruby explained that before white settlers established communities in the Pacific Northwest, visitors to the area arrived by sea. “Sailors who came from Britain and the eastern U.S. had to travel around the end of South America and come up to the West Coast, and the sailors and traders who bought furs from the American Indians kept journals and diaries,” he says.

Pioneers who later journeyed to the Pacific Northwest on the Oregon Trail wrote letters about their encounters with Native Americans. Newspapers recorded major events—treaties with the tribes of the Oregon coast; wars and skirmishes between and within tribes; and laws that banned the Indian languages, tribal organizations, religions, and family life. Government documents traced the transfer of Indian lands to white settlers, the consolidation of tribes, and the formation of tribal reservations for the Colville, Spokane, and Yakima tribes in Washington; the Umatilla and Siletz in Oregon; the Coeur d’Alene
and Nez Perce in Idaho; and the Salish and Kootenai in Montana. The authors also consulted other sources of information, such as letters from pioneers who later journeyed to the Pacific Northwest on the Oregon Trail and wrote about their encounters with Native Americans.

Working before photocopy machines were widely available in libraries, Dr. Ruby and Mr. Brown transcribed entries from different sets of original source documents, copied them, and placed them in duplicate three-ring notebooks so they could confer with one another, by letter, across the 90 miles that separated them, about the meaning of individual facts within an overall historical context. On average, the historians created 20 to 30 three-ring notebooks for each of their books.

**The authors’ style**

The authors’ attention to the details of Indian life and lore placed them on the cutting edge of scholarship in studies of Pacific Northwest American Indians, observes William L. Lang, professor of history at Portland State University. According to Professor Lang, the first edition of the book *The Cayuse Indians* came at a time of renewed interest in the histories of Native American tribes in the region and a wish to present these histories in a fresh light “by putting American Indian interests at the center of the narrative.” The book, therefore, dwells on the most contentious and critical events of the past: the murders of Marcus and Narcissa Whitman, the ensuing war, and the Walla Walla Treaty Council of 1855, which resulted in opening the
Pacific Northwest to white settlers and driving the Indian tribes of the Columbia Plateau off most of their land.  

Despite their exhaustive research of primary and secondary unpublished documents, as well as interviews with Native American elders, Dr. Ruby and Mr. Brown added vibrancy and depth to their storytelling. In one book, for example, they juxtaposed descriptions of the geological formation of the Spokane River with tales of Spokane Indian mythology, which trace the creation of the riverbed to a dragon that dragged trees and rocks from the mouth of the Columbia River to Lake Coeur d’Alene. In another, they explained that the Flathead, or Salish, Tribe did not get its name because their ancestors flattened their heads. The authors related other explanations for the name: sign language identified the tribe by pressing hands to the sides of the head. “Salish” means “we the people,” which is designated by striking the head with the flat of the hand. The Flatheads did not flatten their heads, but left them in a normal configuration, flat on top rather than forcing them to slope toward the crown. The tribes that did flatten their heads included the Chinook, who lived along the coast of Oregon, Washington State, and British Columbia.

The objective of the authors was to reach the average reader. “Few academic books about American Indians have been written for the general public. Anthropologists and archaeologists have done extensive studies and published work in journals, but the average person doesn’t read those things. And a lot of what the academic people write doesn’t read like a good story,” Dr. Ruby says. But

Savoie Lottinville, the director of the University of Oklahoma Press in the 1960s, wanted to publish well-researched and well-documented books that were nonetheless good reads, and the style of Ruby’s and Brown’s books fit this vision.

Dr. Ruby and Mr. Brown, and their books, have been widely praised. Dr. Ruby has received literary awards, including the Northwest Author Award, Pacific Northwest Booksellers Award, and
the Eastern Washington State Historical Society Distinguished Author of History Award, as well as recognition for his contributions to history from the Washington State Historical Society and the Center for Columbia River History, and he was named Soo Huk Min (Caretaker of Tribal History) by the Okanogan Tribe in 2003.

**Authorship leads to more**

Dr. Ruby also served as cultural advisor for the award-winning Hallmark Entertainment Presentation, *Dreamkeeper*, a 2003 made-for-television film that traced the spiritual journey of 17-year-old street-gang member, Shane Chasing Horse, as he learned the tradition of storytelling and the legends of the Pine Ridge Sioux from his grandfather, Old Pete Chasing Horse (see photo, page 17). “The filmmakers wanted the film to be as correct as possible, so they came to me asking about the costumes, the tools, the types of housing of the American Indians,” Dr. Ruby recalls.

His explorations of Indian history have brought Dr. Ruby in contact with many prominent and notorious present-day Native Americans. When he and Mr. Brown were writing *Dream Prophets of the Columbia Plateau: Smohalla and Skolaskin* (University of Oklahoma Press, 1989 and 2002), Dr. Ruby interviewed Crow Dog, author of a book about Wounded Knee and spiritual advisor on the Rosebud Reservation in South Dakota (see photo, page 14). He met with attorney and defender of Indian activists William Kunstler, lead counsel for Yvonne Wanrow, who had shot and killed a man who molested her child in 1976; Vernon Bellacourt, a member of the Ojibway tribe and one of the founders of the American Indian Movement in 1976 (see photos, page 18); and David Sohappy, upon his release from jail for committing a fishing violation in 1988.

Dr. Ruby’s work with American Indians continues today. Just last year he finished updating *The Cayuse Indians: Imperial Tribesmen of Old Oregon*. He regularly visits and consults with elders from the Umatilla Tribe from northeastern Oregon about their history. He is lecturing widely about the five Cayuse Indians from the Whitman Massacre and hopes the U.S. Congress will take the same path as the Washington State Supreme Court, which in 2004 exonerated Chief Leschi of the Nisqually Tribe because he was acting in a time of war when he killed a militiaman in 1858. “The U.S. Congress was the Supreme Court of the Territory, so it has the jurisdiction to exonerate the Cayuse,” Dr. Ruby explains.

If Congress acts on this idea, Dr. Ruby will not only be a recorder of history—he will have played a part in changing it.

**References**


Karen Sandrick is a freelance writer in Chicago, IL.
MEDICAL LIABILITY REFORM AND STATE LAW: West Virginia

by Daniel Foster, MD, FACS.
Charleston, WV
Many people believe that the movement toward reform of the medical liability system has stalled somewhat at the state and federal levels. There seems to be an aura of pessimism, which could be the result of the extremely partisan nature of the discussion, the fact that insurance premiums appear to have peaked, or just a feeling of lethargy because of the lack of progress in Washington and certain state capitals.

Despite the frustrations of many surgeons and other health care providers, there are bright spots around the country. The purpose of this article is to provide specifics from the experience of one such state. Perhaps these details may provide strategic guidance to others and create some optimism that medical liability reform is not a hopeless cause.

The need for reform in West Virginia

In 2001, West Virginia, like much of the rest of the country, was in the midst of a medical liability crisis. Rates had risen considerably over the previous two years and affordability was clearly an issue, but as insurers left or considered leaving the state, availability was also becoming a problem. Responding to the previous liability crisis of the mid-1980s, a $1 million cap on noneconomic losses was signed into law, and rates rose only modestly until early 1999. Although these minimal reforms were certainly helpful, far more important to rate control were that the insurance market was soft and that competition was increased by new companies entering the market in West Virginia.

