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Future meetings

Clinical Congress
2005 San Francisco, CA, October 16-20
2006 Chicago, IL, October 8-12
2007 New Orleans, LA, October 7-11

Spring Meeting
2006 Dallas, TX, April 23-26
2007 Las Vegas, NV, April 22-25
2008 To be announced
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2006 ACS German Traveling Fellow selected

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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

As Executive Director of the American College of Surgeons, I like to periodically step back and evaluate what we are or should be doing to support our increasingly diverse membership during these changing times. As I contemplate where the College has been as an organization, where it is now, and where we need to go, I am pleased to say that I believe we are making good progress toward reaching our goals.

Many of you have shared with me your view that the competence and quality movements are placing new demands on surgeons to not only provide excellent patient care but to prove that they are doing so. As a professional organization, the College must help its members to gather and report their practice information in a timely and efficient manner. We also need to provide a full range of educational programs and more opportunities for surgeons to voice their concerns to the government and other entities that have the power to determine how we practice medicine and how we are paid.

New technology

The ongoing explosion in computer technology continues to make it possible for us to set up systems that will allow the College to become a major resource for tracking and reporting outcomes data. This information is required by the agencies, hospitals, and boards that are attempting to monitor and regulate the quality of care provided to surgical patients in this country and the competence of the professionals who provide medical services. We anticipate that our Web portal project will allow surgeons to maintain electronic case logs, continuing medical education credit documentation, and so on, in one place. Surgeons also will be able to submit all this information to their certifying boards and to government agencies through the College. This sort of technology will reduce the amount of time surgeons must devote to burdensome paperwork and increase their ability to focus on what really matters—providing care to the surgical patient.

To assist surgeons who want to communicate with their lawmakers, we also have established federal and state legislative action centers, located at http://www.capwiz.com/facs/home/ and http://www.facs.org/sslac/index.html/, respectively. Through these Internet services, surgeons can access and send letters regarding issues of relevance to surgery with just a few clicks of the mouse. On several occasions, literally hundreds of surgeons have contacted their lawmakers via these communications vehicles, thereby helping policymakers to more clearly see how their decisions affect our ability to provide surgical care.

And, for those surgeons who want a quick reference tool, the College now offers The Surgical Index online at http://www.facs.org/tsi/index.html. This resource provides a gateway to the best of the surgical literature and is a proven time-saver in the continuing education of surgeons.

Educational programming

As surgeons strive to meet more rigorous continuing medical education credit requirements to maintain certification and to learn more about subjects that are of special interest to them, the College is expanding its educational program-
ming. Whereas our education programs in the past focused largely on clinical issues in general surgery, we are now offering a wider array of subjects at the Clinical Congress, the Spring Meeting, and other venues.

We now offer numerous skills-centered postgraduate courses that allow surgeons to have hands-on experience in the use of cutting-edge technology and the performance of new procedures. These courses often involve the use of simulators and inanimate models, so that surgeons can hone their abilities in a safe environment.

Our Resident and Associate Society and Young Surgeons Committee are presenting special sessions for medical students and residents that focus on their concerns and that will help them as they enter into practice. The July issue of the Bulletin featured a number of articles about these programs.

In addition, we regularly present teleconferences and workshops on coding and practice management. The practice management courses also are becoming available on CD-ROM.

Furthermore, we are providing an assortment of scholarships to support surgeons who are interested in health policy and advocacy. For example, this year we began subsidizing surgeon participation in the Leadership Program in Health Policy and Management at Brandeis University, Waltham, MA.

Advocacy

As the government attempts to remodel the nation’s health care system, we are actively engaging in valuable dialogues with members of Congress and officials at the Centers for Medicare & Medicaid Services. One venture that helped to open the doors to some of these individuals’ offices is the American College of Surgeons Professional Association (ACSPA) and its political action committee (PAC). Furthermore, the ACSPA-SurgeonsPAC contributed to the campaigns of three Fellows who were elected to Congress during the 2004 elections.

Our Washington Office staff is reaching out to the surgical specialty societies to develop strategies for working together to resolve the problems that affect us all. Most recently, we had a very productive discussion about the imminent workforce crisis in emergency care.

Finally, our Divisions of Member Services and Advocacy and Health Policy combined forces once again to present the annual ACS Leadership Conference. During this program, young surgeon representatives and chapter officers learned about the health policy issues that affect surgery and had a chance to meet with their federal legislators or their staffs to advocate on behalf of the profession and the surgical patient (for coverage of the meeting, see page 35 of this issue).

We need you

I believe the College is making progress in terms of providing necessary and appropriate services to surgeons of all ages and in all specialties. We are combining technology and human creativity to build an association that all surgeons will find useful and fulfilling.

Many of these programs were initiated at your request through the Board of Governors. We need you to keep us abreast of your questions and concerns. The College is working hard to be an organization that is truly relevant to all surgeons. With your input, we are achieving this goal.

Thomas R. Russell, MD, FACS
Announcing the ACS Foundation

The future of patient safety just got even brighter.

The new ACS Foundation will underscore the vital role that surgeons play in benefiting society by enhancing and extending life for patients of all nationalities, creeds, and economic levels. It will help surgery continue to advance and make a positive difference in people’s lives for many generations to come.

The American College of Surgeons Foundation invites you to take an active and visible role in continuing to expand research, increasing efforts to enhance patient safety, and doubling scholarship and fellowship funding. We have initiated a program for recognizing significant gifts either publicly or privately. More importantly, there will be no administrative overhead applied to gifts to our Foundation. So, 100% of your donation will actually go to the support of our programs.

Leading the Challenge to Meet the Need

To learn more about the American College of Surgeons Foundation, programs it supports, and opportunities for recognizing your commitment to the advancement of surgery, please call Fred W. Holzrichter, Chief Development Officer, at 312.202.5376 or visit our Web site at www.facs.org.
Congress examines pay for performance

On July 21, the House Ways and Means Health Subcommittee held a hearing on pay for performance (also known as value-based purchasing for physicians) under Medicare. The hearing explored issues related to a legislative proposal being drafted by subcommittee chair, Rep. Nancy L. Johnson (R-CT), that would phase in Medicare payment incentives for physicians to report, and later to meet, quality performance measures developed under a process incorporating recommendations from medical and surgical specialty societies. Among the witnesses at the hearing was Mark McClellan, MD, PhD, Administrator of the Centers for Medicare & Medicaid Services (CMS), who outlined efforts under way at the agency to engage physicians in working toward changing Medicare policies to support better patient outcomes at lower cost.

Surgical specialty societies jointly submitted for the hearing record a proposed framework for phasing in quality performance measures for surgeons. The proposal can be viewed on the College’s Web site at www.facs.org/ahp/views/payforperformance.html.

Patient safety legislation on track

On July 20, the House Energy and Commerce Committee passed the Patient Safety and Quality Improvement Act of 2005, which would permit health care providers to voluntarily report information about medical errors to patient safety organizations (PSOs) that would, in turn, analyze and report on causes and solutions. The legislation, which has been supported strongly by the College, provides protections against using reported safety information in liability lawsuits. It also would allow organizations like the College to apply for PSO status.

Similar legislation was considered in both the House and Senate last year, but it ultimately failed because of irreconcilable views on issues such as the confidentiality of reported information. The legislation, introduced in the House as H.R. 3205, represents a bipartisan and bicameral compromise and ultimately is expected to be passed by both chambers and signed into law by the President.

Wisconsin Supreme Court reviews liability reforms

Because of recent legal decisions, the status of Wisconsin’s liability reform statutes related to caps on noneconomic damages has become uncertain. On March 3, the Wisconsin Supreme Court heard oral arguments in the case of Gregory G. Phelps et al. v. Physicians Insurance Co. of Wisconsin Inc. and Matthew Lindemann, MD. At issue was an appeal of a recent appellate court ruling that first-year residents are not included under the state’s cap because the statute stipulates that only licensed health care providers are covered. As such, this ruling creates a disadvantage because first-year residents are the only group not covered; all medical students and residents beyond the first year of training are protected by the statute. Wisconsin’s cap on noneconomic damages was initially enacted at $350,000 and has an annual inflation adjustment. Currently, the cap is $445,775.
On June 22, the Court issued its ruling, upholding the appellate court’s view that Dr. Lindemann was not a “health care provider” as defined in the noneconomic damage statute. The Supreme Court did, however, remand the case to the Circuit Court for a determination of whether Dr. Lindemann was a “borrowed employee” of St. Joseph’s Hospital and therefore entitled to the cap protection as an “employee” of a health care provider under Wisconsin statute.

In a second case, a divided Court declared the $350,000 cap on noneconomic damages in medical liability lawsuits unconstitutional. In *Matthew Ferdon et al v. Wisconsin Patients Compensation Fund et al*, the jury had awarded Mr. Ferdon and his family $700,000 in noneconomic damages; the court applied the cap, which reduced the award to just over $400,000 (based on annual inflation adjustments) and the case was appealed. The justices ruled four to three that the cap violated the equal protection guarantees of the state’s constitution because it creates two classes of plaintiffs—those who receive full noneconomic damages if the amount granted by the jury is at the full amount of the cap or less, and those whose granted awards are reduced because of the cap. In other words, because these plaintiffs are not fully compensated for their noneconomic damages as determined by a jury, an unequal situation is created that violates the equal protection guarantees. It is important to note, however, that this current ruling does not negate the Wisconsin Supreme Court’s October 2004 ruling that caps are constitutional in cases of wrongful death.


In July, the Senate Appropriations Committee approved its funding legislation for the Departments of Health and Human Services, Labor, and Education for fiscal year 2006. Included in this bill are $3.418 million for the Health Services and Resources Administration’s Trauma-EMS Program and $20 million for Emergency Medical Services for Children (EMSC). The companion House bill does not contain funding for trauma, but it did provide $19 million for EMSC.

In related news, the College, along with 32 other organizations, recently signed a letter in strong support of S. 760, the Wakefield Act. This bill would reauthorize the EMSC program for an additional five years with an annual funding level of $23 million.
Medicare has released a new list of procedures it will cover in ambulatory surgical centers (ASCs), effective for dates of service on or after July 5, 2005. The new list contains 65 additions and five deletions. A complete list of changes, including the amount the ASC is paid for the codes that have been added, is available on the College’s Web site at www.facs.org. The patient is responsible for a 20 percent copayment for the facility payment and, of course, the deductible applies. This article reports on why the changes were made and discusses future changes to the payment rates.

What are the criteria for putting a code on the ASC list? How often is the list revised?

A medical or surgical procedure may be put on the ASC list if it can be safely performed in an ASC (but is not generally done in an office), requires a dedicated operating room or suite and generally requires a short-term postoperative recovery room, and is not otherwise excluded from Medicare coverage. (For example, cosmetic surgery is otherwise excluded from coverage.) Specific standards that have been developed are as follows:

- Procedures should not be on the list if they generally exceed 90 minutes of operating time and four hours of recovery time.
- The anesthesia may be general, regional, or local but generally may not exceed 90 minutes in duration.
- The procedure does not require major blood loss or major invasion of body cavities, does not directly involve major blood vessels, and does not involve procedures that are life-threatening in nature.

The Centers for Medicare & Medicaid Services (CMS) is required by statute to update the list every two years through the notice and comment process in the Federal Register.

How is the amount paid for a given procedure decided?

Each procedure code is grouped into one of nine payment categories (see list below), based on CMS’ estimate of the costs to perform a procedure. The current rates are based on surveys of ASCs performed in 1986 and adjusted for inflation.

CMS originally proposed deletion of approximately 100 codes from the list. Most were proposed by the Office of the Inspector General, who thought Medicare spending would be reduced.

### ASC payment rates

<table>
<thead>
<tr>
<th>Group</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$333</td>
</tr>
<tr>
<td>2</td>
<td>$446</td>
</tr>
<tr>
<td>3</td>
<td>$510</td>
</tr>
<tr>
<td>4</td>
<td>$630</td>
</tr>
<tr>
<td>5</td>
<td>$717</td>
</tr>
<tr>
<td>6</td>
<td>$826 ($676, plus $150 for intraocular lens)</td>
</tr>
<tr>
<td>7</td>
<td>$995</td>
</tr>
<tr>
<td>8</td>
<td>$973 ($823, plus $150 for intraocular lens)</td>
</tr>
<tr>
<td>9</td>
<td>$1,339</td>
</tr>
</tbody>
</table>
substantially if the procedures were moved to the physician’s office with payment based on the physician fee schedule. CMS did a detailed analysis of the comments received on 28 skin procedures and three urology procedures that had been proposed for deletion. The agency found that, in most cases, the procedures would not shift to the office but rather to the hospital outpatient department because the patients needed to be in an environment that has the capability to handle comorbidities, the sterile conditions found at an ASC, and so on. The CMS extended this reasoning to other procedure codes on the list, resulting in the deletion of only five procedure codes with very low ASC usage.

CMS must have been inundated with requests to add codes to the ASC list. How did CMS react to these requests?

CMS proposed to add 25 procedure codes to the list and received comments proposing to add nearly 200 more codes. In the final notice, CMS dealt with each code, explaining the rationale for accepting or rejecting it. Some of the suggested additions were very quickly dismissed by CMS, citing these codes’ extensive use for office or inpatient procedures. Often, CMS did not have data because the code was new, but where the procedure would be performed was discernible by looking at analogous existing codes. Several codes were not added because those procedures are components of other procedures and typically not performed alone. As components of other procedures, they cannot be added to the ASC list. Ultimately, there were 65 additions to the list.

Were there any particularly noteworthy requests for additions to the ASC list that CMS ultimately rejected?

Yes, CMS declined to place three laparoscopic cholecystectomies on the ASC list because of the chance that they would need to be converted to an open procedure, requiring a subsequent hospital admission. CMS wrote, “The potential jeopardy to the beneficiary resulting from undergoing an emergency transfer is significant and far outweighs any benefit of covering these procedures in ASCs. For this reason, we believe laparoscopic cholecystectomies should continue to be performed in a hospital setting (either inpatient or outpatient) as is the current practice” (Federal Register, 2005, codified at 42 CFR§416).

What services are included in the ASC payment?

Facility payments to ASCs include the following:
- Nursing, technician, and related services
- Use of the facilities where the surgical procedures are performed
- Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures
- Diagnostic or therapeutic services or items directly related to the provision of surgical procedures
- Administrative, recordkeeping, and housekeeping items and services
- Material for anesthesia
- Intraocular lenses
- Supervision of the services of an anesthetist by the operating surgeon

ASC facility services do not include items and services for which payment may be made separately, such as through physician services, laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure), prosthetic devices (except intraocular lenses), ambulance services, braces, artificial limbs, and durable medical equipment for use in the patient’s home. They also do not include anesthetist services.

Are the facility fees paid to ASCs approxi-
mately the same as those fees paid to hospi-
tal outpatient departments?

No, they are not. The two payment systems have
developed separately, each in a different context. Payment rates under the hospital outpatient pro-
spective payment system (OPPS), which began in
August 2000, are set to reflect hospitals’ underlying
costs. ASC rates, on the other hand, are based on
special cost surveys conducted in the early 1980s
and reflect the scope of services provided at that
time. The ASC payment system, with only nine
rates and a top rate of $1,338, has not changed to
keep up with the expansion of ASCs and the variety
of services they now can provide. The table above
shows the ASC and OPPS payment amounts for
several high-volume procedures. The payment for
a diagnostic colonoscopy is virtually the same, but
all other procedures have a much higher payment if
the procedure is done in an outpatient department
than if it is done in an ASC. Several factors explain
the differences. A hospital is a much more complex
facility, requiring staff and equipment to treat a
broad range of patients, with a higher case mix
and greater overhead. Hospitals with an emergency
room must staff laboratory and diagnostic depart-
ments as well as surgical suites around the clock. Hospitals also tend to draw sicker patients (even
for the same service) than an ASC, and therefore
the resources used are greater. Finally, hospitals
treat a large number of uninsured patients.

Medicare denies claims from ASCs for pro-
cedures that are not on the ASC list. Is there
another way of getting the facility payment
for these procedures?

There might be another way, but it is a convo-
luted process. The language of the physician fee
schedule, not the ASC payment methodology, is
important. The critical issue is whether there is
a nonfacility practice expense for the procedure
under the Medicare physician fee schedule.
“Nonfacility” typically means the procedure
is performed in an office, but it can also mean
that the procedure is done in an ASC. If there
is a nonfacility fee schedule amount, the pay-

Comparison of ASC and OPPS payment amounts

<table>
<thead>
<tr>
<th>CPT* code</th>
<th>Procedure</th>
<th>ASC payment level</th>
<th>ASC payment amount</th>
<th>OPPS ambulatory payment class number</th>
<th>OPPS payment amount</th>
<th>OPPS payment–ASC payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>19160</td>
<td>Removal of breast tissue</td>
<td>3</td>
<td>$510.00</td>
<td>0028</td>
<td>$1,070.53</td>
<td>$560.53</td>
</tr>
<tr>
<td>29881</td>
<td>Knee arthroscopy/surgery</td>
<td>4</td>
<td>630.00</td>
<td>0041</td>
<td>1,596.97</td>
<td>966.97</td>
</tr>
<tr>
<td>45378</td>
<td>Diagnostic colonoscopy</td>
<td>2</td>
<td>446.00</td>
<td>0143</td>
<td>490.01</td>
<td>44.01</td>
</tr>
<tr>
<td>49505</td>
<td>Repair inguinal hernia</td>
<td>4</td>
<td>630.00</td>
<td>0154</td>
<td>1,599.85</td>
<td>969.85</td>
</tr>
<tr>
<td>52601</td>
<td>Prostatectomy (trans-urethral resection of prostate)</td>
<td>4</td>
<td>630.00</td>
<td>0163</td>
<td>2,055.63</td>
<td>1,425.63</td>
</tr>
<tr>
<td>66984</td>
<td>Remove cataract, insert lens</td>
<td>8</td>
<td>973.00</td>
<td>0246</td>
<td>1,329.48</td>
<td>356.48</td>
</tr>
</tbody>
</table>

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are: © 2004 American Medical Association. All rights reserved.
Understanding pay for performance

by

Frank G. Opelka, MD, FACS,
New Orleans, LA,

and

Cynthia A. Brown, Director,
Division of Advocacy and Health Policy
Currently, the Medicare physician fee schedule awards payments to providers for services delivered, regardless of the quality of care. At the advocacy and health policy levels, the dysfunctional aspects of the current Medicare physician payment system are well understood by policymakers in Congress and in the Administration. And, increasingly, these policymakers are looking at business models in the private sector for solutions. As a result, leaders in this arena are actively trying to identify mechanisms where the concepts of competition, payment incentives, efficiency, and effectiveness can be incorporated into the Medicare system.

Messages from Capitol Hill and the Administration are clear: Medicare intends to follow the lead established by private health plans and business coalitions to evolve into a system where payment is based on providing services effectively and efficiently (rather than paying according to how many services are provided). Hospitals, nursing homes, home health agencies, and end-stage renal disease facilities are all engaged, and they are submitting relatively simple performance data that are benchmarked and publicly reported. There are limited demonstration projects involving physicians as well.

With all this in mind, a task force of the College’s Health Policy Steering Committee has been examining the issue of pay-for-performance (P4P)—also known in legislative parlance as “value-based purchasing for physicians”—in depth, in an effort to understand its implications for surgeons and their patients and to prepare the College for participation in shaping the payment systems of the future.

**Problems in search of a solution**

The U.S. health care system continues to suffer from staggering increases in the cost of care despite efforts to solve this problem. While expenses are rising, some regions of the country are experiencing inexplicable differences in access, quality, and cost of care. Well-insured patients have relatively simple access to costly, high-quality disease prevention and detection services, whereas those who are uninsured struggle to obtain care, see limited health care dollars applied to their conditions, and lack proper disease detection and prevention.

To control costs, this system inadvertently creates obstacles to improved patient health. These hurdles can take the form of access barriers, administrative burdens, and payment reductions. In other words, the U.S. health care system holds down costs by making it more difficult to obtain care.

This system also stifles innovation. When a new treatment is developed, payors cringe at the thought of the additional associated costs. In fact, many simply refuse to adopt new technologies or drugs without overwhelming evidence of patient benefits. As a result, it reportedly takes an average of 17 years for new innovations to be transformed from clinical trials to standards of care. In any other industry, new innovations are embraced for the value they bring to our lives.

It is no wonder that patients, payors, and corporations are beginning to question whether the U.S. model for health care delivery truly fits patient needs. What if the focus changed from a system of restricting costs—and care—to one with incentives to reward high-quality care? What if the U.S. created a model to encourage value, which could be measured and rewarded, in the delivery of care? Some describe this as a P4P insurance model.

**Promise of P4P**

Michael E. Porter and Elizabeth Olmsted Teisberg recently directly addressed some of the apparent peculiarities in the U.S. health care system in a *Harvard Business Review* article.¹ The authors reported that the problem in health care rests in the system’s narrow focus on delivering care in an environment of “zero-sum competition.” In other words, our society has wrongfully valued health care to reduce or avoid costs, has relied on costly legal recourse when health care fails, and has created choices between health *plans* rather than health *care*. As a result, incentives for competitive solutions are perverse and follow the wrong direction for solving the health care crisis.

In considering changes to the U.S. health care model, it must first be determined if competitive health care is based on quality or cost. If it is supposed that health care is a commodity, where all the sellers (providers) essentially produce the same product (such as is the case in the automobile fuel industry), then surgeons and other providers should be viewed as commodities and compete on cost rather than quality.

Evidence suggests, however, that health care is not a commodity and that competition should be
based on quality. For example, Porter and Teisberg point out that the Texas Heart Institute (THI) has one-third to one-half the cost per cardiac operation than other institutions. THI reduces expenses while dealing with more complex patients, providing treatment with the newest innovations, and delivering the best outcomes. Furthermore, the authors cite Birkmeyer et al, who demonstrate improved mortality rates in patients at high-volume institutions and patients of high-volume surgeons. The authors conclude that health care is not a commodity; rather, it is a service that greatly varies in quality, outcomes, processes, and safety.

For surgeons, the zero-sum competition model has been particularly disastrous. This is the environment that led to the establishment of the sustainable growth rate cost-containment system that has prevented Medicare physician payments from keeping pace with the cost of providing care. It also is the foundation of Medicare’s resource-based relative value scale physician payment system, in which any effort to appropriately value and reimburse for any group of health care services must come at the expense of other services.

Porter and Teisberg say it is time to define a more competitive market for health care—one that opens up the opportunity for quality, service, process, and outcome enhancements. They suggest that health care incentives must be redefined to create value through competition, including rewarding increased value rather than shifting costs, publishing information on providers’ experience and outcomes, and creating open access to improve consumer choice.

**Payors and patients take notice**

Payors continue to fine-tune the current care model in an effort to curtail rising costs. They have long toyed with past incentive systems to rein in costs and these efforts have failed repeatedly. Now payors hope to limit costs through various new demands on quality with additional payments tied to improved care.

Quality and safety initiatives gained a spot on center stage when payors and the public took notice of two reports by the Institute of Medicine: *To Err Is Human: Building a Safer Health System*, and *Crossing the Quality Chasm: A New Health System for the 21st Century*. Since the release of these reports, the health care industry has received notice it must establish open safety standards and quality reports. Beyond the industry’s response, the general public has new knowledge about quality and safety in medicine.

Mark McClellan, MD, PhD, Administrator of the Centers for Medicare & Medicaid Services (CMS), has made clear his intention to expand P4P programs for physicians and other providers—which typically suggests that the remainder of the health care insurers will follow.

As one of many examples, CMS has created a three-year demonstration project in 10 large physician group practices that aims to assess quality performance and improvement while focusing on the following costly, chronic illnesses: congestive heart failure, coronary artery disease, diabetes mellitus, hypertension, vaccines (influenza and pneumococcal pneumonia), and cancer screening (breast and colon).

The demonstration project follows several hospital projects that provide financial rewards for quality reporting, including Hospital Quality Initiative, Premier Hospital Quality Incentive Demonstration, Medicare Coordinated Care Demonstration, and Medicare Care Management for High-Cost Beneficiaries Demonstration, in addition to programs applicable to other provider groups such as nursing homes, home health agencies, and end-stage renal disease facilities.

CMS’ quality improvement organizations (QIOs) are partnering with physicians and hospitals on a broad array of quality and safety outcomes and processes—the foundation of P4P. In fact, in their new contract cycle, the QIOs will be working with hospitals and physicians to implement the goals established by the Surgical Care Improvement Project (SCIP), a national quality partnership sponsored by CMS, and a variety of other federal agencies and provider groups, including the College (see page 15 for list of participating organizations). SCIP’s goal is to reduce postoperative mortality and morbidity by 25 percent over five years by focusing on the following four broad target areas:

- *Surgical site infections*, which account for 14 to 16 percent of all hospital-acquired infections and are a common complication of care. By implementing projects to reduce surgical site infections, hospitals could achieve a savings of $3,152 and a reduction in extended length of stay by seven days for each patient who develops an infection.
• Adverse cardiac events, which are complications of surgery occurring in 2 to 5 percent of patients undergoing noncardiac surgery and as many as 34 percent of patients undergoing vascular surgery. Certain perioperative cardiac events, such as myocardial infarction, are associated with a mortality rate of 40 to 70 percent per event, prolonged hospitalization, and higher costs.

• Deep vein thrombosis and pulmonary embolism, which occur after approximately 25 percent and 7 percent, respectively, of all major surgical procedures performed without prophylaxis. More than 50 percent of major orthopaedic procedures are complicated by deep vein thrombosis, and up to 30 percent by pulmonary embolism, if prophylactic treatment is not instituted.

• Postoperative pneumonia, which has been associated with high fatality rates, according to the Centers for Disease Control and Prevention (as cited on the SCIP Web site). Postoperative pneumonia occurs in 9 to 40 percent of patients and has an associated mortality rate of 30 to 46 percent. A conservative estimate of the potential savings of the reduced hospitalization resulting from postoperative pneumonia is $22,000 to $28,000 per patient per admission.

Making physician P4P real

In order for P4P to come to life, the key component(s) of a P4P payment system begin with reliable physician clinical performance assessments (PCPA). To pay for performance, there must be a physician-endorsed, patient-valued performance assessment. If the system is not patient-valued, then clinical performance will measure parameters that do not enhance care and the program will simply become an exercise tied to financial incentives rather than patient well being. Ultimately, the medical community will bring forth pressures that dissolve patient confidence and so lead to the collapse of the system.

Landon et al tried to assess the current state of PCPA. The authors have outlined the current prospects and barriers to PCPA. The true goal of PCPA is the ability to assess physician competency. Obstacles to implementing physician performance measurement systems include the following: lack of evidence-based measures, such as representation, feasibility and cost, and ensured increase in value of care, for many specialties; challenges in defending thresholds for acceptable care; sample size consideration; process, or outcomes, or both; and using appropriate statistical models. The authors note that lack of evidence-based measures reflects the fact that many specialties have not defined measures to assess clinical performance. The limited measures that do exist may not be risk-adjusted, outcome-based, evidence-driven process metrics of proven value.

Indeed, despite the fact that surgeons continue to advance evidence-based care, surgical specialists and the research and processes they have developed have largely been omitted from recent debates on ways to report and measure health care quality in a Medicare P4P program. Instead, the focus has been principally on public health and primary care services and on processes that are relatively simple to measure through ambulatory service claims.

It is important to highlight key distinctions between surgical quality improvement and preventive and chronic care quality measures. For example, surgery is more episodic and less focused on chronic disease management, preventive services, and screening. In surgery, the ultimate outcome produced by a specific intervention is much more immediate and clear than disease-management strategies that may span many years. As a result, surgery lends itself much more readily to rigorous clinical outcome measurements. And, whereas generalist physicians typically see approximately the same wide array of patients, surgeons tend to have more focused areas of practice that make

SCIP Steering Committee organizations

| Agency for Healthcare Research and Quality |
| American College of Surgeons |
| American Hospital Association |
| American Society of Anesthesiologists |
| Association of periOperative Registered Nurses |
| Centers for Disease Control and Prevention |
| Centers for Medicare & Medicaid Services |
| Department of Veterans Affairs |
| Institute for Healthcare Improvement |
| Joint Commission on Accreditation of Healthcare Organizations |
it difficult to apply broad quality measurements. Administrative records other than the operative report—such as claims records—provide much less useful information about processes of care because of the way surgery is packaged and billed. Finally, successful patient management in a primary care setting generally results in increased use of preventive services. In surgery, “more” rarely means “better” care. For surgery, the best measures focus on elaborate decision-making processes that call for direct action to determine the right procedures, at the right time, for the right patient. Surgical quality initiatives limit acute complications and provide immediate cost savings, with enhanced outcomes and improved operational efficiencies through process development.

Obviously, then, as policymakers begin to pursue development of P4P, surgical participation is vital. Even if current proposed measures are accepted, Landon et al question how to decide P4P in terms of the quality delivered. What level of compliance defines quality? What patient-specific parameters provide exceptions or alterations to the metric? What happens when surgeons do not comply because patients are under the auspices of new clinical protocols? Who will set the thresholds for compliance (for example, 5% or 95%)?

**Physician groups respond**

In May 2005, the Ambulatory Care Quality Alliance announced its endorsement of a recommended “starter set” of 26 clinical performance measures for ambulatory care that could be used as the basis of a P4P system. This alliance of stakeholder organizations—initially convened by the American Academy of Family Physicians, American College of Physicians, America’s Health Insurance Plans, and the Agency for Healthcare Research and Quality—considered and selected measures based on clinical importance; validity, feasibility, and relevance to physician performance; and relevance to consumers and purchasers. The starter set addresses the following priority areas: prevention, coronary artery disease, heart failure, diabetes, asthma, depression, prenatal care, and overuse or misuse of antibiotics. Within these areas, individual measures tend to focus on monitoring patients for chronic conditions and improved adherence to screening guidelines.

Surgeons tend to views outcomes reporting as being most familiar and perhaps more valid than process measures. Various outcomes—infection rates, postoperative myocardial infarctions, and so forth—are currently tracked in hospitals. In order for outcomes to have reasonable measures of quality and competency, however, the care must be risk-adjusted for individual patients. Risk adjustment demands large volumes of data and full-time employees hired to collect those data. And, as with process standards, specialty organizations representing the profession involved would need to assign thresholds for appropriate P4P compliance.

Currently, the College has followed the lead established by the Veterans Affairs Health System and has established the National Surgical Quality Improvement Program (NSQIP) outcomes program with numerous participating facilities. The program has risk-adjusted components and it is robust with data. The outcomes parameters are identified for a range of procedures. The surgical profession’s support for the NSQIP program, developed by surgeons, appears likely.

Following are Web sites that provide more information on programs and organizations mentioned in this article.

- For more information on all CMS quality programs, visit [http://www.cms.hhs.gov/quality/](http://www.cms.hhs.gov/quality/).
- For more information on the SCIP program, visit [http://www.medqic.org/scip/](http://www.medqic.org/scip/+.
- For more information on the Ambulatory Care Quality Alliance, visit [http://www.ahrq.gov/qual/qualix.htm](http://www.ahrq.gov/qual/qualix.htm).
- For more information on the ACS NSQIP, visit [https://acsnsqip.org/content/main/default.asp](https://acsnsqip.org/content/main/default.asp).
- For more information on the ACS Maine Chapter’s colorectal diseases project, visit [http://www.maine-acs.org/outcomegroup.htm](http://www.maine-acs.org/outcomegroup.htm).
The Society of Thoracic Surgeons (STS) offers outcomes programs in the areas of adult cardiac, general thoracic, and congenital surgery. By committing to collecting outcomes data to the STS National Database, thoracic surgeons are committing to improving the quality of care that their patients receive. Since 1994, more than 40 publications have been based on studies of the STS National Databases. These studies have been published in a variety of professional journals and textbooks. Furthermore, the STS National Database has recently served as the basis for a federally funded national quality improvement randomized trial, as well as research in targeted areas of cardiac surgery.

Process programs are less well developed. Currently, the ACS has supported a pilot program in conjunction with its Maine Chapter that focuses on several processes in colon and rectal surgery that are evidenced-based and defined by consensus panel. Prospective data collection and reporting of compliance with the processes are compared with the outcomes, without risk adjustment. The quality or value of care is determined by the level of compliance achieved by the individual surgeon and hospital. Currently, the thresholds for quality are undetermined.

Summary
Dr. McClellan has stated his intention to implement some kind of physician P4P initiative by 2006. Similarly, congressional leaders with jurisdiction over Medicare have said quite plainly that any proposal to reform the physician payment update system will likely be linked to some kind of performance measurement and incentives.

What is less clear at this point is the blueprint that will guide the development of physician P4P. The number of individuals and practices involved, combined with the specialized nature of the services each provides and the limited technological and staff resources available to most of them, defies efforts to identify implementation of simple, yet meaningful, across-the-board performance measures of the sort that have been applied to hospitals and nursing homes. For physicians, the picture is further complicated by the sustainable growth rate system and budget neutrality rules that will impose payment reductions on some physicians (even those whose quality is not questioned) in order to offset any incentive payments made to others for whom performance measures have been established. For these reasons, many specialty societies—particularly some surgical specialty societies—are viewing the P4P concept with skepticism.

Of course, the lack of specific direction from policymakers also offers opportunities. Essentially, physicians (for the moment) are free to design their own measures and systems. And, given the current price tag of $155 billion over 10 years, which has dampened congressional enthusiasm for eliminating the sustainable growth rate system, P4P could open the door to meaningful Medicare payment changes that are desperately needed.