Whether attempts by the insurers to secure market share during this time kept rates artificially low can’t be said with certainty, but when premiums started to increase by 30 to 40 percent a year in 1999, physicians became sensitized. Contributing to the woes, a major carrier went out of business, leaving many physicians without adequate protection. Because of the turmoil within the medical community, a special session of the state legislature was convened in the fall of 2001. The constituencies supporting liability reform were poorly organized but still were able to exert enough pressure for some modest reforms in S.B. 601.

The blueprint for reform

The primary objectives of this legislation were the elimination of suits by plaintiffs’ lawyers against insurance companies that refuse to settle in medical liability cases, an increase in the size of the jury from six to 12, requirement of a document from the court certifying that a case has a minimum level of merit before it could proceed, and permission granted to physicians who wanted and needed coverage to purchase liability insurance from the state Board of Insurance and Risk Management. Availability of insurance was no longer an issue, but affordability was still a major concern.

Over the next few months, liability rates continued to increase and there remained considerable unrest in the physician community. Moreover, there were rumblings that other private insurers might leave the state. Despite these concerns, Gov. Bob Wise (D) continued to say that before considering additional liability legislation, he wanted to see what effect S.B. 601 would have.

As spring moved into summer in 2002, pressure for further action was building. During the statewide primary election in May, several physicians ran for the state legislature, and many of them were successful. There was also a growing public concern about the loss of physicians practicing in West Virginia and the difficulty of recruiting others. This concern reached a climax in August, when, with the loss of two orthopaedic surgeons (one to relocation and the other to a change in practice situation), the orthopaedic call schedule at the Level I trauma center at Charleston Area Medical Center remained unfilled and the designation was downgraded to Level III. This situation caught the attention of public policymakers as it had in a similar situation in Nevada several months earlier. This series of events provided the final element of the crisis: the threat to access to quality care. Governor Wise, a lawyer who had been heavily supported by plaintiff attorneys in the 2000 election, became much more engaged almost overnight and responded to the widespread public outcry. Members of his administration were immediately called upon to find a solution. Within a few weeks, a formal agreement was reached, whereby those private physicians providing direct trauma care would receive some of their liability coverage from the original state program for
state employees and university physicians. With the governor’s quick action, the trauma center’s Level I designation was restored.

When the governor realized the true severity of the problem, he concluded that something more dramatic in the way of legislation would be demanded by the public. Added emphasis was given to this realization in November, as two physicians were elected to the House of Delegates, a rare occurrence in West Virginia. Just as importantly, several high-profile trial lawyers were defeated in legislature reelection bids. In the aftermath of the election, the Speaker of the House, a strong supporter of tort reform, reviewed legislative strategy regarding the issue and the governor’s inner circle began working on new substantive legislation in preparation for the beginning of the regular session in January 2003.

A sense of optimism about impending tort reform was palpable. This was enhanced by the increasingly aggressive and well-organized activities of a large group of health and business entities that collectively educated the public on the likely risks to the future of health care in West Virginia if there were no action on the issue.

Passage of Reform
With positive dynamics clearly falling into place, an additional event occurred just before the beginning of the session in early January: because the liability climate was considered particularly onerous in Wheeling, there was a brief work stoppage by surgeons from that area. There was risk associated with this action, but, in retrospect, it unquestionably had an effect on the governor’s “state of the state” address later that week. Somewhat unexpectedly, a tort reform proposal that went far beyond what had been previously considered was included. That night, there was a sense of exhilaration within the medical community and other patient interest groups, but this was just the beginning.

The governor’s bill included a variety of measures, including a flexible cap on noneconomic damages of $350,000; allowance of collateral source information in the courtroom; enhancement of the joint and several provision; a total trauma and emergency cap of $500,000; and state government capitalization of a new physicians’ mutual insurance company. Seemingly in collaboration with the governor, the Speaker of the House had carefully made several new appointments to the House Judiciary Committee, where such legislation had died in past years. On the first Monday of the regular session, the Speaker’s bill, H.B. 2122, was placed on the agenda for the House Judiciary. This bill was similar to that proposed by the governor, but it went further in some respects, most conspicuously by proposing a more rigid cap of $250,000 for noneconomic damages. After a debate of approximately nine hours and with few changes, H.B. 2122 was reported out of committee and three days later it passed the House by a large margin.

The situation in the state senate was a bit more complicated, but with the assistance of the new chairman of the Senate Judiciary Committee, a trial lawyer with a balanced approach, the process was much smoother than anticipated. The only substantive modification was refinement of the concept of the Patient Injury Compensation Fund, which was to be created to deal with situations in which the trauma cap and the joint and several liability changes could leave a victim with uncompensated economic damages. After some additional tweaks to the bill in committee, it was given to the full senate, where the vote was 33-1 in favor.

To pass legislation that was considered by many experts to be the most comprehensive state effort in medical liability reform in more than 25 years since MICRA (Medical Injury Compensation Reform Act) in California was unbelievable, considering the possibilities only a year before. When the governor signed the bill a few weeks later, it was truly a celebration, with a massive turnout of business leaders, health care providers, and grateful patients.

Although premiums did not immediately decrease, the rate of increase certainly slowed in comparison to other states. Within a few months, optimism was prevalent among all interested parties. Fewer physicians were leaving the state and recruiting efforts were much more successful even in the high-risk specialties, enhancing access to quality care in West Virginia. Less than a year after the effective date of the new legislation, there were credible data showing a decreased frequency and intensity of medical liability lawsuits. In fact, the total number of lawsuits and
the dollar amount of judgments and settlements had dropped to less than 50 percent of their previous levels. This dynamic did not change over the subsequent year.

There still remained concern on the part of the liability insurance underwriters that there might be a successful court challenge that could overturn the hard-fought reforms. Since then, two early challenges to these reforms ended in decisions favorable for physicians and their patients. Even more importantly, a new, more conservative Supreme Court justice was elected in November 2004, defeating a sitting judge who was perceived as more accommodating to the trial lawyer lobby. Then two additional bills—“I’m Sorry” and “Innocent Prescriber”—passed during the 2005 regular session. Taken together, these events calmed the insurers, and it became a virtual certainty that there would be a substantial decrease in liability premiums.

**WHAT CAN BE LEARNED FROM WEST VIRGINIA?**

Comprehensive tort reform at the federal level, which most physicians agree is the ideal solution, appears to be out of reach in the short term. With tort reform at the state level currently receiving most attention, one could ask if there are any lessons to be learned from the tort reform experience in West Virginia. At the risk of overgeneralization, I believe there is much food for thought in the West Virginia story. There is little doubt that persistence is a virtue in these complex political altercations. Losing a battle should not create a culture of despair but rather a commitment to better understand the process and to play the game more cleverly.

Forming a broad-based coalition that includes the medical and public health communities, businesses, senior citizen groups, and even labor organizations can pay great dividends. Brute force and self-righteousness rarely work in these circles and that is why civility and empathy should be among the guiding principles for anyone joining the fight for liability reform. Medical liability reform is not a partisan issue—it is not about Republicans versus Democrats, physicians versus lawyers, or even about who is hurt financially and who isn’t. It is about access to high-quality health care for all our citizens, whether they live in cities or rural communities. This idea needs to be emphasized constantly while other, more self-serving, approaches should be downplayed or eliminated.

The leaders of all the West Virginia organizations supporting medical liability reform showed remarkable commitment to the strategy outlined here. It wasn’t easy and it wasn’t always pretty, but the result was more than satisfactory. Despite health care and civil justice systems that still have imperfections, the state and its people can now move forward to a much more stable playing field than they had just a few years ago. More importantly, for physicians, compared with many other states, West Virginia just may be, as the John Denver song claims, “almost heaven.”