References

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July 2005 marked the 40th anniversary of Medicare. The Medicare program was designed by Congress in 1965 to cover health care for seniors and disabled persons in the U.S. Throughout its history, Medicare has responded to the challenge of providing funding for millions of physician visits when beneficiaries are sick or in need of acute care treatment. Today, more than 42 million beneficiaries count on Medicare coverage for physician, hospital, and many other services.

But the practice of medicine was very different when Medicare benefits were first designed and implemented. The Medicare program of 1965 only paid for “those services that are considered to be medically reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member” (Social Security Act, section 1862 [42 U.S.C. 1395y] (1) A). Until recently, the Centers for Medicare & Medicaid Services (CMS) did not have the authority to pay for prevention-oriented care or drugs that would make a substantial difference in preventing disabling disease.

Medicare modernization act
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added new preventive care programs to those services that the Medicare program already covered, including a Welcome to Medicare physical exam and lipid and diabetes screening, as well as new coverage for smoking cessation programs. MMA also provided new ways for Medicare to support programs that help patients with chronic diseases comply with their physician’s plan of care, which CMS and medical organizations are collaborating to implement. Although surgeons are not typically directly involved with prevention, they do often deal with chronically ill patients who could benefit from these preventive measures as well as the new drug benefit provided by the MMA.

In the past, surgeons and their office staff have been instrumental in helping patients understand the coverage of the services they need. As a provider of continuing care for these patients, surgeons are in a position to help them learn more about the benefits they need to stay healthy. In that role as a trusted advisor, surgeons should inform patients of how they may take advantage of the Medicare prescription drug coverage, which will be available in 2006 to all Medicare beneficiaries who apply, beginning on November 15, 2005. Patients living on a fixed income should be encouraged to fill out the related Social Security forms, because it can mean substantial financial help.

Informing patients of the new drug benefits
Understandably, there is pressure on a surgeon’s clinical time with patients, but informing patients with Medicare coverage of the new prescription drug coverage could be valuable to them. CMS will also be providing information to surgeons’ offices.
for distribution to patients. This information will describe the basic coverage and explain how to get more detailed information. In addition, the Social Security Administration is sending 20 million letters to people with Medicare who may be eligible for additional help with their prescription drug payments. Patients might approach physicians, asking about this letter and the coverage. Patients may be referred to their local Social Security or Medicaid office or they may call 800/MEDICARE if they need more help in obtaining medications they have been prescribed.

It is important that patients know they will need to select a drug plan that best meets their prescription payment needs in November, and that plans will begin competing for their business in October. A typical beneficiary who is paying for medication on his or her own today will receive help worth about $1,300 per year; because the coverage will pay for more than half of their prescription drug costs after a deductible. All beneficiaries will also get peace of mind against catastrophic drug costs, because Medicare will pay approximately 95 percent of the cost of prescriptions after a beneficiary’s out-of-pocket expenses reach $3,600 a year. Beneficiaries will pay a monthly premium that is expected to average approximately $37 in 2006. Medicare will also help pay for retiree drug coverage provided by employers and unions. Drug coverage will also be available through Medicare Advantage health plans, which typically offer extra coverage with lower costs.

**Physician payment update**

As CMS is working to expand awareness of the new prescription drug benefit, it also acknowledges that physicians have legitimate concerns about the physician payment rate update scheduled to occur in 2006. CMS is carefully reviewing and considering proposed administrative fixes, such as removing drugs from the sustainable growth rate. According to estimates, removing drugs from the sustainable growth rate prospectively will not yield a positive update until perhaps 2011.

Even if this administrative fix should solve the negative update problem in the short term, it substantially increases beneficiary premiums and worsens Medicare’s overall financial outlook, especially if substantial growth in the use of Part B office visits, diagnostic tests, and minor procedures continues. To find better ways to pay effectively for innovative and coordinated care that will improve health and reduce costs—and not just for the number of services provided, regardless of their quality and impact on patient health—is a challenge. Any effective payment system in Medicare must recognize that physicians are the most essential part of the solution, and CMS is working closely with physicians to develop better ideas for physician payment.

Based on feedback from physicians, more support for physicians who provide services that are not covered—but that are believed to improve quality and efficiency in the health care system—is being examined. The MMA offered CMS new opportunities to test approaches that pay more for better care and better results, so that physicians get the support they deserve for innovative ideas, such as using electronic records or e-mail and phone reminders effectively.

However, Medicare can only succeed if patients can continue to get the physician care and services they have come to rely on. As CMS acts to ensure that physicians are paid appropriately for providing care and works on resolving the sustainable growth rate issue, physicians should ensure that beneficiaries know how to get the most from Medicare by explaining the value of prescription drug coverage and that 800/MEDICARE is an easy way to find local resources to help them make those choices.

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**Note:** See related “Socioeconomic tips” column about the Medicare prescription drug program on page 29.

**Dr. McClellan** is the Administrator for the Centers for Medicare & Medicaid Services, Washington, DC.
I first went to the Central American country of Belize with my wife in 1996. We always took a week off during the winter holidays to travel to a warm-weather location to participate in scuba diving and to get some sun. I had to refer to a map to find out where Belize was located when this destination was first suggested. Little did I realize that this trip, unlike any other, would be the start of an adventure and a fulfilling undertaking in which my skills as a surgeon and endoscopist would find a rewarding and satisfying venue.

**Background on Belize**

Belize, formerly known as British Honduras, lies at the northeasternmost point of Central America, nestled under the Yucatán peninsula of Mexico, with the Caribbean Sea to the east and Guatemala to the west. It is about the size of Vermont, with a population of about 250,000 that includes European whites, African blacks, indigenous Mayans, Asians, Mennonites, and even a few descendants of the post-Civil War American confederacy, giving testimony not only to the extensive history of migration to Belize but also its ready tolerance of people from all walks of life. Formerly a British colony, independence was granted in September 1981, although a British military contingent remains in place because Guatemala and Belize have a long-standing border dispute.

The laws and court system, as well as most other areas of political and administrative life, have retained their British origins. The official language of Belize is English, unlike in the rest of Latin America. Close ties with the U.S. as a trading and political partner are evident most notably in the country’s monetary system; the Belize dollar is fixed to the U.S. dollar at two to one. In addition, the standard electrical current is 115 volts, as it is in the U.S., and the television standard is that set by the National Television Standards Committee (as in the U.S.), which is not used in Europe, Asia, and other parts of Latin America.

The barrier reef of Belize is the second largest in the world, second only to the Great Barrier Reef of Australia, and provides one of the main attractions to tourists and thrill-seekers looking for superb diving in a reef barely 10 minutes from their hotel rooms. The Blue Hole of Belize became well known following the Public Broadcast System special by Jacques Cousteau, who explored its 400-plus foot depths in the late 1960s.

**State of health care in Belize**

On our first trip to Belize, we stayed at a small hotel on the beach built and owned by Will Lala and his wife, Susan. Will is a retired dentist from Manhattan, KS, who has provided and organized volunteer dental missions to Belize and was therefore well versed in the dental and medical needs and organization of health care delivery in that part of the world. We struck up a friendship and, several conversations later, it became clear to me that a great vacuum existed in health care delivery in Belize. Notably, little or no endoscopy was available anywhere and no colorectal specialist practiced in the country.

Above: View of San Pedro, Ambergris Caye, an offshore island near the Blue Hole of Belize.
Patients requiring endoscopy (esophagogastroduodenoscopy or colonoscopy) either traveled north to Mexico or went to the U.S. completely at their own expense. Those patients who could not afford the fees or the travel expenses simply did without. Complex colorectal or anorectal surgery likewise was referred to physicians abroad or simply not done as the situation dictated. It began to occur to me that perhaps this was a place where I could offer my skills and background and do a good deed for the less fortunate.

There is very little by way of health insurance in Belize. Medical services are delivered on either a cash basis in private clinics or may be obtained through the government-administered hospital and clinic system at little or no charge. A nationwide Social Security plan has not been all that was planned or promised and the lawmakers have gone back to the drawing board for the time being. Therefore, I decided to render services to those who could not afford to pay for their health care or for whom the particular service was not available.

**How the idea became reality**

What made this all come together was the Rotary Club of Belize City. Being a Rotarian myself, introductions to the local club members resulted in my clinic being set up at a local Rotarian physician’s private clinic. Funding was obtained from local charities both in Belize and at home in Charleston, SC, including my own Rotary Club. When necessary, my own funds for travel, food, and lodging were used. A Belize Rotarian owned a local hotel and a deep discount was offered.

The next and perhaps most difficult step was obtaining and shipping a complete video endoscopic laboratory from the U.S. to Belize. Through the generous efforts of the Olympus Corporation of America, this became a reality and was soon followed by donations of equipment and supplies from several major contributors, including Johnson & Johnson and Tenet Healthcare Corporation. When the shipments arrived in Belize, the local Rotarians facilitated clearance through customs and ultimately ensured the safety of the supplies until my team and I arrived.

**Our first clinic**

Leaving in the morning allowed a noon arrival (Belize follows Central Standard Time) and time to set up our equipment. Accompanying me were two nurses from our endoscopy unit who were also charged with training the local staff to assume these responsibilities independently. The local Rotarians had set up a clearinghouse for patient referrals and scheduling and for distribution of bowel preparation kits or other instructions in the weeks before our arrival.

In April 2003, we were finally ready for our first clinic, in which we would offer upper and lower endoscopy and consulting services for any referred or hospitalized patients in my field of interest.

The response was overwhelming. In four and a half days, we performed more than 50 endoscopies. Much pathology was discovered, including five colorectal cancers and numerous cases of upper gastrointestinal (GI) pathology, including H. pylori-positive gastritis, duodenal ulcer disease, Barrett’s esophagus, and gastric ulceration, to name a few. We introduced the use of proton-pump inhibitor pharmacology to treat many of these patients with upper GI disease while plans were made to operate...
on or refer the patients with lower GI cancers for treatment as the circumstances dictated. Several patients with low-lying rectal cancer were brought to Charleston for sphincter-sparing surgery and adjuvant therapy, which I didn’t believe could be safely done in Belize.

The local media got wind of what we were doing (because the Belize Rotarians owned the radio and TV stations) and I appeared on TV and radio to raise the awareness of upper GI symptomatology or lower GI bleeding, which later received national coverage. The call-in phone numbers were overloaded with patients’ calls and requests. I decided to try to hold a clinic every three months, as this was the most that I could reasonably spare in time and funds and I thought that a continuum of care would be essential in this project rather than just a one-time, flash-in-the-pan event.

We have been returning to Belize every three months since that time. The project has developed a life of its own, with frequent e-mail consultations with patients in anticipation of our return, plans for a freestanding clinic to be staffed by visiting and volunteer specialists in all areas of medicine and surgery, and an ever-increasing patient load during our stays, which have proven to be much too short.

**The future**

The events described previously took a long time to finalize. For anyone wishing to do a similar undertaking, be prepared for the unexpected, the unplanned, and the unexplainable. Don’t be in a hurry, as time moves much more slowly outside the U.S. Be persistent but always respectful, not only of your target population but also the local physicians and contacts with whom you will develop lifelong friendships. The future for Project Belize is bright and professionally satisfying. As noted previously, plans for a freestanding specialty clinic are being finalized and have received the written endorsement of the Prime Minister of Belize. Fundraising to support this project remains the most challenging aspect of the whole program for me. I produced a video documentary about Project Belize on digital video disk to be used as part of our fundraising. The disk is of high quality and is free upon request (e-mail FriedMD@chscr.com). Our ability to accept funds as a tax-exempt entity is nearly complete. A full schedule of patients awaits us on each return visit and several surgeries for colon cancer have been successfully performed there. Those patients brought to Charleston for their surgery have all done well and have returned to Belize.

From a personal perspective, in a world of ever-increasing regulation and diminishing satisfaction with the practice of surgery, I may have chanced upon an undertaking that restores in me the vigor, delight, and sense of worth and accomplishment that had begun to ebb over these past several years. Each of us must find in our own way some meaning and satisfaction in what we are doing. Many of my patients back home in Charleston allow that in me, and now my new adventure in Belize has given me a second forum to expand on those feelings.
Surgeons and surgical leaders:

Mixing expectations with needs

By Richard H. Dean, MD, FACS, Winston-Salem, NC

I was recently asked by the American College of Surgeons to participate in the panel for its course on leadership and provide my views on “Approaches to Integrating the Needs of Leadership with the Expectations of Surgeons.” It was gratifying after almost eight years in my current position to participate in a panel with old friends and present to an assembled group who, in no small part, represents the leadership of our discipline for the era to come. This article is a reconstruction of my presentation.
Defining needs and expectations

“Approaches to integrating the needs of leadership with the expectations of surgeons” could be addressed from many points of view. First, I could pursue a description of the needs of institutional leaders—individuals in positions similar to mine—and the convergence or conflict of those needs with the expectations of surgeons. In that context, one could characterize such a discussion as a debate between the needs of the collective versus the needs of the individual or, in a political context, a debate between federalism and states’ rights—an interesting topic, but one on which I am only partially qualified to speak, as I am both a states’ rights Southerner and, on occasion, am accused of thinking and acting, in my position, too much like a surgeon. However, I didn’t believe this was the appropriate approach.

I suspect that my presentation title, more likely, relates to a couple of other topics. It could be interpreted as a request to have me list components of a survival guide to provide future surgical leaders with the tools to survive or even thrive in the “foreign territory” inhabited by academic medical center leaders, outside the comfort of the operating room and the like-minded fortress of surgery. Unfortunately, I don’t think such a detailed guide would be of much use and, more to the point, I don’t have one.

Instead, I believe it’s a request for a discussion of how leaders of surgeons should weave expectations from institutional leaders with the needs and expectations of their faculty surgeons. This topic is quite germane to a person’s maturation as a leader of any group, including surgeons.

How perception can affect integration

Before fleshing out my thoughts on how to achieve a balance between needs of surgical leaders and expectations of surgeons, I believe that a few disclaimers and personal observations are in order.

I feel compelled to disclose that my experience is only mine. It is limited to the issues, interactions, and personalities that I have experienced in only the part of the universe to which I have been exposed. Having said that, however, experience is a great teacher and provides valuable lessons for developing one’s own philosophy or strategy for leadership.

In addition, I realize that I have left surgery and now have lived on the “dark side” long enough to be contaminated and labeled as “one of those administrators.” I can’t argue that point, but I will say that it does give me some perspectives from the other side that otherwise would be ignored in a meeting on development of surgeon leaders.

Lastly, I have a couple of personal biases—observations related to how surgeons as a whole, as well as some surgical leaders, are perceived by others, and how this perception can be used to the advantage of the surgical leader when interacting with institutional leaders and the public—that I cannot prove as true but are worth considering.

I have observed that the public, members of most other medical disciplines, and most institutional heads (as most are nonsurgeons) see surgeons as isolationists—not consensus builders—who are self-confident to the extreme of arrogant, dictatorial, and intolerant of bureaucracies such as those found in medical school administrations.

I don’t know how any of these other groups could come up with such a bizarre opinion about a group of humble, self-effacing, concerned physicians/healers, but nonetheless they have. So, my pearl of wisdom in response is as follows:

People expect other chairs in a medical school to be collaborative, consensus-building, institutionally minded, and so on. But when a surgeon exhibits such traits, it’s unexpected and disarming to others, providing her or him a leg up in discussions, debates, or whatever the interaction with others may be, including such interactions with institutional leaders.

As a matter of fact, these same disarming traits are just as important in dealing with the diverse personalities within a group of surgeons. Some surgical faculty members may even see their chair as having some of the same traits of self-centeredness that others ascribe to surgeons, and, when a chair exhibits such traits, that chair becomes disabled in his or her ability to lead a diverse faculty of surgeons and ultimately will fail.

My second observation is that many outsiders, including many institutional leaders, see surgeons and surgical leaders as individuals resistant to change, especially if such change is imposed. I think there are many reasons for such a perception. For
example, many surgeons were reared learning how to do something one way and then they do it that way for their entire careers—as long as it works, many wonder, “Why would I change?” Thankfully, most surgeons exhibit their greatest commitment to the patient and their work as physicians. Their lives are filled with managing patient issues both in and out of the operating room. They desire to have the rest of their environment be constant. How one manages this inborn desire for stability and status quo on behalf of faculty with the reality that “change will occur” will be one of the greatest challenges and opportunities for a leader of surgeons.

**Achieving the integration**

Rather than suggesting how to *balance* the needs of leadership with the expectations of surgeons, the title of this presentation asked how to *integrate* those needs and expectations. I believe that leadership (be it as a leader of surgeons or of an academic medical center) is not about maintaining balance between constituencies; instead, it is about searching for directions, solutions, and positions that are advantageous to both the individual surgeon and the profession as a whole. Although balance in outcomes of decisions is important, I believe that leadership should not think in terms of quid pro quo balance—for example, “Because I did something for one physician, I have to do the same thing for another physician.” Leaders should not put themselves in a position of doing something for one department that will force them to provide a quid pro quo for another. Instead, solutions for managing individuals and departments should be based on premises that apply to the whole, whether the individual department or the entire institution. I believe one should pursue leadership approaches that focus on both the individual and the whole—this presents a subtle difference in approach from quid pro quo balance, and it is an approach that is reflective, I believe, of a higher order of leadership. There will be times when a leader will have to make decisions that do not benefit the individual, but when doing so, that leader should seek solutions that enhance principles that, in turn, benefit the greater population of individuals—or, in other words, the whole.

**A hypothetical example**

You are a new chair and you have a couple of research faculty members who have been supported with excess clinical revenue for several years (the good old days!). These two faculty members have not received external funding for many years and are pursuing their pet projects with hard-earned dollars from clinical activities of others. What do you do? Do you simply leave this agreement as is? Do you simply fire them to show everyone who is the boss and to let all others know that productivity is required? Or do you consider, for example, setting up internal criteria for funding all intramurally supported research based on merit, and work with those two faculty members to redirect their efforts in directions more beneficial to the department—be it increased clinical or teaching workloads? I suggest this latter course. Then, if they can’t adjust and change, you have a depersonalized, “premised” basis on which to terminate their employment and do it with the support of all common sense and with productive faculty members on your side. Such a course depersonalizes the consequences to the faculty and sets up a better plan for managing future distributions of resources within your faculty.

Now, apply this story to a larger hypothetical platform. Suppose you are the chair of surgery
and you realize that portions of the institutional dollars—funds likely previously generated by surgeons—are supporting research in another, unproductive department. Are you best served by sitting quietly; by grandstanding and arguing that the school should cut off funding to that department; or by suggesting that an institution-wide algorithm be developed to distribute institutional dollars for research support to all departments, which appropriately benefits the productive departments? From my position, this latter approach is an example of an action taken by a great institutional leader who just happens to be a surgeon and who is deeply appreciated for devising a solution for an unresolved institutional problem.

One could substitute similar hypothetical examples in the clinical arena for the one that I chose in the research arena, as the same premises hold. In the end, the issues are really no different for managing a department than for managing a school. My point is that leaders should look for answers that benefit a greater goal whenever tackling an individual problem and for opportunities for institutional improvements that may also indirectly benefit the department’s or individual surgeon’s accomplishments.

**Culture of change management**

Management of change, and its relationship to the joint role of a chair as an advocate for his or her department and as a member of the institution’s leadership, should also be addressed.

Change is constant. As much as people would like for it to be different, the only constancy with which we all live is the constancy of external stresses that ultimately are relieved by change. The only issue is whether one discerns those stresses or forces and channels eventual change toward favorable directions, or whether one is left to respond to the new environment created from without. From my vantage point, chairs should be in touch with and embrace the constancy of change. They should approach their duties as leaders through recognition of opportunity to lead change rather than to resist it. By doing so, they become strong advocates not only for their individual faculty but also for their entire institution.

Following is a review of the recommendations or guideposts for decision making and interactions with the surrounding environment, which can help leaders in implementing change:

- Recognize and embrace the fact that change will be constant in any position or environment. The options are to react to it or to create it. Look for opportunities for preemptive change that benefit faculty members and the environment in which they live as a whole.
- When faced with a specific problem, attempt to place it into a larger context and create a solution that simultaneously advances the larger goal.
- Where possible, look for solutions to problems and needs by searching for those outcomes that will also benefit the largest possible constituency’s goals, including your own. In that manner, you end up being a constructionist rather than someone who owes others for successes.

Taken together, these guideposts will not make the role of leadership any simpler. However, they will make the leadership experience more meaningful and rewarding as a career path.
Revised statement on health care industry representatives in the operating room

The following statement was developed by the ACS Committee on Perioperative Care, and was approved by the Board of Regents at its June 2005 meeting.

The ACS recognizes the need for a structured system within the perioperative setting for education, training, and introduction of procedures, techniques, technology, and equipment to the surgical health care team. Health care industry representatives (HCIR), by virtue of their training, knowledge, and expertise, can provide technical assistance to the surgical team, which expedites the procedure and facilitates the safe and effective application of surgical products and technologies. The purpose of this statement is to supply guidelines to health care facilities and members of the perioperative health care team to ensure an optimal surgical outcome, as well as the patient’s safety, right to privacy, and confidentiality when a HCIR is present during a surgical procedure.

Institutional policies

Surgical department administrators in all facilities, including the acute care hospital, ambulatory surgery facility, and office-based operating room (OR) settings, should establish specific written policies governing the presence of HCIRs in the OR. These policies should define (1) the requirements and procedures for manufacturers’ representatives to be present in the OR, and (2) the role and limitations of the HCIR in the perioperative setting. These policies should comply with applicable state laws and regulations and should be consistent with the organization’s existing policies, such as those promulgated by the OR and/or credentialing/privileging committees, and should include, but not be limited to, the following elements.

Facility requirements and procedures for manufacturers’ representatives to be present in the OR should include the following:

1. The institution should designate an authority for approving an HCIR’s presence in the OR. A time frame for securing this approval should be established. This authority should:
• Supply a time-limited approval and appropriate identification (to be worn at all times) for the HCIR
• Ensure orientation to the facility is provided
• Verify the documentation that certifies the HCIR has had education and training in:
  —Health Insurance Portability and Accountability Act compliance and all matters related to patients’ rights and confidentiality
  —Appropriate conduct and attire in the OR environment
  —Aseptic principles and sterile techniques
  —Infectious disease and bloodborne pathogens
  —Occupational safety: biohazardous waste, fire, electrical, radiation, and other safety protocols
  —Other applicable practices that may be related to the operation
2. The HCIR should be present at the request of the operating surgeon. The HCIR should be introduced to the entire OR team and the purpose of the visit explained. If the surgeon did not initiate the request, the surgeon should be notified and approve the visit prior to the operation.
3. The patient should be informed of the presence and purpose of the HCIR in the OR and give written, informed consent. This should be documented within the medical records.

Roles and limitations of the HCIR in the OR
The HCIR is present as an advisor to the perioperative team to ensure the safe and effective application of surgical devices and technologies. The presence of the HCIR in the operating room is not an appropriate substitute for preoperative training of the surgical team. The surgical team must have the theoretical understanding and knowledge, training, and skills necessary for the application of these surgical devices and technologies prior to surgery. In the role of educator and facilitator, the HCIR:
• Should not engage in the practice of surgery, nursing, or medical decision making
• Should not scrub or be involved in direct patient contact
• May be involved in the remote calibration or adjustment of medical devices to the surgeons’ and manufacturers’ specifications (for example, pacemakers, laser technicians)
• Should have his or her activities monitored and supported by the surgeon or, at the surgeon’s discretion, by the perioperative nurse responsible for the patient’s care

A clearly defined institutional mechanism should exist to address any departures from the established policies above.
Medicare coverage for prescription drugs
by the Division of Advocacy and Health Policy

Medicare coverage for prescription drugs begins January 1, 2006. This article complements the article on page 18 of this issue by Mark McClellan, MD, PhD, Administrator of the Centers for Medicare & Medicaid Services (CMS), and contains basic information about the Medicare prescription drug program that surgeons and their staffs should know.

What are the basic features of the Medicare drug plan?

All people with Part A and/or Part B of Medicare are eligible to participate in the Medicare prescription drug program, which is known as Part D of Medicare. Beneficiaries must choose between a minimum of two drug plans this fall. Prescription drug coverage begins with drugs delivered on or after January 1, 2006, for those who enrolled in a plan by December 31, 2005. The drug plans will vary based on the following:

- The monthly premium (approximately $37 in 2006)
- The drugs covered
- The beneficiary’s copayment for the drugs
- The pharmacies a beneficiary may use

The initial enrollment period for current beneficiaries begins on November 15, 2005, and ends on May 15, 2006. There are special rules for beneficiaries with existing drug coverage from an employer, a union, or a Medigap policy. Special rules also apply to people with both Medicare and Medicaid. People with limited income and resources may apply for additional help with prescription drugs.

Of course, a beneficiary may decide not to join a plan at this time, but that beneficiary will be subject to a higher premium if he or she decides to join after May 15, 2006. A beneficiary may change plans each year between November 15 and December 31. People with Medicare Advantage will get additional drug benefits from their health plan.

Why are there special rules for people with existing drug coverage from an employer, a union, or a Medigap plan, and those who are dually eligible for Medicare and Medicaid?

In the case of employer, union, or Medigap plans, the potential for duplicate insurance coverage exists. In September, employer, union, and Medigap plans will notify beneficiaries of how their plan compares with Medicare’s plan and inform them of their options. People who are dually eligible for Medicare and Medicaid now get their prescription drugs covered under Medicaid but, starting Janu-

Around the corner

September
- Economedix will hold teleconferences on Dealing with Difficult People on September 14 and on Maximizing Patient Collections on September 28. For more information and to register, go to http://yourmedpractice.com/ACS.
- ACS will sponsor basic and advanced coding workshops for surgeons and their office staff September 15 and 16 in Dallas, TX. To register, visit the ACS coding workshop Web page at http://www.facs.org/ahp/workshops/index.html.

October
- Medicare will implement the Correct Coding Initiative, version 11.3, on October 1.
- Economedix will hold teleconferences on Scheduling Techniques for Improved Productivity on October 12 and on ICD-9-CM Coding & ICD Changes for 2006 on October 26. For more information and to register, go to http://yourmedpractice.com/ACS.
- The ACS will sponsor basic and advanced coding workshops for surgeons and their office staff on October 17 and 18 at the Clinical Congress in San Francisco, CA. Also at the Clinical Congress, a practice management course, Charting a Sound Course for Surgical Practices, will be presented October 17. Advanced registration has closed but spaces may still be available for on-site registration.

Socioeconomic tips
ary 1, their drug coverage under Medicare Part D will be their primary coverage. To avoid any lapse in coverage, they will be signed up automatically for a drug plan but can change their coverage if they do not like the plan chosen for them.

**What is the benefit structure?**

The first $2,250 of drug costs is covered, with a $250 deductible. The copayment amount depends on the specifics of the plan, but overall it must be 25 percent of the cost of the drug. The beneficiary is responsible for paying 100 percent of the next $3,600 in drug costs. Medicare then pays 95 percent of all remaining drug costs, with the beneficiary responsible for the other five percent.

**How will the plans be structured to meet the needs of beneficiaries?**

Generally, plans will be required to include multiple drugs in every therapeutic category in their formularies. Each plan has to cover both generic and name-brand drugs. Each submitted formulary is checked against commonly used formularies, the drugs actually used by beneficiaries, and broadly accepted practice guidelines. CMS anticipates that plans will cover all or substantially all of the drugs used for human immunodeficiency virus/acquired immune deficiency syndrome, mental illnesses, immunosuppression, and other diseases where a specific medication or combination of medications could make a real positive difference for a patient and where transitions in medications could have a negative impact. Each plan is required to meet the needs of institutions such as nursing homes and to permit the use of mail-order pharmacies.

**What drugs are covered by the statute?**

The statute defines “covered drugs” as a drug that may only be dispensed by prescription, a biological product, or insulin and medical supplies associated with the injection of insulin. Drugs excluded by Medicaid are also excluded by Medicare except smoking-cessation drugs.

**How should a beneficiary choose a drug plan?**

Beneficiaries should select a plan based on whether the drugs they use are covered by the formulary, whether the pharmacies assigned to the plan are convenient and satisfactory to them, and the amount of the beneficiary’s cost sharing. Comparative information about the drug plans will be announced in October 2005 and will be available from the resources listed later in this article. Beneficiaries should remember that they are only signing up for a year; they can change their plan during the next year from November 15 to December 31 if their needs change.

**What are the requirements for people with limited income and resources in obtaining additional assistance?**

If a beneficiary’s income is below $14,355 for a single person (or $19,245 if the person is married and living with a spouse), the person may qualify for extra help. Slightly higher income levels apply in Alaska or Hawaii or if the beneficiary provides support to certain other family members. Still more help is provided if a beneficiary’s resources are less than $11,500 for a single person (or $23,000 for a married couple). In calculating resources, savings and stocks are included but not the beneficiary’s home and car. The extra help can pay for the premium, the drug deductible, and/or copayment. In May 2005, the Social Security Administration began mailing applications to people who might qualify and began notifying beneficiaries if they qualified in July. Those who did not receive an application in the mail and think they qualify for help should apply for extra help at the Social Security Administration or their local Medicaid office. It is estimated that almost one-third of all beneficiaries will qualify for extra help.

**When will coverage become effective for current beneficiaries who do not qualify for coverage on January 1, 2006?**

For people who join a plan after December 31, 2005, coverage begins the first day of the next month after they join the drug plan. Beneficiaries have until May 15, 2006, to join a drug plan with-

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College news

In memoriam:

A tribute to Claude H. Organ, Jr.

by Thomas R. Russell, MD, FACS, Executive Director

Claude H. Organ, Jr., MD, FACS, 84th President of the American College of Surgeons and a mentor of mine, died of heart failure on Saturday, June 18, in Oakland, CA, at age 78. I had the good fortune to have trained under Dr. Organ, to have worked with him after entering practice in San Francisco, and to have assisted him in achieving his goals as President of this organization.

Overcoming challenges

Dr. Organ’s roots were humble, and he never forgot where he came from or how much determination it took for an African-American individual born in the segregated South to succeed in this demanding and, frankly, often elitist profession.

He was born October 16, 1926, in Marshall, TX, and received his secondary education in the public schools of Denison, TX. He graduated cum laude with a bachelor of science degree from Xavier University, New Orleans, LA. He was then accepted by the University of Texas Medical School, but when the school’s administration discovered that he was black, they offered to pay the difference in tuition for him to matriculate elsewhere.

Although such discrimination may have driven some people to cynicism or despair, Dr. Organ held onto his dream of becoming a surgeon. He went on to earn a medical degree from Creighton Medical School, Omaha, NE, where he also completed his surgical training. His dissertation for a master of surgery degree focused on the acid-reducing mechanisms of the duodenum and was completed with the assistance of his scientific advisors, C.M. Wilhmenj, MD, and R.S.K. Lim, MD.

Dedicated educator

After serving as a lieutenant commander in the U.S. Navy Medical Corps, Dr. Organ joined the faculty of the department of surgery at Creighton University, where he rose to the rank of professor and was appointed chair. While at Creighton, he developed an elective surgical honors program for senior medical students who wanted to pursue a career in academic surgery. He went on to serve

In accordance with Article I, Section 6, of the Bylaws, the Annual Meeting of the American College of Surgeons is called for seven-thirty o’clock in the morning of Thursday, October 20, 2005, at the Moscone Convention Center, San Francisco, CA.

This session constitutes the annual business meeting of the Fellows, at which time Officers and Governors will be elected and reports from officials will be presented. Items of general interest to the Fellows will also be presented. Each Fellow is respectfully urged to be present.

John O. Gage, MD, FACS
Secretary
American College of Surgeons
August 2, 2005

OFFICIAL NOTICE

Annual Meeting of Fellows, American College of Surgeons

SEPTEMBER 2005 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS

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as professor of surgery at the University of Oklahoma Health Sciences Center.

In 1989, Dr. Organ established and became chair of the surgical residency program at the University of California San Francisco–East Bay. His work to support and encourage surgical residents to engage in biomolecular research and enter academic surgery was a valued part of his career. Approximately 30 residents in the University of California San Francisco–East Bay program went on to undertake two to three years of research experience in prominent laboratories.

Dr. Organ truly loved being a surgical educator and always recognized that the future of this profession depends on how well we meet the evolving needs of medical students and surgical residents. As an educator, Dr. Organ demanded excellence from the residents he trained. He accepted no excuses for poor performance and maintained the highest standards. Some residents and colleagues found his tenacity and expectations a bit off-putting. But after all was said and done, one had to admit that he was only trying to ensure that the surgeons he trained received the best possible education and were prepared to meet the challenges they would face in patient care. Dr. Organ was an inspiration to his residents, and he took enormous pride in their accomplishments.

Surgical leadership

Given his commitment to surgical education, it came as no surprise when he announced that he wanted his term as President of the ACS (2003-2004) to be known as “the year of the resident.” During the course of that year, he encouraged the development of the Resident and Associate Society of the ACS and a range of activities intended to advance the role of young surgeons in this organization.

His presidency was the culmination of many years of service to the College. Dr. Organ was initiated into the College in 1961 and thereafter served as an active participant in and leader of this Fellowship. In 1999, the ACS Board of Regents presented him with its highest honor—the Distinguished Service Award. Dr. Organ served as Second Vice-President of the College from 2001 to 2002. He was a member of the Commission on Cancer (1979-1989), a senior member of the Postoperative Care Committee (1986-1996), and a member of the International Relations Committee (1991-2001). He was installed as the second African-American President of the College at the Convocation Ceremony during the 2003 Clinical Congress.

Numerous other surgical organizations and societies benefited from Dr. Organ’s leadership acumen. In 1984, he was elected president of the Southwestern Surgical Congress. His presidency of that organization was marked by significant changes in the association’s policies, programs, and initiatives. To recognize his profound effect on the Southwestern Surgical Congress, the organization inaugurated the Claude H. Organ, Jr., Basic Science Lecture in 1995.