This article was generated through the efforts of the ACS Committee on Patient Safety and Professional Liability. Members of the committee believe that this and other articles published in the Bulletin should stimulate thought and possible action on a wider spectrum of issues related to patient safety and professional liability.

**Dr. Foster** is a West Virginia state senator; physician state senator for the Charleston Area Medical Center; Charleston; clinical professor of surgery, West Virginia School of Medicine, Charleston Division; and a member of the ACS Committee on Patient Safety and Professional Liability.
Statement on blunt suture needles

Cuts or needlestick injuries occur in 1 percent to 15 percent of operations. The most common cause of suture needle injury is suturing fascia, during which 59 percent of all suture needle injuries occur.

Blunt suture needles permit suturing of fascia and other structures with minimal risk of injuring the team, even when the glove is punctured. All published studies to date have demonstrated that the use of blunt suture needles can substantially reduce or eliminate needlestick injuries from surgical needles.

The ACS supports the universal adoption of blunt suture needles as the first choice for fascial suturing to minimize or eliminate needlestick injuries from surgical needles. Blunt suture needles should be available in various sizes and with a range of sutures adequate for different surgical applications.

The ACS encourages further investigation of blunt suture needles for use in other surgical applications.
In compliance...

with HIPAA’s NPI provisions—Part II

by the Division of Advocacy and Health Policy

In June, this column presented a general overview of the National Provider Identifier (NPI) provisions in the Health Insurance Portability and Accountability Act (HIPAA).

This month, this column provides more detailed information about the NPI.

To briefly summarize, the major provisions related to the NPI in HIPAA are as follows:

- The Centers for Medicare & Medicaid Services (CMS) is responsible for assigning the NPI.
- The existing numbers used by each payor to identify physicians and other health care providers will be done away with sometime between now and May 23, 2007. (Small health plans have an additional year to convert to the new numbers.)
- Generally, the surgeon is responsible for applying for a NPI but large practices may submit an electronic file of bulk applications.
- You must have a NPI and your system must be able to handle it before the first payor you deal with requires one.

Overview of NPIs

All individuals and organizations that bill for their services electronically must obtain and use a NPI. Hence, physicians, advanced practice nurses, physical therapists, hospitals, nursing homes, ambulance companies, durable medical equipment suppliers, and other health care providers must have a NPI. Obviously, the NPI will be used to identify the provider who performs a service on an electronic claim or other electronic transaction. It will also be used on an electronic claim for a service ordered by a physician. For example, Medicare will require a clinical laboratory to show the referring physician’s NPI on the claim for a laboratory service instead of the existing, or “legacy,” number now required.

Once issued, the NPI will not change and remains with the provider regardless of job or location changes. A NPI is never reissued to another provider. The application for and issuance of a NPI does not replace the enrollment process with health plans; enrolling with health plans authorizes the person or entity to bill and be paid for services.

Applying

According to CMS, health care providers should apply for their NPI as soon as possible and definitely before the date on which their first payor requires the NPI. CMS believes early issuance of the NPI will facilitate the testing and transition processes and will decrease the possibility of any interruption in claims payment.

Physicians may apply for a NPI in one of three ways:

• A Web-based application process is available at https://nppes.cms.hhs.gov. That is the Web address of Fox Systems, Inc., the enumerator under contract to CMS to handle issuance of NPIs and all inquiries about NPIs from providers.

• A paper application is available at https://nppes.cms.hhs.gov or by calling 800/465-3203.

Around the corner

November

Economedix will hold three teleconferences this month. The first, on November 2, is “E&M Coding...Beyond the Basics.” The second, on November 16, is “CPT Coding and 2006 Updates for Surgeons.” The third, on November 30, is “Building a Bottom-Line Budget for 2006.” For more information and to register, go to http://yourmedpractice.com/ACS.

December

Economedix will hold a teleconference December 14 on Billing Compliance: Avoiding Fraud and Abuse. For more information and to register, go to http://yourmedpractice.com/ACS.
Individuals with hearing impairments may call 800/692-2326 for TTY service. The enumerator’s mailing address will be supplied with the paper application.

- With the physician’s permission, an organization, such as an employer, will be able to submit an application on behalf of a physician via an electronic file interchange. When available later this fall, this option may be attractive to large group practices.

CMS says that it takes about 20 minutes to complete an application. The organization also says that physicians who apply online may get their NPI in minutes, but offer no other information on the time that could elapse between submission of an application and issuance of a NPI.

As noted in the June column, one possible complication for physicians is selecting a specialty. Selecting a specialty requires either consulting a list of codes on the Internet at http://www.wpc-edi.com/codes/taxonomy or writing the specialty (in English) for the enumerator to convert to the proper code. In addition to the specialties that the College recognizes, the enumerator also includes transplant surgery and oral and maxillofacial surgery as specialties. General surgeons are recognized simply as “surgery” and have code 208600000X. The subspecialties of surgery are pediatric, plastic and reconstructive, hand, critical care, oncology, trauma, and vascular surgery.

For several specialties, there is more than one choice of specialty code. For example, hand surgery appears under orthopaedic surgery, plastic surgery, and surgery, each with different code numbers. The entire specialty of plastic surgery appears twice: once as its own specialty and again as a plastic and reconstructive subspecialty of surgery. Subspecialists should remember this overlap if they expect the enumerator to select the specialty code. For example, if you are a hand surgeon and want to be classified under orthopaedic surgery, indicate your specialty as “orthopaedic surgery, hand surgery.”

Surgical practices may also need to register other people, such as advanced practice nurses and physician assistants. Their specialty codes are under the headings of “nursing service providers,” and “physician assistants and advanced practice nursing providers.”

### Medicare implementation

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<thead>
<tr>
<th>Date claim reaches Medicare</th>
<th>Medicare processing</th>
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<tr>
<td>January 3, 2006–October 1, 2006</td>
<td>Medicare systems will accept claims with a NPI, but a legacy Medicare number also must be on the claim. Medicare systems will reject as unprocessable any claim that includes only a NPI. Medicare will send the NPI as primary provider identifier and legacy identifier as secondary identifier in outbound claims, claim status response, and eligibility response electronic transactions.</td>
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<tr>
<td>October 2, 2006–May 22, 2007</td>
<td>Medicare systems will accept claims with a NPI and/or a legacy Medicare number on the claim. However, if there is any issue with the NPI and the Medicare legacy number was not on the claim, it may be denied. Therefore, Medicare strongly recommends continuing to submit the legacy identifier as the secondary identifier. Medicare will send the NPI as primary provider identifier and legacy identifier as secondary identifier in outbound claims, claim status response, remittance advice, and eligibility response electronic transactions.</td>
</tr>
<tr>
<td>May 23, 2007, and after</td>
<td>Medicare systems will accept only the NPI and will not accept any legacy identifiers. This is also the deadline for most health plans although small health plans have an additional year to become NPI-compliant.</td>
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In addition to getting a NPI ...

- Know each insurer’s implementation schedule and plans for the use of legacy numbers.
- Be sure your billing system or service can handle a NPI.
- Share your NPI with those who must identify you on claims.
- Find out how both the performing and referring physician should be identified on paper claims.

NPI implementation schedule

Watch for information on the NPI implementation schedule from your health plans. Health plans should also provide information on whether you need to supply legacy numbers. Keep in mind that each health plan will have its own schedule and rules regarding the use of legacy numbers. Medicare has announced its implementation schedule and plans for legacy numbers (see table, page 26).