In addition, Dr. Organ served as a national director of Alpha Omega Alpha Honor Medical Society (1979-1989), director (1978-1986) and chairman (1984-1986) of the American Board of Surgery, and president of the Western Surgical Association (2002). He also was a member of numerous professional scientific organizations, including the American, Western, Pacific Coast, and Southern Surgical Associations.

He was an honorary fellow of several international organizations, including the Royal Australasian College of Surgeons, the Royal College of Surgeons of South Africa, the Royal College of Surgeons (Edinburgh and England), and the Association of Surgeons of Great Britain and Ireland. He also held honorary doctorate degrees from the University of Nebraska, Xavier University, and the University of Athens, Greece.

Author/lecturer

With a professional interest in general and endocrine surgery, Dr. Organ authored or co-wrote more than 250 scientific articles and book chapters and served as editor of the Archives of Surgery for 15 years. One of his articles refuted the myth that Charles Drew, MD, died because he was refused a blood transfusion at a segregated hospital. He also contributed several books to the surgical literature, including the two-volume A Century of Black Surgeons (1987), Gasless Laparoscopy with Conventional Instruments (1993), and Abdominal Access in Open and Laparoscopic Surgery (1996).

Dr. Organ shared his knowledge and communication skills
Space sold by Elsevier
with surgeons in all corners of this country and the rest of the world through the many named lectureships he delivered. For example, he twice gave the Opening Ceremony Lecture at the Clinical Congress of the American College of Surgeons (1990 and 1995). He also presented the Archibald Watson Lecture (Australia), the Zollicoffer Lecture (North Carolina), the Michael and Jamie Miller Lecture (South Africa), and many more.

**Concerned citizen**

During his very moving Presidential Address, Dr. Organ urged the College’s Initiates “to embrace a deeper professional purpose...to be the complete concerned citizen of society” and to “make a difference” in this organization, in their communities, and their institutions. He concluded his address by noting that “where poverty exists, all are poorer; where hatred flourishes, all are corrupted; and where injustice reigns, all are unequal.”

He lived what he preached. Dr. Organ gave back to his community by willingly accepting his fair share of responsibility for treating the “walking wounded.” He also was active in a number of community groups and charitable organizations. He was a former president of the Urban League of Omaha and served on the board of directors of Boys Town. He also was director of the National Catholic Conference for Human Justice (1972-1974) and a trustee of both Howard University and Meharry Medical College.

**Family man**

Dr. Organ is survived by his wife of 52 years, Elizabeth (Betty) Lucille Mays Organ and seven successful adult children—specifically, Brian C. Organ, MD, FACS, a general surgeon; Gregory M. Organ, MD, FACS, a pediatric surgeon; Paul Organ, MD, a psychiatrist; Claude H. Organ III, a bank executive; David Organ, a university professor in geography; Sandra Organ, a former principal dancer with a ballet company who now owns the Sandra Organ Dance Company; and Rita Organ, a museum curator. He is also survived by 10 grandchildren; his sister, Claudesta Gould; and his brother, Henry Organ, Sr.

I know his children and those who trained under Dr. Organ would attribute much of their success to his uncompromising standards of excellence. His inspiration will be sorely missed.
2005 Leadership Conference offers insider’s view of Capitol Hill

by Diane S. Schneidman, Manager of Special Projects, Communications

The College’s Division of Advocacy and Health Policy and Division of Member Services combined forces to present the 2005 ACS Leadership Conference June 12-14 at the Washington Court Hotel in Washington, DC. Approximately 150 Chapter Officers and Young Surgeon Representatives participated in the program, which focused largely on the inner workings of Capitol Hill and effective strategies for communicating with legislators and other governmental policymakers. On the final day of the meeting, chapter leaders and young surgeons participated in visits to Capitol Hill with members of Congress and their health policy staff.

The insider’s view

Judy Schneider, a specialist on the history and structure of Congress at the Congressional Research Service (CRS) and an adjunct scholar at the Brookings Institution, offered a candid perspective on how Capitol Hill functions. (The CRS is an apolitical service that is responsible for providing responses to queries about the federal government from members of Congress and their staffs.)

“Congress operates like no other institution in the world,” Ms. Schneider said. Almost every day that Congress is in session, senators and representatives drop bills into a hopper. The bills are then referred to the congressional committee with “predominant jurisdiction” over the issue for review.

Members of Congress may serve on an unlimited number of committees. Chairs of committees are often selected based on their length of service. “The seniority system is alive and well on Capitol Hill. You outlive everybody, and you get to be chair,” Ms. Schneider said.

Congressional committees regularly hold hearings about legislative proposals. Contrary to popular belief, “Hearings are not big fact-finding meetings, but a way to get public interest up,” Ms. Schneider said. Indeed, over the last two decades, starting with the 1986 hearings held on the “Farm Bill,” testimony from celebrities has become a common means of attracting news coverage and public interest, she said. However, approximately only 10 percent of the bills introduced in Congress move beyond the hearing stage.

Ms. Schneider noted that the U.S. government is simply a modified version of the British model. England has its House of Commons; the U.S. has the House of Representatives. Britons have the House of Lords; the U.S. has the Senate.

“The Senate lives and dies by two words: ‘unanimous consent,’” Ms. Schneider said. In order for a bill to pass in the...
Senate, 60 members must vote to end debate. To avoid reaching “cloture,” senators may filibuster, or wrest control of the floor and speak at great length about the bill or any other topic “until [a] knee touches the floor,” she said. “As long as you can stand, you can talk.”

The House, on the other hand, “lives and dies by procedure.” It also is the body intended to represent the interests of average citizens. “We expect them to represent us and not ‘go Washington’ on us,” Ms. Schneider said.

Because Congress “was not created to pass laws but to prevent bad laws from being passed,” political advocacy requires patience, Ms. Schneider said, adding, “Nothing happens quickly.”

Ms. Schneider told the individuals planning to participate in Capitol Hill visits not to be intimidated by federal legislators. “Most of them are average people who have been asked to do an extremely difficult job,” she explained. “Don’t talk platitudes. Don’t talk big picture. Talk about how the issue affects you. Tell them what you want and why you want it.”

She also forewarned the surgeons that they probably would be meeting with some of the 2,500 staff people who report to legislators. The typical House staffer is 24 years of age and works on Capitol Hill for 18 months. The average Senate staff person is a few years older and likely to work in the same office for about three years. In other words, “What we’ve got is a staff under the age of 30 with no institutional experience,” Ms. Schneider said. However, surgical advocates should remember that these are the individuals who provide information about topics to members of Congress. So although they’re young, they’re also powerful.

The College’s big picture

ACS Executive Director Thomas R. Russell, MD, FACS, provided an overview of how the College is scanning the horizon and developing new programs to respond to the various factors influencing surgery today. He noted that when he left surgical practice to assume his current position, he “moved from the ‘micro world’ and had to move up to the ‘macro world.’” He had to stop thinking about how issues affected him, his practice, and his hospital and start dealing with some of the big issues affecting surgery.

As a result, Dr. Russell’s views on certain subjects have shifted during the nearly six years he has served as ACS Executive Director. For instance, when he was a practicing surgeon, he viewed as intrusive the activities that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) carries out. “Now I truly believe that the JCAHO is trying to change health care for the better,” he said.

In assuming the mantle of the College, Dr. Russell said he had to start thinking more about the future of the profession and organization. One issue of great concern to all of surgery over the past few years has been attracting young people to the profession and encouraging their active interest and involvement in the profession. As a result, Dr. Russell noted, the College has developed the Resident and Associate Society, which has initiated programs that ensure that this organization provides a home base for young surgeons.

One of the more hotly debated socioeconomic topics of late is the concept of pay for performance, under which physicians would be reimbursed on the basis of their ability to provide safe, quality, and cost-effective care. “Laws are going to be drafted,” Dr. Russell said. Hence, the College needs to continue its involvement in the Centers for Medicare & Medicaid Services’ (CMS) efforts to assess and measure the outcomes that will serve as the future yardstick for payment. “We can’t do it. If we don’t do it, someone else will do it for us,” he added.

In addition, Dr. Russell stressed that all of the surgical specialties need to work together on the broad issues that affect all surgeons. “The College needs to speak with a unified voice for the house of surgery. We need to be together,” he said.

President Bush’s perspective

Lance Leggitt, special assistant for domestic policy to George W. Bush, shared the President’s views on health care. President Bush believes that “the health care system is badly in need of reform,” Mr. Leggitt said.

One problem that President Bush strongly believes should be addressed is the medical liability crisis. The President “is firm in his commitment to achieving tort reform,” Mr. Leggitt stated.
President Bush also believes that the nation needs to upgrade health information technology as a means of improving quality. “This is a goal we can achieve and that we have a moral obligation to achieve,” he asserted. The administration has formed an advisory committee to examine this subject.

**Rep. Paul Ryan**

Meeting attendees also heard from Rep. Paul Ryan (R-WI), who serves on the House Ways and Means Committee. This committee has “predominant domain” over the Medicare program and other health care issues, and Representative Ryan offered his perspective on burgeoning issues.

“We are at the proverbial fork in the road with regard to health care reform. The current system is unsustainable,” Representative Ryan said.

Nonetheless, he warned against the adoption of a government-run, single-payer system. “Medicare is an example of the government running the health care system,” he said, noting that in 1997, the government imposed price controls to financially salvage the program. “We want to get away from that because you end up rationing care,” Representative Ryan added.

He believes that a better approach would be a consumer-driven system that offers merit pay incentives to providers of quality care. He also called for the establishment of health savings accounts to expand access to care and suggested using means testing to determine eligibility for Medicare Part B coverage. “We’re trying to put more flexibility into the system,” Representative Ryan explained.

He urged surgeons to play an active role in reshaping the health care system. “You have to give us input on the issues. Otherwise, we will enact another global, price-control system,” Representative Ryan cautioned.

The congressman also said he anticipates that the House will once again successfully pass a liability reform bill this year, adding that it is possible that the Senate will finally gather enough support to pass this sort of legislation as well.

**Congressional committee staff**

Senior staff from various congressional health care committees discussed the progress being made in implementing the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) and on a number of bills currently under consideration.

Madeleine Smith, professional staff member for the House Ways and Means Subcommittee on Health, noted that since the expiration this spring of a moratorium on physician referrals to specialty hospitals in which the referring physician has ownership interests, Congress and CMS are giving new thought to how specialty hospitals are paid.

With regard to physician payment under the Medicare fee schedule, Ms. Smith noted that surgeons will face a pay reduction from 2006 through 2011 unless Congress takes action. The pay cuts are the result of the fee schedule’s dependence on the sustainable growth rate (SGR), which ties health care expenditures to the gross domestic product, to calculate reimbursement updates. To avert these reductions, the Congressional Budget Office recommends freezing payment for a number of years, she said.

Melissa Bartlett, Medicare counsel for the House Committee on Energy and Commerce, said surgeons need to continue to work with the federal government on these and other issues. “Your voice is being heard, and your story is an important one to tell,” Ms. Bartlett said.

She noted that surgeons especially should assist the government in its analysis of quality and the potential development of a pay-for-performance schematic. A number of pay-for-performance options are on the table, and careful thought must be given to these proposals. “Doing it on the cheap won’t help and might make things worse—not just for physicians but for patients as well,” Ms. Bartlett added. “We need to look closely at incentives.”

Ms. Bartlett also indicated that the Energy and Commerce Committee will revisit the issue of professional liability reform and anticipates completing its work on the patient safety bill later this year.

Whereas Ms. Bartlett provided the Republican majority’s perspective, Amy Hall, professional staff member, House Committee on Energy and Commerce, represented the Democratic minority’s point-of-view. “We want to improve quality, but we need to level
the playing field,” Ms. Hall said. More specifically, she explained, “We need to get everyone on the same level technologically, and we need to develop good outcomes measures.”

In addition, Ms. Hall said that some Democrats on the committee remain dedicated to passing a “Patient Bill of Rights,” one that may now be linked to pay for performance in some way.

Ms. Hall also noted that the committee had held a hearing recently with the National Governors Association (NGA) regarding the Medicaid program. At that hearing, the NGA asserted that states need to increase cost sharing and flexibility in the program in order to sustain it.

Joelle Oishi, health policy advisor to the Senate Committee on Finance, indicated that the chair of the committee, Sen. Charles Grassley (R-IA), is interested in paying physicians based on quality. “We appreciate that the College is working on quality measurements,” she stated.

In addition, Ms. Oishi noted that Senator Grassley was a key player in ensuring this year’s revision of the list of procedures that would be reimbursed when provided in ambulatory surgical centers (ASCs). He sent a letter to the CMS supporting the development of the ASC list changes, she said.

**CMS’ perspective**

Mark McClellan, MD, PhD, Administrator of the CMS, provided an update on the agency’s efforts to develop a pay-for-performance mechanism for Medicare reimbursement and other activities. Dr. McClellan said that physician involvement in developing the quality measures and outcomes data that are integral to pay for performance “is important—even critical. We can only do this effectively with your input.” Dr. McClellan acknowledged the College’s cooperation in determining how the ACS National Surgical Quality Improvement Program measures and findings from the Surgical Care Improvement Project might be incorporated into a Medicare pay-for-performance initiative.

In addition, Dr. McClellan pointed to efforts to ease administrative burdens on physicians, as well as confusion on the part of beneficiaries. He noted that the CMS now offers one Web site for coding information and has developed pilot projects for testing customer service over the Internet.

Dr. McClellan also provided an update on implementation of the Medicare prescription drug benefit. Applications for coverage have been sent to all beneficiaries, and CMS intends to start delivering drug coverage to beneficiaries beginning January 1, 2006. Under the drug benefit, “Medicare will typically pay for 50 percent of drug costs,” he said. (See related article by Dr. McClellan, page 18.)

**The College’s perspective**

Staff from the College’s Division of Advocacy and Health Policy provided briefing information on the issues topping the organization’s legislative agenda. Leading this session was Christian Shalgian, Manager of Legislative Affairs. Other members of the College’s legislative staff who participated in the meeting included Adrienne Roberts, Shawn Friesen, and Geoff Werth.

One issue that has been high on the College’s list of priorities for many years is Medicare reimbursement and the effects of the SGR. According to Mr. Friesen, the SGR changes payments in three ways: (1) it sets one target for all physician services; (2) it links payment to growth in the gross domestic product; and (3) it requires Medicare to recoup payments that exceed the SGR target.

Because of the SGR, CMS estimates that Medicare payment will be reduced by 4.3 percent in 2006 and that payment will be cut a total of 26 percent between 2005 and 2011. To avert this situation, the College wrote to House and Senate committees and endorsed the Preserving Patient Access to Physicians Act of 2005 (S. 1081 and H.R. 2356), Mr. Friesen said. The staff encouraged Fellows to raise this subject during their Capitol Hill visits and to seek out cosponsors of S. 1081 and H.R. 2356.

Furthermore, the College generally supports efforts to link payment to performance across health care, particularly if it results in a reimbursement device that would replace the SGR. Surgeons should try to be part of these efforts and to offer their input. “Members and staff are willing to listen. You
have the experience and the knowledge. By being involved, surgeons can make pay for performance work for surgeons and their patients,” according to Mr. Friesen.

Another subject that surgeons were encouraged to discuss during their Capitol Hill visits is professional liability. Mr. Shalgian reported that approximately 19 states are in crisis, and 25 more are on the verge of being in that situation. The College maintains that the solution to the problem is MICRA (Medical Injury Compensation Reform Act), which includes a $250,000 cap on noneconomic damages, a statute of limitations, joint and several liability, collateral source reform, and limits on attorney fees. The House has repeatedly passed this type of legislation, but the Senate has continually rejected it.

When discussing this issue on Capitol Hill, the legislative staff suggested that surgeons explain how they have been affected personally by the crisis. Mr. Shalgian also said that surgeons should thank those members who have supported liability reform and question the resistance of those who have opposed it.

Trauma care systems funding is another issue of great concern to the College. It is of particular interest this year because the House committee that appropriates funding for trauma systems development did not provide any money for the program in fiscal year 2006. Meeting participants were encouraged to seek continued funding of at least $3.5 million, Ms. Roberts said.

In keeping with its long-standing commitment to the surgical patient, the College considers patient safety a highly relevant issue. Mr. Werth noted that F. Dean Griffen, MD, FACS, Chair of the ACS Committee on Patient Safety and Professional Liability, testified before Congress on initiatives that the College has launched in this area.

**ACSPA-SurgeonsPAC**

Andrew L. Warshaw, MD, FACS, Chair of the American College of Surgeons Professional Association political action committee (ACSPA-SurgeonsPAC), updated meeting participants on the political action committee’s recent activities and the role of surgical leaders in advocacy.

According to Dr. Warshaw, the ACSPA-SurgeonsPAC is a broad coalition, not specific to any single specialty, and seeks to gain access to policymakers. “We do not make the policies we advocate for; you do,” he explained to the surgeons in the audience.