In addition to getting a NPI in plenty of time, remember to ensure that your billing system or service can handle a NPI by the time the first payor requires it. In addition, you are responsible for sharing your NPI with any entity that must identify you in a claim or other standard transaction. Hence, surgeons must share their NPI with the same entities that have their legacy identifying numbers. Finally, find out what numbers should be used for the performing physician and the referring physician on paper claims.

It is important to note that HIPAA and its provisions apply only to electronic transactions. Some states require the NPI to be used on paper claims but others are silent on the subject, leaving the decision to the insurers.

Additional information

Many additional sources of information about the NPI are available. The enumerator, of course, has all of the necessary information and is available by telephone or at the Web site. See the telephone numbers and Web address listed on pages 25 and 26. A helpful and electronically sophisticated tool that provides an overview of the NPI and the application process is available at http://www.cms.hhs.gov/medlearn/npi/npiViewer.asp. That site has a copy of the application that is annotated with tips on completing it.

The latest information about the NPI, including frequently asked questions and guidance documents, is available at http://www.cms.hhs.gov/hipaa/hipaa2.

Your Medicare carrier has information and, of course, other insurers should have information, especially when May 27, 2007, approaches. Finally, local collaborative organizations may be working to address NPI implementation issues.
Kathryn D. Anderson installed as 86th ACS President

Kathryn D. Anderson, MD, FACS, FRCS, a pediatric surgeon from San Marino, CA, was installed as the 86th President of the American College of Surgeons during the Convocation ceremonies that preceded the College’s 2005 Clinical Congress in San Francisco, CA. Dr. Anderson is professor emeritus at the Keck School of Medicine, University of Southern California (USC), Los Angeles.

A native of Ashton-under-Lyne, Lancashire, UK, Dr. Anderson is a 1964 graduate of Harvard Medical School, Boston, MA. She completed an internship in pediatrics (1964-1965) at Boston Children’s Hospital, Boston, MA, before serving as a resident (1965-1969) and chief resident (1969-1970) in the department of surgery at Georgetown University Hospital, Washington, DC. From 1970 to 1972, she had a fellowship in pediatric surgery at Children’s National Medical Center in Washington, DC. In 1971, Dr. Anderson became a diplomate of the American Board of Surgery and achieved board certification in pediatric surgery in 1975.

Dr. Anderson spent many years teaching and practicing in the Washington, DC, area. She founded the division of pediatric surgery and served as assistant professor of surgery and pediatrics at Georgetown University from 1972 to 1974. From 1974 to 1992, she held the positions of assistant professor, associate professor, and then professor of surgery and pediatrics at George Washington University, Washington, DC. Dr. Anderson also served as a surgical consultant to the U.S. Army at Walter Reed Army Medical Center in Washington, DC (1976-1992). From 1984 to 1992, she served as an adjunct scientist in the molecular hematology branch of the National Institutes of Health, National Heart, Lung, and Blood Institute in Bethesda, MD, where she also served as a consulting surgeon from 1978 to 1992.

Dr. Anderson then moved to southern California to assume responsibilities as surgeon-in-chief, vice-president of surgery, and head of the division of pediatric surgery, Children’s Hospital Los Angeles. During this time, she served as vice-chair in the department of surgery and professor of surgery at the USC. Since 2004, she has been professor emeritus, Keck School of Medicine, USC.


In addition to her service to the College, Dr. Anderson has held many leadership positions in organized surgery. She has served as chair of the American Academy of Pediatrics Surgical Section (1985-1986), president of the American Pediatric Surgical Association (1999-2000), and
second vice-president of the American Surgical Association (2004-2005). Dr. Anderson has also served as both a guest examiner and a senior board examiner (pediatric surgery certification) for the American Board of Surgery and as a site visitor for the Residency Review Committee for Pediatric Surgery. She is also a member of many surgical organizations, including the Royal College of Surgeons of England, the Society of University Surgeons, and the Association of Women Surgeons.

Dr. Anderson has shown a strong commitment to the dissemination of surgical knowledge, having served as associate editor of both the Journal of the American College of Surgeons and Journal of Pediatric Surgery and as a member of the editorial boards of the Journal of the American College of Surgeons, Journal of Pediatric Surgery, Pediatric Surgery International, the Annals of Surgical Oncology, Practice of Surgery, and Journal of Women’s Health.

Dr. Anderson has devoted a major part of her career to surgical research. She has studied esophageal replacement in infants and children, surgical implantation of gene-engineered hepatocytes, and transplantation of vascular grafts.

In addition, Dr. Anderson has served as a visiting professor at hospitals and universities and lecturer at medical meetings around the world. She has been a lecturer at the Lucile Salter Packard Children’s Hospital, Children’s Hospital-Denver, the Royal Australian College of Surgeons, the Royal College of Surgeons of Canada, St. Jude Children’s Research Hospital, Mt. Sinai Medical Center, and the Children’s Hospital of Halifax, NS. In 2003, the National Library of Medicine held an exhibition, “Women Pioneers in Medicine,” in which Dr. Anderson was featured.

Dr. Anderson currently resides in San Marino, CA.

Donald D. Trunkey receives Distinguished Service Award

Donald D. Trunkey, MD, FACS, a general surgeon from Portland, OR, received the 2005 Distinguished Service Award, the highest honor of the American College of Surgeons, during the Clinical Congress last month in San Francisco, CA.

The Board of Regents presented Dr. Trunkey with this award in recognition of his dedicated service as a Fellow of the College, his service on College committees, his commitment and unselfish dedication to the surgical profession, and his distinctive service to the surgical community through membership and participation in numerous surgical and trauma societies on the local, state, regional, and international levels. Dr. Trunkey was also commended for service to his patients, community, state, and country that he has provided throughout his surgical career.

A nationally recognized expert on trauma care, Dr. Trunkey presently serves as professor, department of surgery, Oregon Health and Science University, Portland. Dr. Trunkey received his medical degree from the University of Washington in 1963 and then performed a rotating internship.
with J. Englebert Dunphy, MD, FACS, at the University of Oregon Medical School, Portland (1963-1964). After completing his internship, he spent two years in the U.S. Army as a general medical officer and was stationed in Germany.

Dr. Trunkey returned to the U.S. for his general surgery residency, which he completed at the University of California Hospitals, San Francisco (UCSF), from 1966 to 1970, where he also served as chief resident from 1970 to 1971. During his residency training, Dr. Trunkey concurrently served as a researcher in the Organ Preservation Lab at the UCSF on a postdoctoral research training grant (1968-1969). From 1971 to 1972, he completed a fellowship with the National Institutes of Health in the trauma unit at the University of Texas Southwestern Medical School, Dallas. During that time, he also served as an assistant research professor of surgery at the medical school.

After he returned to the UCSF department of surgery in 1972, Dr. Trunkey held the positions of assistant professor (1972-1976), director of surgery (1973-1976), associate professor (1976-1978), vice-chairman (1978-1986), and professor of surgery (1979-1986), until his departure in 1986. During his tenure at UCSF, Dr. Trunkey also served as chief of surgery at San Francisco General Hospital from 1978 to 1986. He returned to Oregon Health Sciences University in 1986, to serve as professor and, until 2001, chair of the department of surgery.

In 1985, Dr. Trunkey rejoined the Army Reserves and served during Operation Desert Storm in 1991.