The PAC raised nearly $600,000 in its first election cycle. Recipients of the campaign funds were chosen based largely on their past voting record and whether they hold leadership seats on health care committees.

Dr. Warshaw noted that the ACSPA-SurgeonsPAC is very active in Doctors for Medical Liability Reform. The message this coalition is sending to the public is that “if doctors can’t get coverage, patients can’t get care,” Dr. Warshaw said.

Surgeons may support the ACSPA-SurgeonsPAC and its efforts in a number of ways, Dr. Warshaw noted, including through their participation in Capitol Hill visits and donations to the PAC.

**State issues**

A panel of representatives from three of the College’s state chapters demonstrated how they have successfully achieved passage of state legislation.

Roxie M. Albrecht, MD, FACS, of the Oklahoma Chapter, noted that surgeons advocated for the passage of S.B. 1554, which increases trauma funding by imposing new fines and fees on motorists without car insurance and hiking the tobacco tax. The legislation ties licensure to a hospital’s readiness to respond to emergency situations. It also establishes eight new regional trauma boards and several transfer centers.

Dr. Albrecht explained that surgeons spent a great deal of time educating the public and policymakers about the functions of trauma centers. They also recruited trauma survivors to testify at hearings.

Sidney F. Miller, MD, FACS, of the Ohio Chapter, said, “As surgeons, we have to have a presence in Washington and the state capitals,” and outlined the lengthy process surgeons in his state underwent to establish a trauma system. According to Dr. Miller, the Cleveland Academy of Medicine first called for development of a trauma system in 1983. The state trauma system went through various permutations and was under the oversight of multiple agen-
cies in subsequent years, until the state legislature recently passed H.B. 138. This law establishes a statewide trauma system and requires that all trauma centers be verified by the ACS.

Successful advocacy “requires coalition building, lobbying, and effective media campaigns,” Dr. Miller concluded.

Heather Bennett, JD, Executive Director of the New York Chapter, echoed Dr. Miller’s sentiments, emphasizing that forming coalitions with the state medical society and specialty groups has allowed the New York Chapter to successfully influence the legislature. Ms. Bennett also noted the importance of identifying the competition, sending out member alerts, maintaining a key contact list, using the Surgery State Legislative Action Center, and sharing information with the College’s State Affairs staff.

The New York Chapter applied all of these strategies this past legislative session to defeat a proposal to tax services provided at ambulatory surgery centers, Ms. Bennett said. The tax was rejected by the New York Senate and therefore not incorporated into a budget resolution. In addition, the state assembly amended the proposal to just levy the tax on cosmetic procedures, but this plan too was ultimately rejected by the senate. “Therefore, the proposal never made it to Governor Pataki’s desk. The issue is defeated for now, but I am sure it will be back,” Ms. Bennett said.

The second Arthur Ellenberger Award for Excellence in State Advocacy was presented to Robert Harvey, Executive Director of the Florida Chapter of the ACS. In presenting the award to Mr. Harvey, Mr. Ellenberger pointed to a track record of encouraging surgeons to advocate at the state level and of coalition building. This award is presented periodically to recognize an individual’s commitment to state advocacy.

Communication/leadership

Michele G. Kayden, PhD, principal, Kayden Enterprises, led a session aimed at helping surgeons to understand the various communications styles of politicians, surgeons, and others and how to engage their interest in the speakers’ subject matter.

According to Dr. Kayden, there are four types of communicators: “thinkers” respond to facts, “sensers” want action, “feelers” are concerned about people’s reactions, and “intuitors” like to discuss theory. Thinker communications are deliberative, prudent, logical, rational, analytical, exact and precise, objective, and formal. Bankers and accountants tend to fit into this niche. Senser interactions are pragmatic, assertive, results-oriented, practical, technically skillful, direction-giving, decisive, and controlling. Surgeons and chief executive officers tend to fall into this category. Feelers are spontaneous, persuasive, introspective, loyal, and informal, and tend to predict the reactions and feelings of others. Politicians and psychologists often fall into this group. Intuitors are conceptual, original, imaginative, creative, idealistic, intellectually tenacious, and forward thinking. Software designers and artists are in this grouping.

To communicate effectively with others, it helps to know
the type of person with whom one is interacting because each personality responds to a different presentation style, Dr. Kayden said. Thinkers like information to be presented in a step-by-step, logical, and systematic way. Sensors want speakers to get to the bottom line quickly and to stress the practical applications of their ideas. Feelers react positively to small talk, like to know how proposals will affect the other people involved, and prefer informal discussion. Intuitors want to hear about the “big picture,” unique strategies, and innovative ideas.

**Chapter finances**

Paula Cozzi Goedert, Esq., Barnes & Thornburg, LLP, reviewed the fiduciary responsibilities of chapter leaders. Ms. Goedert also spoke about how chapter leaders can protect themselves from liability. Specifically, she suggested following “The Washington Post Rule,” which is, “If there is a fact that can’t be made public, then don’t do it.”

In addition, Ms. Goedert explained the different restrictions on campaign contributions for not-for-profit organizations that have 501(c)3 or 501(c)6 tax-exempt status. She also noted that ACS chapters do not have to pay taxes on dues and exhibit revenues. Advertising revenue, however, is taxable, whereas corporate contributions are tax-exempt, provided some sort of acknowledgment is offered.

Ms. Goedert also spoke about copyrights. “Everything belongs to someone,” she said. Furthermore, “It is the ‘law of unintended consequences’ that if you use someone else’s material, you will get caught.”

Before using any item originated by another individual in your newsletter or on a Web site, either get the person’s permission or do not use it.

**Continuing education**

The program also included a session entitled Accomplishing Your CME Mission, moderated by Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the College’s Division of Education. This session covered a variety of topics related to continuing medical education (CME), including: (1) the effects of CME on physicians’ practices; (2) effective CME program design; and (3) corporate sponsorship of CME activities. Speakers were as follows: David A. Davis, MD, CCFP, FCFP, department of health policy, management, and evaluation, and faculty of medicine, University of Toronto, ON; Barbara Barnes, MD, University of Pittsburgh (PA) Medical Center; Bruce J. Ballande, PhD, executive director, Alliance for Continuing Medical Education; and Fred W. Holzrichter, CFRE, Manager of the College’s Development Office.

**Senators speak**

Before spending several hours on Capitol Hill the morning of June 14, meeting participants engaged in role-playing activities and attended a reception that gave them the opportunity to meet with various members of Congress in a more relaxed setting.

Sens. John Ensign (R-NV) and John Thune (R-SD) addressed the group during a breakfast briefing. Both spoke about medical liability reform.

“Some of the best surgeons in Las Vegas have quit practice” because their malpractice premiums have risen so dramatically, Senator Ensign said. However, “We can’t get anything through the Senate right now,” he noted.

“Most people think that because we have 55 Republicans in the Senate, we should be able to pass liability reform,” Senator Thune added. The rules of engagement in the Senate that call for 60 votes in favor of a bill in order to end debate make enactment of liability reform difficult.

Other topics the senators addressed include electronic medical records and health savings accounts.

**Conclusion**

This year’s Leadership Conference provided participants with opportunities to better understand how Congress functions and how the College interacts with federal law- and policymakers. Staff from the Division of Advocacy and Health Policy and the Division of Member Services surveyed participants to determine the value of the meeting. The majority of participants indicated that they appreciated being able to meet with members of Congress and their staff to voice their concerns and that they had learned a great deal about the legislative process.
Surgeons find success at AMA House of Delegates meeting

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

The American College of Surgeons achieved success on several fronts during the American Medical Association’s (AMA) annual House of Delegates (HOD) meeting, which took place last month in Chicago, IL. More specifically, two ACS Fellows were elected to serve in leadership positions, and the College achieved passage of resolutions on physician workforce issues and medical imaging.

Fellows win elections

Elections for seats on the AMA’s councils and board of trustees take place during the HOD meeting, and during this year’s elections, two Fellows of the College achieved prominent leadership positions with the AMA. The HOD unanimously selected William G. Pledger II, MD, FACS, a thoracic and cardiovascular surgeon in Los Angeles, CA, to be AMA president-elect. Dr. Pledger served for many years on the board of trustees, and recently was its chair.

In an election victory “first” for the College, Richard Reiling, MD, FACS, a general surgeon from Charlotte, NC, and member of the ACS delegation, was elected to the AMA council on medical education. A lifelong educator, Dr. Reiling received strong support from surgical specialty and state medical society delegates. He is the only surgeon serving on this important council, which is responsible for studying all facets of medical education and developing policies to address medical education issues.

Workforce resolution

Advocating on behalf of surgery and surgical issues gives the College an opportunity to introduce resolutions of its own. The ACS delegation has an excellent track record with regard to passing resolutions, and the 2005 meeting was no exception. A College-authored resolution centered on the effects of the impending physician workforce shortage on emergency and trauma care was introduced as a result of an ACS-led meeting of the surgical specialty societies held earlier in the year and was unanimously adopted by the HOD.

Resolution 309-A-05, cosponsored by seven surgical and medical specialty societies, directs the AMA to convene a work group of the specialties affected by the imminent shortage of specialists for emergency and trauma care and those organizations closely involved in physician workforce issues.
The panel will be responsible for developing solutions to the problem. The College looks forward to participating in the deliberations of this work group and applauds the HOD for taking this action.

**Pay for performance**

Pay for performance (P4P) has become a frequent topic of discussion, with many medical organizations sponsoring forums and other meetings focused on the subject. The AMA Board of Trustees, in response to the overwhelming interest expressed at the December 2004 interim meeting of the HOD, issued a report proposing guidelines and principles for the development of these programs. Hours of testimony and debate resulted in adoption of principles and guidelines addressing patient safety and quality care, the patient/physician relationship, physician participation in these programs, and specialty pilot testing of performance measures. The report is available at [http://www.ama-assn.org/ama/pub/category/15254.html](http://www.ama-assn.org/ama/pub/category/15254.html).

The AMA’s surgical caucus, which is administered by the College and supported through the dues donations of surgeons in the HOD, sponsored an educational forum on pay for performance titled “P4P: Current Perspectives/Initiatives...And What It Means for Surgeons.” Panelists at this well-attended session included: Thomas Russell, MD, FACS, ACS Executive Director; Dennis O'Leary, MD, president of the Joint Commission on Accreditation of Healthcare Organizations; Michael Rapp, MD, director of the quality measurement and health assessment group for the Centers for Medicare & Medicaid Services; Reed Tuckson, MD, senior vice-president of consumer health and medical care advancement at UnitedHealth Group; and John Armstrong, MD, FACS, secretary of the board of trustees and chair-elect of the surgical caucus.

**Medical imaging**

Federal and state legislative attempts to restrict reimbursement for imaging services as well as self-referral to physician-owned imaging centers (and in-office imaging services) except for radiologists resulted in the introduction of a strongly worded resolution to the AMA House of Delegates. Resolution 228-A-05, “Freedom of Practice in Medical Imaging,” was adopted by the HOD and directed the AMA to take the following positions:

1. Oppose efforts by private payors, Congress, state legislatures, and the Administration to impose policies designed to control the use and costs of medical services unless those policies can be proven to achieve cost savings and improve quality without curtailing appropriate growth or compromising patient access to or quality of care.

2. Oppose efforts requiring patients to receive imaging services at facilities mandated to have specific medical specialty supervision, and support patients receiving imaging services at facilities where appropriately trained medical specialists can perform and interpret imaging services regardless of medical specialty.

3. Oppose attempts to restrict reimbursement for imaging procedures based on physician specialty, and continue to support the reimbursement of imaging procedures performed and interpreted by physicians based on the proper indications for the procedure and the qualifications and training of the imaging specialists in that specific imaging technique regardless of their medical specialty.

The College and 11 other specialty societies cosponsored this resolution, which expands upon existing AMA policy. In past years, the College had authored a resolution calling on the AMA to vigorously advocate that all appropriately trained physicians, regardless of specialty be reimbursed for performing diagnostic sonography with appropriate documentation (including sonographically directed biopsy, aspiration, and so on) in situations with defined clinical indications.

**More about the HOD**

The HOD functions much like any other deliberative body, such as Congress or state legislatures, and is another venue for issue advocacy. Reports and resolutions are heard in reference committees, where AMA members may testify. Delegates consider numerous resolutions over the course of four to five days; in fact, during the 2005 meeting, 538 delegates reviewed 230 resolutions introduced by state and national societies, and 64 reports (with...
recommendations for action or policy) submitted by the AMA through its Board of Trustees or various councils.

The College’s delegation is ably led by LaMar S. McGinnis, Jr., MD, FACS, Atlanta, GA, and has attained respect among other specialty delegations because of its ability to generate action on issues of concern to surgery. For example, at the College’s suggestion, the HOD has passed resolutions on office-based surgery principles, payment for sonography regardless of physician specialty, expert witness qualifications and guidelines, and so on. Along with Dr. McGinnis, the College’s delegation includes: Charles Logan, MD, FACS, Little Rock, AR; Dr. Reiling; Ami Rothhammer, MD, FACS, Colorado Springs, CO; and Thomas Whalen, MD, FACS, New Brunswick, NJ.

In addition, Patricia Turner, MD, Baltimore, MD, is the College’s representative in the Young Physicians Section (YPS). She also chairs the YPS surgical caucus, unifying the surgeon delegates to advocate on behalf of the profession within the section. Meanwhile, Jacob Moalem, MD, a pediatric surgery resident from New Jersey, serves as the College’s delegate to the Resident and Fellow Section.

The ACS is already preparing for the next meeting of the AMA House of Delegates, scheduled to begin the first weekend of November in Dallas, TX. This meeting will focus on legislative and regulatory advocacy issues, with payment issues likely to dominate the agenda.

As part of the College’s advocacy program and emphasis on collaboration with surgical and medical societies, the ACS will maintain its level of involvement in the HOD and other AMA activities and programs. Surgeons seeking further information on actions taken by the AMA HOD should visit the AMA Web site at http://www.ama-assn.org/ama/pub/category/14887.html, or contact the author at jsutton@facs.org

2005 Wylie Scholar selected

Rajabrata Sarkar, MD, PhD, FACS, assistant professor of surgery at the University of California, San Francisco (UCSF), has been named the 2005 Wylie Scholar in Academic Vascular Surgery by the Pacific Vascular Research Foundation (PVRF). Dr. Sarkar will receive a three-year grant from PVRF, a nonprofit research and educational foundation based in San Francisco, CA.

PVRF established this annual career development award in memory of Edwin Jack Wylie, MD, FACS, a pioneer and visionary in vascular surgery. The award supports a promising surgeon-clinical scientist whose research might qualify him or her for additional independent support as an investigator. Dr. Sarkar is the ninth Wylie Scholar Award recipient.

Dr. Sarkar’s research involves the complex problem of resolution of deep venous thrombosis (DVT). His aim is to define the molecular mechanisms of activation of matrix metalloproteinase (MMP)-2 in DVT and the significance of MMP function in resolution of DVT. It is anticipated that this research will lead to the development of a potential molecular therapy to accelerate DVT resolution and prevent post-thrombotic syndrome.

The application deadline for the 2006 Wylie Scholar Award is February 28, 2006. Application requirements for the award will appear later this year in the Bulletin and will be posted on the PVRF Web site, www.pvrf.org.
Philosophical society calls for nominations for award, fellowships

The American Philosophical Society has announced its call for nominations for the Judson Daland Prize and fellowships in clinical investigations.

The Judson Daland Prize

The recipient of the Judson Daland Prize for outstanding achievement in patient-oriented research will be awarded $20,000 at the meeting of the American Philosophical Society in November 2006.

• Eligibility. Although candidates are not required to be U.S. citizens, the clinical investigative work must have been performed at a U.S. institution. Nominees should have earned a medical (MD) degree within the past 15 years.

• Nomination process. Candidates must be nominated by the chair of a clinical department of a medical school or hospital located in the U.S. The nominator must submit an abstract of the work to be honored (maximum 500 words), the curriculum vitae and a bibliography of the nominee, and a letter that details the patient-oriented nature of the nominee’s investigation. Three additional letters of support (of which only one can be from the same institution as the nominee) are required and must be sent to the Society separately.

• Deadline. Nominations and all three letters of support must be received by March 15, 2006.

Daland Fellowships in Clinical Investigation

Daland Fellowships in Clinical Investigation are awarded for research in the several branches of clinical medicine, including internal medicine, neurology, pediatrics, psychiatry, and surgery, with an emphasis on patient-oriented research.

This one-year fellowship, with a possible one-year renewal based on demonstration of satisfactory progress, provides a stipend of $50,000 (for each year). Funds for institutional overhead will not be provided.

The fellow is expected to devote 100 percent of his or her time to research; the fellowship will constitute salary support. Limited teaching or clinical service is permitted, and a small portion of the fellowship may be used for supplies.