A Fellow since 1974, Dr. Trunkey has made outstanding contributions on behalf of and to the College. He served as a member of the Long Range Planning Committee of the Board of Regents (1978-1981); as a member (1972-1982) and chair (1979-1982) of the Northern California Committee on Trauma; a member of the Task Force on Optimal Criteria for Trauma Centers (1977-1982); chair of the National Committee on Trauma (1982-1986); a member of and reviewer for the Committee on Trauma Verification and Consultation Program for Hospitals Committee (1989-1990); a member of the Ad Hoc Legislative Committee on Trauma (1989); a member of the Ad Hoc Nominating Committee of the Committee on Trauma; and a member of the Surgical Education and Self-Assessment Program Committee (1993).

Dr. Trunkey delivered several lectures at past Clinical Congresses: he delivered the Scudder Oration on Trauma at the 1989 Clinical Congress in Atlanta, GA; the Opening Ceremony Lecture in San Francisco in 1993; and the Charles G. Drake Lecture on the History of Surgery in 2004 in New Orleans, LA.

In addition to Dr. Trunkey’s involvement with the College, he has also been an active member and leader of numerous organizations within the surgical and trauma care communities, including the American Surgical Association, Western Surgical Association, Pacific Coast Surgical Association, North Pacific Surgical Association, Society of University Surgeons, American Association for Vascular Surgery, International Society of Surgery, American Association for the Surgery of Trauma, American Burn Association, Association for Academic Surgery, and the Surgical Infection Society. He has also served as a member of the Accreditation Council for Graduate Medical Education Residency Review Committee for Surgery and as a member of the organization’s appeals panel.

Furthermore, Dr. Trunkey has held key leadership positions in a number of societies, including serving as director and vice-chair of the American Board of Surgery, president of the American Association for the Surgery of Trauma, and president of the Society of University Surgeons. He was the recipient of the National Safety Council’s Surgeons’ Award for Service to Safety in 1989.

In recognition of Dr. Trunkey’s continued and dedicated service to and on behalf of the College and the surgical community, the Board of Regents is pleased to present Dr. Trunkey with the College’s highest honor, the 2005 Distinguished Service Award.
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College names three Honorary Fellows

Honorary Fellowship in the American College of Surgeons was awarded to three prominent surgeons from Australia, the United Kingdom, and Italy during Convocation ceremonies at last month’s Clinical Congress in San Francisco, CA. The awards presentation is one of the highlights of the Clinical Congress. The recipients were as follows:

- **Bruce Benjamin, MB, DLO, FRACS, FAAP.** Professor Benjamin is clinical professor of otolaryngology–head and neck surgery at Sydney University, and is a visiting medical officer at Sydney Hospital, Royal Alexandra Hospital for Children, Royal North Shore Hospital, and St. Luke’s Hospital, Sydney, Australia.
- **Prof. Sir Alfred Cuschieri, FRS (Edin), MD, MD (Hon), ChM, FRCS (Edin, Eng), FRCPS (Glas)(Hon), FRCSI (Hon).** Sir Alfred is a professor of surgery at the Institute of Medical Science and Technology at the University of Dundee, Dundee, Scotland, and the Scuola Superiore S’Anna di Studi Universitari, Pisa, Italy.
- **Prof. Sergio Pecorelli.** Professor Pecorelli is chair of the department of obstetrics and gynaecology and professor of gynaecologic oncology at the University of Brescia, Brescia, Italy.

Presenting the Honorary Fellowships on behalf of the College were: Gerald B. Healy, MD, FACS, Boston, MA; Frederick L. Greene, MD, FACS, Charlotte, NC; and Karl C. Podratz, MD, FACS, Rochester, MN.

During the College’s Convocation ceremonies this year, 1,336 surgeons from around the world were admitted into Fellowship. Sir Rickman Godlee, President of the Royal College of Surgeons (England), was awarded the first Honorary Fellowship in the College during the College’s first Convocation in 1913. Since then, 395 internationally prominent surgeons, including the three chosen this year, have been named Honorary Fellows of the American College of Surgeons.

Citation for Prof. Bruce Neil Benjamin

*by Gerald B. Healy, MD, FACS, Boston, MA*

Mr. President, it is my distinct privilege to present Prof. Bruce Neil Benjamin of Sydney, Australia, to you for Honorary Fellowship in the American College of Surgeons. Professor Benjamin is a son of Australia, but he is a physician, teacher, mentor, and medical ambassador to the world.

Bruce Benjamin was born in Wagga Wagga, New South Wales, and received his medical education at Sydney University. He completed his training in otolaryngology at Sydney Hospital and then began his lifelong dedication to patient care, academic pursuit, and the training of young physicians. This career pathway has been recognized by his professorship at Sydney University, but, more importantly, it has earned him recognition as the premier pediatric otolaryngologist in the world. Professor Benjamin’s contributions and innovations in the diagnosis and treatment of disorders of the pediatric airway are legendary. His early attention to the assessment of surgical outcomes has led to pioneering changes in the treatment of tracheoesophageal fistula, esophageal atresia, la-
ryngeal cleft, and many other congenital and acquired diseases of the upper aerodigestive tract. He was also founding secretary of the Board of Otolaryngological Studies in his native Australia.

Professor Benjamin has personally designed an arsenal of 21st century endoscopic instruments that are utilized in most pediatric operating rooms throughout the world. His seminal contributions have helped countless children everywhere overcome the devastation of acute and chronic airway obstruction. He is also the premier endoscopic photographer in the world, and his atlas and teaching slide collection are used by students and teachers on every continent.

Dr. Benjamin has trained countless registrars and fellows who have brought his innovations to many of the world's medically devastated children. He has been awarded the Order of Australia, the Order of the British Empire, the Chevalier Jackson Award, and countless other honors by more organizations than there is time or space to relate. Perhaps his most cherished recognition is the medal named in his honor given annually by the Australasian Society of Pediatric Otolaryngology.

On a personal note, he is the dedicated father of Gregory and Susanne and a devoted husband to his wife, Nellie. He also can very adeptly defend Australia’s honor on the golf course.

Mr. President, I am deeply honored and immensely proud to present to you and the American College of Surgeons my dear friend, Bruce Neil Benjamin, who has taught the world, and me personally, so much about how to care for and love sick and vulnerable children.

Citation for Prof. Alfred Cuschieri

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

Mr. President, it is both an honor and a privilege to present my friend and colleague, Prof. Sir Alfred Cuschieri, from Dundee, Scotland, and Pisa, Italy, as he receives this prestigious Honorary Fellowship in the American College of Surgeons. For many years, Sir Alfred has been a mentor, teacher, surgical innovator, and consummate scientist role model to the myriad students, house staff, and practicing surgeons who have had the privilege to work with him. His achievements have been recognized worldwide, and his prowess as a teacher and surgeon has culminated in the singular recognition of achieving in 1998 the designation of Knight Bachelor from Her Majesty, Queen Elizabeth II.

Professor Cuschieri began his early training in his home country of Malta, where he graduated from medical school with honors. He traveled to the U.K. in the 1960s to complete his surgical training at the Liverpool Royal Infirmary, where his surgical brilliance started to blossom. Sir Alfred remained on the faculty of the University of Liverpool until he was named professor of surgery and molecular biology at the University of Dundee in Scotland, the institution where his creativity truly flourished. At this juncture of his academic life, he recognized the future importance of endoscopic surgery and was truly the prophet who told of the significance of minimally invasive approaches for the surgical patient. At Ninewells Hospital in Dundee, he created hands-on laboratories where young surgeons could train on simulators and black boxes to
learn the intricacies of hand-eye coordination that would be beneficial in the reality of the operating theater.

For these efforts and for his monumental contributions to the surgical literature, he has been recognized throughout the world by organizations dedicated to endoscopic surgical pursuits and minimally invasive surgery. Through his editorship of both the Journal of the Royal College of Surgeons of Edinburgh and Surgical Endoscopy, Professor Cuschieri has fostered the concepts of surgical science and has been a spokesperson for surgical innovation. He has used his presidencies of both the British Association of Surgical Oncology and the International Hepato Pancreate Biliary Association to promote futuristic approaches for patients with cancer and gastrointestinal surgical illnesses.

We not only honor Professor Cuschieri for his major scientific contributions evidenced through 430 peer-reviewed publications and 19 books on surgical topics, but also pay tribute to him for his honorary memberships in many of the leading surgical societies throughout the world. In addition, we respect him for his visionary pursuits of novel ideas that two decades ago were not even considered. More importantly, we acknowledge him this evening for launching new surgical ideas and for giving us the conceptual building blocks that have enlightened thousands of surgeons and have benefited countless surgical patients throughout the world.

Mr. President, it is my great and special honor to present to you and to the Fellows of the American College of Surgeons a surgical pioneer and innovator who has literally redefined surgical approaches to the abdominal and thoracic cavities and who—through his concepts of surgical technology, robotics, surgical simulation, and training—has given us the tools and the encouragement to seek innovations that were previously unimagined. Mr. President, I present my friend and fellow surgeon, Prof. Sir Alfred Cuschieri, for Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Sergio Pecorelli

by Karl C. Podratz, MD, FACS, Rochester, MN

Mr. President, it is my honor to introduce Prof. Sergio Pecorelli, a pelvic surgeon from Brescia, Italy, for Honorary Fellowship in the American College of Surgeons.

Professor Pecorelli is chair of the department of obstetrics and gynaecology and director of the division of gynaecologic oncology at the University of Brescia. He received his medical degree from the University of Pavia in 1969. Thereafter, he completed a residency in obstetrics and gynecology, a fellowship in surgical oncology, and advanced training in pelvic surgery in the U.S. In addition, he earned a doctoral degree for cogent investigative strategies in gynecologic oncology.

Professor Pecorelli is recognized internationally for his dedication to improving the early detection, diagnosis, and treatment of cancers of the female reproductive tract, the leading cause of death from cancer among women in the world. Particularly noteworthy has been his ability to harness the energies of international communities through participation in clinical trials focused on improving the outcomes for
cancers unique to women. His influential role as the chair of the gynaecologic cancer division within the European Organisation for Research and Treatment of Cancer resulted in demonstrable advances in the management of gynecologic malignancies. Such advances include the multicenter studies pertaining to ovarian cancer, which documented the meritorious role of adjuvant therapy in early disease, the value of cytoreductive surgery in advanced disease, and the benefit of neoadjuvant chemotherapy in facilitating more optimal surgical cytoreduction.

The Minister of Health in Italy has charged Professor Pecorelli with developing a national cancer research program, which includes a government-funded clinical trials program. Professor Pecorelli’s ability to objectively communicate observations gained from his involvement in clinical outcomes assessments has resulted in ongoing requests that he participate in regional and international educational forums, many of which he is asked to direct. His contributions to the gynecologic literature are chronicled in more than 200 peer-reviewed publications. He is a member of numerous editorial boards and edits the Annual Report on Gynecologic Cancer for the International Federation of Gynecology and Obstetrics. He has been an active member of and involved in the administrative activities of multiple organizations and has recently served as president of the International Gynecologic Cancer Society.

Professor Pecorelli is acknowledged globally for his resolve to decrease the loss of life from gynecologic cancers through education and clinical trials. Mr. President, it is a distinct privilege to present my distinguished colleague in gynecologic oncology, Prof. Sergio Pecorelli, to you for Honorary Fellowship in the American College of Surgeons.

Young Surgical Investigators Conference to be held in March 2006

The American College of Surgeons is offering the Eighth Biennial Young Surgical Investigators Conference March 3–5, 2006, at the Bethesda North Marriott Hotel and Conference Center in North Bethesda, MD. The conference is designed to assist surgeon-scientists in obtaining extramural, peer-reviewed grant support for their work and to introduce them to the process, content, style, and people involved in successful grant-writing and interactions with the National Institutes of Health (NIH).

As participants, young surgeon-scientists meet their peers, selected mostly from surgery departments in U.S. and Canadian academic medical centers. The conference provides opportunities to meet and talk with key NIH staff as well as many of the leading surgeon-scientists who have been successful in obtaining NIH grant support for their work and participate in the conference as leaders of various small group meetings and as plenary session speakers.

The program includes intensive exposure to the following:

- NIH programs and policies
- How to apply to the programs most appropriate for the participant’s research
- Workshops in hypothesis testing, methodology, background, and preliminary results
- Grant-writing strategies
- Mock study sections for reviewing model grants

The conference fee is U.S. $1,750 (or $1,575, if registration and payment are received by December 16, 2005). This fee includes all related conference materials, meals, breaks, receptions, and lodging for two nights. The deadline for registration is January 6, 2006.

Information and a registration form are available on the College Web site at www.facs.org/cqi/src/youngsurg.html. Direct questions to mfitzgerald@facs.org, or call 312/202-5319.
Report of the 2005 ACS Traveling Fellowship to Germany

by Joe Hines, MD, Los Angeles, CA

When the American College of Surgeons announced the first Traveling Fellowship to Germany last fall, I was ecstatic. It had always been a goal to participate in a fellowship to another country, and this opportunity was ideal. Over the previous seven years, Howard Reber, MD, FACS, and I had hosted five German surgical residents in our laboratory at the University of California–Los Angeles (UCLA), where each investigated various aspects of pancreatic cancer biology. I established close ties with these colleagues, and we often talked about surgical training and departmental structure in Germany. In addition, I had had the honor to meet their mentors from Germany at various meetings in the U.S. These relationships piqued my interest in German surgery and I was elated to have been given the opportunity to experience this first-hand.

During the two-week fellowship, I visited Munich, Heidelberg, and Berlin. The first week in Munich was spent at the annual Congress of the German Surgical Society (Deutschen Gesellschaft fur Chirurgie). I met my host, Norbert Senninger, MD, FACS, at a traditional German restaurant. While in Munich, I saw some of my former laboratory fellows and met several well-known German surgeons. The Congress talks were instructive, and by the end of the week, I was sure my understanding of the German language had progressed to the point that I was comprehending the content. The German Surgical Society was very nice to ask me to speak on the recent progress in multimodality treatment of pancreatic cancer.

Moritz Wente, a surgery resident and former laboratory fellow, escorted me by train to the next destination: Heidelberg. This city is idyllic, complete with a castle and an old town dating back to the early 1700s. The Heidelberg department of surgery, under the direction of Prof. Marcus Buchler, MD, is a world leader in pancreatic surgery, so I was especially glad to visit this department. While there, I observed the daily morning report and had the opportunity to watch Professors Buchler and Helmut Friess perform a number of pancreatic procedures. The department graciously allowed me to speak about our pancreatic cancer research. Peter Buchler, MD, also a former laboratory fellow and friend, spent much time with me. He and his wife, Manuela, hosted me in their home for a lovely dinner. The visit to Heidelberg was extraordinary, and I hope the association with Professor Buchler, Professor Friess, Moritz Wente, and Peter Buchler will continue and thrive.