• Eligibility. Daland fellowships—which are awarded to persons who have held an advanced medical degree (MD or MD/PhD) for less than eight years—are generally intended to be an individual’s first post-clinical fellowship; each case will be decided on its merits. Preference is usually given to candidates who have less than two years of postdoctoral training and research. Applicants can be a U.S. citizen or foreign national, but research must be performed at a U.S. institution under the supervision of a scientific advisor. Direct contact with patients is required.

• Nomination requirements. Candidates are to be nominated by their department chairs, in a letter providing assurance that the nominee will work with the guidance of a scientific advisor of established reputation who has guaranteed adequate space, supplies, and so forth. The advisor need not be a member of the department nominating the fellow, nor need the activities of the fellow be limited to the nominating department. As a general rule, no more than one fellowship will be awarded to a given institution in the same year of competition.

• Deadline, notification. Applications for first-year fellowships are due September 1, 2006. A complete application includes all materials requested on the form, in the correct number of copies, and three confidential letters supporting the application.

For more information on the Daland Fellowships in Clinical Investigation or the Judson Daland Prize, contact Linda Musumeci, research administrator, at LMusumeci@amphilsoc.org, or call 215/440-3429. Application forms and a more detailed explanation of requirements are also available at www.amphilsoc.org.
2006 ACS German Traveling Fellow selected

Michael G. Franz, MD, FACS, assistant professor of surgery, University of Michigan, Ann Arbor, has been selected as the 2006 ACS Traveling Fellow to Germany.

As the German Traveling Fellow, Dr. Franz will participate in the annual meeting of the German Surgical Society in Berlin, May 2-5, 2006. He will attend and participate in the ACS Germany Chapter meeting during that event. Dr. Franz will also travel to several surgical centers in Germany, with assistance from mentors provided by the German Surgical Society and the Germany Chapter. One of Doctor Franz’s particular interests is the biological and mechanical mechanism of surgical wound failure. He looks forward to consulting with German colleagues on this and other topics during his visit.

The application deadline for the 2007 Traveling Fellowship to Germany is April 1, 2006. Application requirements will be published in a future edition of the Bulletin and posted to the College’s Web site, www.facs.org.

Fellows honored with 2005 Surgical Volunteerism Awards

Immediately following the 2004 Clinical Congress, the Governors’ Committee on Socioeconomic Issues put out a call seeking nominations for the 2005 ACS/PMHI Surgical Volunteerism Awards in association with the Pfizer Medical Humanities Initiative. A great number of College members submitted nominations for the award. The committee had a challenging time in scoring the excellent candidates.

For his service in the international arena, the committee nominated Domingo T. Alvear, MD, FACS, Harrisburg, PA. Dr. Alvear began his volunteerism in 1966, and in 1977 founded the World Surgical Foundation, Inc.

The committee also nominated George F. Ellis III, MD, FACS, Longwood, FL, for his work in the domestic arena. As the founding chair of the Primary Care Access Network (PCAN), Dr. Ellis’ tireless dedication to the less fortunate gave him the motivation to consider the tremendous challenge of caring for the uninsured in “his own backyard.”

Drs. Alvear and Ellis will receive their awards at the Board of Governors dinner on Tuesday, October 18. The dinner takes place during the College’s annual Clinical Congress.
College cosponsors rural surgery symposium

The American College of Surgeons and Mithoefer Center for Rural Surgery of Bassett Healthcare cosponsored the first Annual Rural Surgery Symposium May 22-24, in Cooperstown, NY. The symposium—which focused on the current status, educational issues, and research in rural surgery—hosted 101 participants, including surgeons from 27 states, residents, medical students, exhibitors, and Bassett Healthcare staff.

According to Charles Rinker II, MD, FACS, Chair of the Advisory Council for General Surgery’s Rural Surgery Subcommittee, only 19 percent of surgeons are employed in rural settings, with 9 percent in small rural towns.* Groups such as the Rural Surgery Subcommittee and Mithoefer Center serve as advocates for rural surgeons and are looking for ways to increase this surgeon population and meet its education and training needs. The purpose of this symposium is to provide a national meeting that focuses on these issues.

To begin the symposium, after the director of the Office of Rural Health Policy delivered an overview of rural health care programming and policy, Hiram C. Polk, Jr., MD, FACS, chronicled the recent history of training rural surgeons.

In the Present State of Rural Surgery session, Steven Heneghan, MD, FACS, discussed a recent national survey conducted by the Mithoefer Center regarding the differences in practice among rural versus urban surgeons, particularly that rural surgeons are concerned about the difficulty in obtaining appropriate training to maintain current practice-related knowledge. In other contributions to this session, Richard J. Field, MD, FACS, discussed his perspectives on the scope of a rural surgeon’s practice; Stephen Olson, MD, FACS, presented his experiences in changing from an urban to a rural surgical practice; and representatives of a rural hospital provided insights on developing a surgical program.

Dr. Rinker moderated a session that focused on the educational issues facing rural surgeons. The focus of the sessions regarding educational issues were attracting students to rural areas and creating effective training programs for the rural practice setting, as well as the Mithoefer Center’s role in offering such programs. In this educational session, Karen Deveney, MD, FACS, reviewed the model being used at her institution, Oregon Health and Science University in Portland, to train residents for rural practice; J. Patrick O’Leary, MD, FACS, of Louisiana State University, Baton Rouge, presented his thoughts on effective training programs for rural practice; and Patrick Dietz, MD, FACS, program director for Bassett Healthcare’s surgical residency, discussed educational programs the Mithoefer Center offers.

In a session focused on research that addresses rural surgery, presenters called for demonstration of economic value and general importance of surgical programs in rural communities and hospitals. In this session, Samuel Finlayson, MD, MPH, FACS, of Dartmouth Medical School, Hanover, NH, moderated a panel discussion on quality of care in rural settings; Andrew Coburn, PhD, from the Maine Rural Health Research Center in Portland, delivered a presentation on “Assuring Rural Hospital Patient Safety”; William Weeks, MD, MBA, shared findings of recent research he conducted with the Veterans Health Administration; and current research findings about the supply and distribution of rural surgeons in the U.S. were presented by Dana C. Lynge, MD, FACS, of the WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) Rural Health Research Center.

Thomas Russell, MD, FACS, Executive Director of the American College of Surgeons, attended the symposium. In his address to attendees on the second day, Dr. Russell expressed his support for rural surgical issues and praised the Mithoefer Center and the Rural Surgery Subcommittee for their efforts. Dr. Russell also emphasized the need

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to track cases and outcomes as he reviewed the Practice-Based Learning System.
Response to this first symposium was positive, and participants indicated that future symposia should include practice-management topics such as reimbursement, liability, credentialing, and employee retention, and surgical practice-related topics such as advanced laparoscopy, endoscopy, and obstetric/gynecological procedures.

Clinical Trials Methods course to be offered in November

The American College of Surgeons’ Surgical Research Committee will sponsor the eighth Clinical Trials Methods course November 11-15, at ACS headquarters and the Wyndham Hotel in Chicago, IL. This course is recommended for surgeons who plan to engage in clinical research at a leadership level. It includes concepts and development of skills in the design, implementation, and analysis of randomized clinical trials; observational studies; the use of large administrative databases; meta-analysis; funding mechanisms and budget development; outcomes (medical, patient-centered, cost); and dissemination of results.

Registration for the Clinical Trials Methods course is limited to 50 participants, and preference is given to members of the American College of Surgeons.

The deadline for registration is September 16, but a discounted fee is available to surgeons who sign up early.

For more information on the Mithoefer Center and the Annual Rural Surgery Symposium, contact Lori Sawicki, administrative director of the Mithoefer Center, at 607/547-3518, or e-mail lori.sawicki@bassett.org.

What surgeons should know about..., from page 11

MMA requires CMS to develop a new payment system that is effective sometime between January 1, 2006, and January 1, 2008. CMS has announced that it will take the maximum amount of time to develop the new payment system, so it will be effective on January 1, 2008. The General Accountability Office is expected to conduct a study of the appropriateness of using the groups of services and relative weights under the OPPS as the basis for the ASC rates, perhaps paying a percentage of the amount paid under OPPS. The General Accountability Office is also to consider the appropriateness of a geographic adjustment in the payment system. Of course, the new payment system will be published in the Federal Register as a proposal to give interested parties an opportunity for comment.
I am honored to be the 19th recipient of the American College of Surgeons Australia/New Zealand Travelling Fellowship (for a description of the Fellowship, see page 50). I had always wanted to visit New Zealand, because one of the giants of the plastic surgery specialty, Sir Harold Gillies—whose contribution to both World Wars in shaping the field of plastic and reconstructive surgery is legendary—was born in Dunedin.

**North and South Islands**

My first stop was Auckland, New Zealand. Auckland is a beautiful city in the North Island and is a wonderful, picturesque metropolis. I was exposed to the Maori culture by visiting the Auckland Museum and, in the War Memorial Museum, I learned about the sacrifices of Australia and New Zealand in the World Wars. Ross Blair, MB, CHB, FACS, who will assume the presidency of the Australia/New Zealand Chapter of ACS, and his wife met me in Auckland. We had a vigorous discussion regarding the training of surgeons in our respective countries. We shared our mutual goals of working to attract the best into the surgical fields through structured mentorship and innovative surgical training programs.

The South Island of New Zealand has been reported to be one of the most picturesque places on earth (see photo above), but it was more beautiful and magnificent than I had ever imagined it could be. My visits to various lakes, mountains, and ocean sounds were breathtaking. I initially had difficulty with driving on the left side of the road and constantly making the mistake of switching on the windshield wiper when making turns. Overall, the drive in New Zealand proved to be rather exciting and challenging because of the narrow, winding roads through the ever-changing terrains. The New Zealanders are known as some of the friendliest people. This reputation is well deserved and I enjoyed the kind hospitality everywhere I went.

**Sydney**

My trip to Australia was just as wonderful. The Great Barrier Reef, the rainforest, and the beautiful harbor of Sydney left me with a lasting fond memory. I was met at the airport by Stephen Deane, MB BS, FACS, current President of the ACS Australia Chapter, and his wife (see photo on page 50). They took me on a comprehensive tour of various suburbs of Sydney. It is certainly one of the most magnificent cities in the world. I visited the Royal North Shore Hospital in Sydney to observe Prof. Michael Tonkin at work. Professor Tonkin is one of the most respected figures in
hand surgery and I am privileged to have had an opportunity to visit him. He has a vibrant hand surgery practice in Sydney that encompasses many fields within the specialty, including treatment of fractures, brachial plexus injuries, and congenital conditions. We had a productive discussion about the training of hand surgeons, as the scope of this specialty has become even more broad and complex.

**Melbourne**

My next trip was to St. Vincent’s Hospital in Melbourne to visit Prof. Wayne Morrison. Prof. Morrison has carried on the legacy of Bernard O’Brien, MD, FACS(Hon), one of the pioneers of microsurgery. Since the 1970s, microsurgery has flourished in St. Vincent’s, and many of the leaders in various surgical disciplines from around the world trained in this hospital. The introduction of microsurgery was important to surgery—for the first time, surgeons were able to reattach severed body parts and to transfer tissues from various regions of the body to reconstruct complex defects. The impact of microsurgery was felt in all surgical disciplines and contributed greatly to the care of patients. Prof. Morrison leads an active research effort in tissue engineering by assembling an impressive research team from various fields. Current projects include engineering of artificial liver, pancreas, and nerve.

**Perth**

The Royal Australian College of Surgeons (RACS) meeting was held in the beautiful city of Perth in Western Australia. The organizing committee assembled a most impressive list of speakers from this region and around the world. Lecture topics included workforce issues in surgery, minimizing surgical errors, use of population data for surgical research, and new surgery education models. The excellent organizational skills of the meeting planners were displayed when attendees received a last-minute addition to

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**History of the ANZ Travelling Fellowship**

The first Australia and New Zealand (ANZ) Chapter of the ACS Travelling Fellowship was awarded in 1982. The purpose of this travelling fellowship is to encourage international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships. The ANZ Chapter and the College sponsor a North American Fellow to travel to Australia and New Zealand to attend the Annual Scientific Congress of the Royal Australasian College of Surgeons. After the Scientific Congress, the Traveller visits medical centres in several different cities to lecture and to share clinical and scientific expertise with local surgical colleagues.

The closing date for receipt of completed applications for the 2007 ANZ Travelling Fellowship is November 15. The requirements for the fellowship will appear in the October issue of the Bulletin.
the program: a videoconference lecture from Susan MacKinnon, MD, FACS, an international authority on peripheral nerve surgery, while she was attending a meeting in Arizona.

I was privileged to deliver the ACS Travelling Fellows lecture in the main auditorium of the convention center. My lecture on the Treatment of Mutilating Injuries of the Upper Extremity, The University of Michigan Experience, paid tribute to Sir Harold Gillies and Professor O’Brien, whose contributions enabled plastic surgeons to apply their teachings to trauma patients. I was thrilled to be able to give this lecture in the presence of Edward Laws, MD, FACS, President of the ACS (see photo, page 50).

Conclusion

Words cannot describe my gratitude to the leadership of the ACS and the RACS for this honor. I want to thank my sponsors—Lazar Greenfield, MD, FACS; Michael Mulholland, MD, PhD, FACS; and William Kuzon, MD, PhD, FACS—for their support. I am proud for the privilege of representing the American College of Surgeons and the department of surgery at the University of Michigan. Finally, I want to thank many of my hosts in Australia and New Zealand for their generosity and hospitality. I hope we will maintain a lasting bond between our two societies through this Travelling Fellowship.

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The American College of Surgeons Division of Education presents the Personal Financial Planning and Management Course for Residents and Young Surgeons, which uses an interactive/lecture format to arm surgeons with basic financial management skills. The course is designed to educate and equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children), and proper planning for financial stresses related to their surgical practice.

**Intended audience:** Surgical residents and surgeons recently in practice.

- Fellows of the American College of Surgeons: $120
- Non-Fellow: $215
- RAS member: $75
- Surgical resident, not a RAS member*: $95

*Non-RAS residents must supply a letter confirming status as a resident from a program director or administrator, and purchase is limited to one CD-ROM.

(Additional $16 for shipping and handling of international orders.)

Orders may be placed through ACS Customer Service at 312/202-5474 or via the College’s Web site at:

www.acs-resource.org

For more information, contact Dawn Pagels, MBA, at dpagels@facs.org, or tel. 312/202-5185.
Education in the making: The SESAP development process

by John A. Weigelt, MD, DVM, FACS, Milwaukee, WI

The SESAP Advisory Committee is the standing committee of the American College of Surgeons charged with the responsibility of developing and overseeing the College’s Surgical Education and Self-Assessment Program (SESAP). The twelfth edition of this popular program debuted in October 2005, and the SESAP faculty is beginning its work for SESAP 13, which will debut at the 2007 Clinical Congress. In the American Board of Surgery’s new maintenance of certification (MOC) program, SESAP participation every three years can be used to demonstrate compliance with the second MOC component, Commitment to Lifelong Learning and Self-Assessment. Following is an overview of the development of SESAP.

Background

The first edition of SESAP premiered in 1971, and subsequent editions have been released at two- to four-year intervals ever since. Currently, SESAP is produced every three years. Each edition enrolls more than 9,000 surgeons, more than half of whom are Fellows of the College. SESAP is primarily used as a study guide for the American Board of Surgery certification and recertification exams and as a continuing medical education (CME) product for surgeons throughout the world. It has undergone changes during its tenure, but it has essentially always been written by Fellows of the College in a consensus-driven process.

The development process

SESAP is written by seven committees, each composed of six members who are assigned to write approximately 25 questions each from an assigned list of topics. This list correlates with the American Board of Surgeons list of topics identified as a curriculum for recertification in general surgery. This allows concordance between SESAP and which topics might be included on recertification exams.

Although many authors have expertise within a specific niche, authors receive questions in most topic areas rather than concentrating on only one area. This shared responsibility for the questions allows a richness in the questions that is hard to duplicate if members would all just concentrate on what they routinely focus on. It also gives SESAP its general surgery “flavor” because the authors must produce questions that would be pertinent to a general surgeon. The questions are structured and all answers, correct or incorrect, are required to be documented with evidence from the literature. Most questions will have at least two references with supporting evidence for the correct and incorrect answers.

After the questions are submitted, another member of the committee reviews a colleague’s questions and comments on them. In a series of face-to-face meetings, all questions are reviewed by committee. The quality of the question and supporting data is reviewed and a consensus reached as to whether the question can stand as written or what changes would be necessary to improve it. The edited question is then given back to the Fellow who wrote it in order to develop a critique.

The process is repeated for the critiques as the authoring committees once again meet to review each critique and decide whether editing is necessary. During this process, the committees work on identifying radiologic images, patient photographs, and other illustrations that can help clarify the points the question is trying to make and improve the learning potential of the question. As the questions are developed, the committees continually ask themselves how the question relates to the practicing general surgeon. The goal of each committee is to produce questions that have pertinence to the practice of general surgery and will have a chance of being included in the next SESAP.