The trip then moved to Berlin, where Hubert Hotz, MD, and Heinz Buhr, MD, FACS, served as my hosts. Dr. Buhr, the chair of the department of surgery
at the Benjamin Franklin University, invited me to his home for a great dinner. Berlin is a beautiful and bustling city, and the weather was perfect while I was there. Many members of the department talked about their current research efforts and I especially enjoyed observing a variety of operations, including a Whipple, thyroidectomy, and colectomy. I had the chance to discuss the UCLA experience with pancreaticoduodenectomy and some of our recent research findings. This department is busy and vibrant, and I look forward to continuing my close ties with my friends, Drs. Hotz and Buhr.

German surgeons are a proud and traditional group. The history of surgery is deep in this country—this is where the innovation of many modern surgical procedures and teachings began. Now, the practice of German medicine appears to be evolving with the advent of “fast track” to shorten hospital stay and the use of diagnosis-related groups for reimbursement. At the same time, in the operating room, the strong traditions of sharp dissection and suture ligation continue; it reminds me of the importance of anatomic knowledge and surgical precision.

This travel award allowed me to make new connections with many surgeons as well as strengthen existing connections. After 13,500 miles traveled, four talks delivered, a dozen operations observed, many liters of weissbeer consumed, and many handshakes with new and old friends, I am eternally grateful to the American College of Surgeons and the German Chapter for this opportunity.

Finally, I especially want to thank my sponsors for this fellowship application: Howard Reber, MD, FACS; Fred Eilber, MD, FACS; and Ronald Busuttil, MD, PhD, FACS.

Dr. Hines is associate professor of surgery at UCLA in Los Angeles, CA.
The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at the 92nd Annual Clinical Congress, October 8–12, 2006, in Chicago, IL.

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

**Video-Based Education Session**

Program Coordinator: GayLynn Dykman (gdykman@facs.org).


Submission deadline: February 1, 2006.

Presentation type: Video (acceptable formats: Mini-DV, SVHS, Betacam SP, DVCPRO, DVCAM).

**Papers Session**

Program Coordinator: Molly Clear (mclear@facs.org).

Abstracts are to be submitted online only, via www.facs.org/education/congress/paperssession.html.

Submission deadline: 5:00 pm (CST), March 1, 2006. Late submissions not permitted.

Presentation type: Oral.

**Posters Session**

Program Coordinator: Lisa Richards (lrichards@facs.org).

Abstracts are to be submitted online only, via www.facs.org/clincon2006/sciexhibit.html.

Submission deadline: 5:00 pm (CST), March 1, 2006. Late submissions not permitted.

Presentation type: Poster display.

**Surgical Forum**

For surgical residents and scientific investigators in-training.

Program Coordinator: Kathryn Koenig-Matousek (kkoenig@facs.org).

Abstracts are to be submitted online only, via www.facs.org/sfabstracts/index.html.

Submission deadline: 5:00 pm (CST), March 1, 2006. Late submissions not permitted.

Presentation type: Oral

The Division of Education appreciates your continued support of its programs.
Disciplinary actions taken

The Board of Regents took the following disciplinary actions at their June 11, 2005, meeting:

• An ophthalmic surgeon from Anaheim Hills, CA, was placed on probation following charges that he violated Article VII, Sections 1(b), (f), and (i) of the Bylaws for providing expert witness testimony that was false or misleading.

• Peter M. Schick, a general surgeon from Santa Monica, CA, was suspended from the College after being charged with violation of Article VII, Section 1(b) of the Bylaws. This action was taken following disciplinary action by the California Medical Board for unprofessional conduct and committing dishonest acts. The suspension will remain in effect until this surgeon has a full and unrestricted medical license; full and unrestricted surgical privileges in an accredited hospital; and having his practice pattern reviewed and approved by the Central Judiciary Committee.

• A general surgeon from Scotch Plains, NJ, was admonished after being charged with violation of Article VII, Sections 1(f) and (i) of the Bylaws. This action was taken in response to expert witness testimony that was found to be false or misleading.

• A general surgeon from Wilson, NC, had his full Fellowship privileges reinstated following a period of probation. The probation followed charges that he violated Article VII, Section 1(b) of the Bylaws, when his license to practice medicine in the State of North Carolina was restricted and he was referred to the Physicians Health Program.

This surgeon fulfilled the requirements of having a full and unrestricted medical license; full and unrestricted surgical privileges in an accredited hospital; and having his practice pattern reviewed by the Central Judiciary Committee.
Advances in Trauma seminar to be held in Kansas City

The College’s Committee on Trauma, Region 7 (Iowa, Kansas, Missouri, and Nebraska), is sponsoring the 28th annual Advances in Trauma seminar at the Westin Crown Center in Kansas City, MO, December 9–10, 2005.

The regional and state chairs have planned a program that will benefit all involved in trauma patient care. The objective of this two-day continuing medical education course is to present nationally recognized faculty who will discuss timely trauma and critical care issues aimed at improving care of the acutely injured patient. Current trauma diagnostic and therapeutic techniques will provide the audience with the most up-to-date information available.

The program on Friday will include the following presentations: Optimal Pediatric Resuscitation before Transfer to a Trauma Center; Why Rural Hospitals Should Have ACS Verification; Optimal Trauma Care in a Dysfunctional Health Care System; The Mangled Extremity: State of the Art; The Acute Care Surgeon: A New Model; Prehospital Care for the Trauma Patient: Does It Make a Difference?; Diagnosis and Treatment of Shock: Is ATLS® Right?; The ACS Trauma System Consultation Program; The DaMattasox Code—A Traumatic Mystery; Cavitary Endoscopy in Trauma; Abdominal Compartment Syndrome and the Open Abdomen: Tricks of the Trade; Controversies in Thoracic Trauma; and Cases from Region 7.

The program continues on Saturday with the following presentations: Initial Treatment of the Burn Patient in a Rural Center; Ground, Rotor Wing, or Fixed Wing? Optimal Transfer of the Injured; Errors in the Initial Treatment of the Multi-Trauma Patient; Nonoperative Management of Solid Organ Injuries: State of the Art; The Injured Spleen: Have We Gone Too Far?; Resuscitation from Shock: What Fluids? What Endpoints?; Level I, Level II, Level III: Where Should the Injured Patient Go?; What Have We Learned? From Oklahoma City to the Next Terrorist Attack!; Contemporary Management of Pelvic Fractures; Pitfalls in the Treatment of Injured Geriatric Patients; Bones, Thoracic Injuries: Should They Be Treated Operatively?; The Injured Child: Essentials of Care; and Cases for Region 7: Stump the State Chairs.

Faculty members include the following: L. D. Britt, MD, MPH, FACS; Reginald A. Burton, MD, FACS; Philip R. Caropreso, MD, FACS; Chris Cribari, MD, FACS; Demitrius Demetriades, MD, FACS; David V. Feliciano, MD, FACS; Robert P. Foglia, MD, FACS; Thomas S. Helling, MD, FACS; G. Patrick Kealey, MD, FACS; Anna M. Ledgerwood, MD, FACS; Lee V. Ludwig, MD, FACS; Robert C. Mackersie, MD, FACS; Kenneth L. Mattson, MD, FACS; Frank L. Mitchell, Jr., MD, FACS; Frank L. Mitchell III, MD, FACS; J. David Richardson, MD, FACS; Thomas M. Scalea, MD, FACS; R. Stephen Smith, MD, FACS; Donald D. Trunkey, MD, FACS; and David W. Tuggle, MD, FACS.

For more information, visit the ACS Trauma Committee Web site at: http://www.facs.org/trauma/cme/traumtgs.html.

Trauma meetings calendar

The following continuing medical education courses in trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

• **Advances in Trauma**, December 9–10, Kansas City, MO.
• **Trauma and Critical Care 2006**, March 20–22, Las Vegas, NV.
• **Trauma and Critical Care 2006—Point/Counterpoint XXV**, June 5–7, Williamsburg, VA.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
ACOSOG news: Clinical trials update

**New trials highlight surgical innovations**

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

The American College of Surgeons Oncology Group (ACOSOG) is excited to offer several new trials with advancements in surgical innovations, including cryoablation for primary breast cancer, local excision plus neoadjuvant therapy for early rectal cancer.

Three times a year, we will summarize new concepts, new trials, and ongoing trial activity, both through ACOSOG and the Cancer Trials Support Unit (CTSU).

Future efforts will be directed toward creating dialogue between the American Col-

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**Figure 1—Z1052**

[Diagram of trial process]

*Core biopsy obtained prior to registration may be used.*

**Figure 2—Z4032**

[Diagram of trial process]

*Patients may be offered Z4031 if available at institution.
**For patients with CT scan, PET suggesting N2/N3 involvement.*

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NOVEMBER 2005 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
lege of Surgeons members and ACOSOG on surgical innovations of clinical trial interest.

Further information on other opportunities to participate in clinical trials is also available on the Web sites provided. We encourage you to join the effort of creating tomorrow’s practice through today’s clinical trials.

**New trial concepts**
- Z1052—Cryoablation for Primary Breast Cancer. (See Figure 1, previous page.) A Phase II Trial Evaluating the Efficacy of Pre- and Post-Treatment Imaging to Determine Residual Diseases in Patients with Invasive Breast Carcinoma Undergoing Cryoablation Therapy.
  Primary investigator (PI): Rache Simmons, MD.

**New trials**
- Z4032—Brachytherapy and Sublobar Resection in Non-Small Cell Lung Cancer. (See Figure 2, previous page.) A Randomized Phase III Study of Sublobar Resection versus Sublobar Resection Plus Brachytherapy in High Risk Patients with Non-Small Cell Lung Cancer (NSCLC), 3 cm or Smaller
  PI: Heran Fernando, MD.
  Web posting: July 15, 2005
- Z6041—Local Excision Neoadjuvant Chemoradiation for Early Rectal Cancer. A Phase II Trial of Neoadjuvant Chemoradiation and Local Excision for uT2uN0 Rectal Cancer. (See Figure 3, this page.)

**Figure 3—Z6041**

**Figure 4—Z1031**
<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Protocol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>NSABP B-35*</td>
<td>A clinical trial comparing anastrozole with tamoxifen in postmenopausal patients with ductal carcinoma in situ (DCIS) undergoing lumpectomy with radiation therapy.</td>
</tr>
<tr>
<td>Breast</td>
<td>NSABP B-39*</td>
<td>A randomized phase III study of conventional whole breast irradiation (WBI) versus partial breast irradiation (PBI) for women with stage 0, I, or II breast cancer.</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>Z0360</td>
<td>A trial of lymphatic mapping and sentinel node lymphadenectomy for patients with T1 or T2 clinically N0 oral cavity squamous cell carcinoma.</td>
</tr>
<tr>
<td>RTOG</td>
<td>0234*</td>
<td>A phase II randomized trial of surgery followed by chemoradiotherapy plus C225 (cetuximab) for advanced squamous cell carcinoma of the head and neck.</td>
</tr>
<tr>
<td>GI</td>
<td>Z5031</td>
<td>A phase II study of interferon-based adjuvant chemoradiation in patients with resected pancreatic adenocarcinoma.</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>Z9001</td>
<td>A phase III randomized double-blind study of adjuvant ST1571 versus placebo in patients following the resection of primary gastrointestinal stomal tumor (GIST).</td>
</tr>
<tr>
<td>SWOG</td>
<td>S0344/ Z9041*</td>
<td>A phase II surgical trial of intraleisional resection of low-grade intracompartmental chondrosarcoma of bone.</td>
</tr>
<tr>
<td>SWOG</td>
<td>S0220*</td>
<td>A phase II trial of induction chemoradiotherapy with cisplatin/etoposide followed by surgical resection, followed by docetaxel for non-small cell lung cancer involving the superior sulcus (Pancost tumors).</td>
</tr>
</tbody>
</table>

**PI:** Julio Garcia-Aquilar, MD.  
Web posting: August 15, 2005  
• **Z1031—Neoadjuvant Ani- mates Inhibitors in Breast Can- cer.** (See Figure 4, page 42.) A Randomized Phase III Trial Comparing 16 Weeks of Neoadjuvant Exemestane (25 mg daily), Letrozole (2.5 mg daily) or Anastrozole (1 mg daily) in Postmenopausal Women with Clinical Stage II or III Estro- gen Receptor Positive Breast Cancer

**PI:** Matthew Ellis, MD.  
Web posting: September 15, 2005  
• **Clinical trials Web sites**  
Visit the following Web sites for more information on clinical trials:  
• National Cancer Institute, 800/4-CANCER, [http://www.nci.nih.gov/clinicaltrials](http://www.nci.nih.gov/clinicaltrials)  
• ClinicalTrials.gov (pro- vides updated information on federally and privately sup- ported clinical research), [http://www.clinicaltrials.gov](http://www.clinicaltrials.gov)  
• Coalition of National Cancer Cooperative Groups, 877/520-4457, [http://www.cancertrialshealp.org](http://www.cancertrialshealp.org)  
• EmergingMed.com (a free referral service for clinical tri- als), 877/601-8601, [http://www.emergingmed.com](http://www.emergingmed.com)  
• Association of Cancer Online Resources, [http://www.acor.org](http://www.acor.org)
A-hunting we will go

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

According to the most recent National Survey of Fishing, Hunting, and Wildlife-Associated Recreation by the U.S. Fish and Wildlife Service, 82 million U.S. residents aged 16 and older participated in wildlife-related recreation and spent more than $108 billion enjoying their pastime during one year. Thirteen million hunters donned camouflage while spending more than $20 billion, and each hunted an average of 18 days. Unfortunately, the animals are not the only ones injured in the process. One would expect that, with 13 million armed individuals wandering around the woods and streams of our great land, there would be a significant risk of unintentional injury from a fellow hunter. After all, the only thing separating the game from the hunters is their bright, blaze orange hat and/or vest, which are mandated by law in many states.

In order to examine the occurrence of these injuries in the National Trauma Data Bank™ Annual Report 2004, we used cause of injury codes (E codes) for place of injury E849.4 and E849.8, which relate to injuries occurring at a place for recreation and sport or other specified places (for example, a forest, lake, or mountain) and cross-referenced with E codes for cause of injury E922.1 and E922.2 (shotgun and hunting rifle). Much to our surprise, there were only 485 records. These injuries resulted in an overall mortality rate of 4 percent, an average length of stay of seven days, an intensive care unit length of stay of just more than one day, and average charges close to $31,000. Of those injured while hunting who were tested for drugs, almost one in three tested positive. Roaming the woods with a loaded gun should be a drug-free activity! These data are depicted in the figure on this page.

For drug-impaired hunters, even 400 square inches of blaze orange material may not be sufficient to separate the hunter from the hunted. Limited national statistics are available for hunting injuries but appear to demonstrate that hunting is relatively safe—that is, unless you are the 12-point buck in the sights of the shotgun. The National Safety Council’s annual statistical report on unintentional injury rated hunting with seven injuries per 100,000 participants, whereas football was rated at 2,740 injuries per 100,000 participants. Individuals who participate in this outdoor activity should be encouraged to shoot responsibly and be reminded to wear their blaze orange cap—and “a-hunting we will go.”

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