Once the questions and critiques have been written, they are divided into categories by the course director and assigned to
the chairs of the seven committees for final review. Co-chairs of the seven committees, 14 ACS Fellows, review their assigned questions and choose the best of the group for inclusion in the final SESAP product. After this is done, authors can determine how many of their questions actually made the grade. The final 650 questions with critiques are then compiled into the next SESAP. Every effort is made to provide program materials in formats that will be most useful to participants. SESAP is currently offered in CD-ROM and print versions.

This process has stood the test of time, creating a product that has helped many thousands of surgeons in many different ways. The SESAP Advisory Committee is constantly trying to do its best to make SESAP a premier CME program for the ACS. The newly offered electronic format allows for immediate feedback, which is crucial to SESAP’s improvement.

The committee appreciates feedback, positive and negative. All questions are answered by the course director and ideas are used to fine-tune the edition in development. All comments are taken seriously and the committee would like to thank everyone who takes the time to provide them. Many comments that have been received indicate a positive view of the SESAP. Thanks to all who have used SESAP, and any newcomers are welcome to participate.

Dr. Weigelt is professor and vice-chairman, department of surgery, Medical College of Wisconsin, Milwaukee, WI, and SESAP Course Director.

**JACS to host centennial symposium during Congress**

In celebration of 100 years of publishing excellence for surgeons, the *Journal of the American College of Surgeons* (JACS) will host a symposium during this year’s Clinical Congress in San Francisco, CA, as part of the celebratory events that will take place throughout the week. To be held on Monday, October 17, at 4:00 pm in the Hilton San Francisco, the symposium will honor the role JACS played in the formation of the American College of Surgeons in 1913.

First published as *Surgery, Gynecology & Obstetrics* by Franklin H. Martin, MD, in July 1905, the journal was renamed the *Journal of the American College of Surgeons* in 1994. During the symposium, four renowned leaders in publishing will provide perspectives on the importance of scientific publishing for surgeon education and patient safety. Seymour I. Schwartz, MD, FACS, Editor Emeritus of JACS, will moderate the session. The speakers will be: George Lundberg, MS, MD, ScD, editor-in-chief, *Medscape General Medicine*, and adjunct professor of health policy, Harvard School of Public Health; Michael Sarr, MD, FACS, co-editor, *Surgery*; Jerome Kassirer, MD, former editor, *New England Journal of Medicine*; and Timothy J. Eberlein, MD, FACS, Editor-in-Chief, JACS.

All attendees are invited to a reception immediately following this symposium, which will also be attended by members of the JACS editorial board, guest speakers, the members of the College’s Board of Regents, JACS authors, and ad hoc reviewers. For more information, contact whusser@facs.org.

**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, 2005, 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](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312/202-5342.
Faculty career development award for head and neck surgeons available

The American College of Surgeons and the American Head and Neck Society (AHNS) are offering a two-year faculty career development award to head and neck surgeons. The award is to support clinical, basic science, or translational research in the study of neoplastic disease of the head and neck. The award is $40,000 per year for two years to support the research and is not renewable thereafter.

July 1, 2006–June 30, 2008

General policies covering the granting of the Faculty Career Development Award for Oncology of the Head and Neck are as follows:

- The award is open to surgeons who (1) are members or candidate members in good standing of both the American College of Surgeons and the AHNS; and (2) have completed specialty training within the preceding five years and have received a full-time faculty appointment at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Applicants should provide evidence (by publication or otherwise) of productive initial efforts in laboratory research.

- The award is to be used to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient's institution.

- Applicants may not be current recipients of major research grants. Application for this award may be submitted even if comparable application to another organization has been made. If the recipient accepts a scholarship, fellowship, or career development award from another agency or organization, the Faculty Career Development Award for Oncology of the Head and Neck will be withdrawn. It is the responsibility of the recipient to notify the ACS Scholarships Section of competing awards.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the senior investigator (if applicable) supervising the applicant's research effort should be submitted. This approval would involve a commitment to continuance of the academic position and the availability of facilities for research.

- The applicant must submit a detailed research plan and propose a budget for the two-year period of the research, even though renewed approval by the ACS and the AHNS is required for the second year. The applicant is also required to submit a cover letter of approximately 400 words that describes the applicant's career objectives; how these career objectives will be achieved; how the research protocol furthers the applicant's career development; and, in particular, how this award will provide data for subsequent major funding.

- The awardee is expected to attend both the annual meeting of the AHNS (July 19–23, in San Francisco, CA) and the Clinical Congress of the American College of Surgeons (October 12–16, in San Francisco, CA) in 2008 to present reports to the ACS Scholarships Committee and AHNS representatives.

- The American College of Surgeons and the AHNS require a research progress report after one year and a summary of research progress and information regarding current academic rank, sources of research support, and future plans at the conclusion of the research period.

The closing date for receipt of applications is November 1, 2005. Application forms may be obtained upon request from the Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings

June 10-11, 2005

by Paul E. Collicott, MD, FACS, Director, Division of Member Services

American College of Surgeons Professional Association (ACSPA)

The College’s political action committee (ACSPA-SurgeonsPAC) had an excellent start in 2005. With a $500,000 fundraising goal for the year, $343,000 in contributions had already been received by early May.

Telephone fundraising has proven successful. As of early May, $202,700 had been pledged to the ACSPA-SurgeonsPAC via telephone.

Of 215 U.S. members of the Board of Governors, 70 (33%) contributed to the ACSPA-SurgeonsPAC for an average contribution of $362. The names of all leaders who have donated to the ACSPA-SurgeonsPAC in 2005 will be listed at the ACSPA-SurgeonsPAC booth during the Clinical Congress in October.

So far in 2005, the ACSPA-SurgeonsPAC has organized five political fundraiser events. Two additional events will be hosted later this year.

American College of Surgeons

ACS Statements

The Board of Regents approved a Statement on the Prevention of Retained Foreign Bodies after Surgery. This statement emphasizes patient safety and urges hospitals and health care organizations to take responsible measures to prevent retention of foreign bodies in the surgical wound. The new statement will be posted on the College’s Web site once it has been published in a future edition of the Bulletin.

The Board of Regents approved a revised Statement on Surgical Technology Training and Certification. Initially developed by the Committee on Perioperative Care (CPC) and approved by the Regents in 2004, this statement was revised by the CPC to clarify the role of the surgical technologist as a member of the surgical team. This revised statement will be published in the Bulletin and subsequently posted on the College’s Web site.

The Board of Regents approved a revised Statement on Health Care Industry Represen-
tatives in the Operating Room. Developed in 1999 by the Committee on Operating Room Environment (now called the CPC) and subsequently approved by the Regents, the statement was revised by the CPC to reflect various changes in the perioperative setting, such as the introduction of the Health Insurance Portability and Accountability Act, advances in technology, and so forth. The revised statement appears on page 27 of this issue of the Bulletin and will be posted on the Web site.

The Board of Regents approved a Statement on Blunt Suture Needles. This statement was developed by the CPC to encourage the universal adoption of blunt suture needles as the first choice for closure of fascia and other structures to minimize the risk of injury to the surgeon, even when the surgeon’s glove is punctured. The CPC believes that greater awareness of the benefits of blunt suture needles and a better understanding of barriers to their use will benefit all members of the operative team. This statement will be published in a future issue of the Bulletin and then posted on the Web site.

Scholarships

The Board of Regents approved the funding of a third shared career development award. The College will cosponsor this award with the American Head and Neck Society. The College awards approximately $1.5 million annually in scholarships.

Accreditation

The Board of Regents approved a business plan for pilot testing an ACS Accreditation Program for Surgical Education Centers. The primary goals of the program are to enhance the standardization of surgical education at the national level, to increase access to education programs, and to support surgeons’ efforts in acquiring and maintaining surgical knowledge and skills. This program would also serve the needs of surgical residents, medical students, and members of the surgical team.

The purpose of the accreditation program is to create a national system of centers accredited by the ACS to offer high-quality, regional educational activities in surgery. The purpose of the pilot test is to confirm the level of interest in such accreditation efforts and to refine the accreditation process.

Trauma

The Board of Regents approved a proposal of the Committee on Trauma (COT) and the American Burn Association (ABA) for a joint relationship to administer the Burn Verification/Consultation Program for Hospitals. A memorandum of understanding was developed to shift the oversight of the Burn Verification Program to the administrative office of the ABA. This relationship proposes to maintain quality assessment of the verification program within the COT while shifting administrative responsibilities to the ABA.

The Advanced Trauma Life Support® (ATLS®) program’s Trauma Evaluation and Management (TEAM) course has been used for medical students and in areas where it is not feasible to conduct the ATLS course. Materials for this course are being revised and include an instructor manual, student material, and a digital video disc. The ATLS program will celebrate its 25th anniversary at this year’s Clinical Congress. More than 39,000 students were trained in ATLS in 2004.

Accrual of data for the National Trauma Data Bank™ (NTDB™) is now taking place in preparation for the 2005 Annual Report. More than 100 researchers have used NTDB in their analyses. Articles on various aspects of NTDB data are offered each month in the Bulletin, and a new feature on the College Web site, NTDB Online, provides an interactive tool that allows for quick aggregate data analysis and graphing.

ACS Foundation

The Board of Regents approved the appointment of the following Fellows and nonmember to serve as members of the Foundation Committee on Development: Richard B. Reiling, Chair; Lynn H. Harrison, Jr., Vice-Chair; Oliver H. Beahrs; Robert E. Berry; John E.
DeLauro; Roger S. Foster, Jr.; Robert E. Hermann; Norman M. Kenyon; LaSalle D. Leffall, Jr.; Michael S. McArthur; Mary H. McGrath; H. Bryan Neel III; Amilu S. Rothhammer; William F. Sasser; Hugh H. Trout III; Jon A. van Heerden; H. Davis Vargas (all MD, FACS); and Mr. Leslie J. Armour, vice-president, corporate relations, Ethicon, Inc. The ACS Foundation officially began operations on July 1.

During the current fiscal year, the Development Program has received gifts and pledges totaling $1,250,522. During the upcoming Clinical Congress, 28 new Life Members are scheduled to be recognized. All members of the Board of Governors, Board of Regents, and Officers are encouraged to become Life Members.

**Operation Giving Back (OGB)**

Capacity and functionality enhancements, via Web site configuration, are under way for OGB in collaboration with Newfangled Web Factory in Providence, RI. The enhanced Web site is expected to launch in late summer of this year.

Volunteer agencies such as Project HOPE (Health Opportunities for People Everywhere) and Crudem have expressed an interest in inclusion in the OGB database. Through collaboration with staff at Project HOPE, OGB was able to mobilize Fellows in response to the tsunami and subsequent earthquake in South-East Asia. Surgeons’ responses outnumbered the available slots for these missions.

Kathleen M. Casey, MD, FACS, Director of Operation Giving Back, spoke to the ACS Resident Education Committee regarding opportunities and hurdles for surgical residents interested in volunteerism. In addition, discussions have been ongoing with the Resident and Associate Society regarding the high level of interest in volunteerism-related topics among residents and young surgeons.

**Surgical volunteerism awards**

The Governors’ Committee on Socioeconomic Issues solicited the College’s membership for nominations for the surgical volunteer-ism award. The award is offered annually in recognition of Fellows who make substantial contributions to surgical care through organized volunteer activities. This year, the committee will give two awards. The award for volunteer activities in the international arena will be given to Domingo T. Alvear, MD, FACS, of Harrisburg, PA. The award for volunteer activities in the domestic arena will be given to George F. Ellis III, MD, FACS, of Longwood, FL. (See related article, page 46.)

**Commission on Cancer (CoC)**

The Board of Regents approved a business plan to develop a Cancer Programs Online Education Program. To meet the continued demand for training and education on CoC requirements, the CoC will build upon its current foundation of educational offerings by establishing a fee-based online educational resource area with a library of audio and slide presentations that can be used to earn continuing medical education (CME) and continuing education credits.

A request for proposals will secure an external vendor with expertise in the construction and management of Web-casting applications. The online program content will be of value to cancer program administrators, cancer committee chairs, cancer liaison physicians, cancer registrars involved in the operations of the cancer program at their respective CoC-approved cancer programs, and programs working to maintain their CoC approval.

**John B. Murphy Auditorium**

The Board of Regents approved funding for the completion of the renovation of the John B. Murphy Auditorium in Chicago, IL, so that the facility may be used as an additional meetings and special events venue available to the College and to the public.

**ACS Web portal**

Progress continues on e-FACS.org—the ACS Web portal. Staff is investigating the possibility of hosting the portal technical infrastructure outside the College. An outside
infrastructure would provide higher Internet bandwidth and could provide around-the-clock customer support. A beta test of the portal prototype was scheduled to be conducted in mid to late July.

Pertinent staff participated in a design workshop with outside consultants to ensure that the organizational and user goals for eFACS.org are reflected in the home page and secondary page designs. Final designs for the portal’s home page and secondary pages were developed and approved in April. The portal contains specialty communities.

**Member advocacy**

Since February, the College has testified before Congress and federal agencies on various subjects. The College also secured appointments for Fellows on the newly established Emergency Medical Treatment and Active Labor Act technical advisory group.

The College is leading an effort to preserve and improve payments for surgical services in the upcoming five-year review of the Medicare fee schedule. In addition, federal and congressional policymakers are committed to implementing some type of pay-for-performance system for physicians under Medicare, and the College is actively working to develop proposals that would benefit surgical patients.

The Centers for Medicare & Medicaid Services (CMS) informed the Medicare Payment Advisory Commission (MedPAC) that the projected update to the 2006 physician fee schedule would be –4.6 percent. Unless Congress intervenes, the across-the-board payment cuts will occur in 2006 because of how the sustainable growth rate system is used to calculate annual physician payment updates. The College wrote to key congressional committees with jurisdiction over Medicare physician payment issues, urging them to stop the cuts from taking effect and explaining that the viability of surgical practice and patients’ access to surgical services is in jeopardy. The letters pointed out that surgical procedures accounted for a disproportionately small amount of the growth, and that, unlike other physicians, surgeons cannot recover lost revenue by increasing volume.

CMS issued a final rule on May 4, which updated the list of procedures that Medicare will cover when they are provided in ambulatory surgical centers. Following many of the recommendations made by the College, the agency added 65 procedures to the list, which had initially contained only 25 proposed new procedures. In addition, the agency removed only five procedures from the list of 100 procedures proposed for deletion. (See related article, page 29.)

On June 18, the 18-month moratorium prohibiting physicians from referring patients to specialty hospitals in which they have an ownership interest expired. The moratorium was put in place in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA also included provisions requiring MedPAC and CMS to analyze, within 15 months, the costs, payment system issues, referral patterns, and quality of care issues associated with specialty hospitals.

On March 8, the Senate Finance Committee and the House Ways and Means Health Subcommittee held hearings regarding MedPAC and CMS reports. At both hearings, the College submitted testimony for the record supporting efforts to refine the diagnosis-related group system to provide more equitable reimbursement for procedures in hospital settings and opposing any efforts to extend the moratorium or to prohibit physician ownership of specialty hospitals.

The College has partnered with the National Aneurysm Alliance (NAA) to introduce a Medicare ultrasound screening benefit for the detection of abdominal aortic aneurysms. The NAA has garnered 18 cosponsors to the SAAAVE (Screening Abdominal Aortic Aneurysms Very Efficiently) Act of 2005 (H.R. 827), which was introduced to create this benefit. The legislation also provides screening for women with a history of aneurysms.

On April 28, the House and Senate passed the congressional budget for fiscal year 2006. Although much discussion surrounded po-
tential reductions in Medicaid spending, the conference report assumes no reductions in Medicaid spending in 2006. The budget includes a reserve fund for legislation to create a bipartisan commission charged with reviewing Medicaid and making recommendations regarding long-term goals for the program. The College has stated its support for creating a bipartisan commission to review Medicaid.

On April 20, approximately 500 surgeons and physicians from nine northeastern and mid-Atlantic states traveled to Washington, DC, to rally for federal medical liability reform. The rally was sponsored by the Coalition for Accessible Physicians and was supported by the College.

In 2002, CMS fiscal intermediaries began denying payments—often retroactively through audits—for the time residents spent in non-hospital settings where teaching physicians were freely volunteering their time to supervise resident training. The College joined other physician groups to oppose CMS audits and retroactive denial of direct and indirect graduate medical education payments.

Last year, CMS set new associated principles for informed consent and operative notes. Although most of the conditions of participation and the companion interpretive guidelines apply to hospital staff, this change has a direct effect on surgeons who practice in hospitals certified by state survey and certification agencies. Teaching programs, in particular, have expressed grave concern about these provisions. In response, the College has been leading a coalition effort involving the Association of American Medical Colleges, the American Medical Association (AMA), the Society of Thoracic Surgeons, and other organizations to persuade CMS to revise the guidelines.

The College hosted a meeting of surgical specialty society leaders in Chicago on March 29 to explore emerging issues regarding the surgical workforce and the future of emergency and trauma care. The College and the surgical specialty groups will continue efforts to highlight these issues and work collaboratively to develop and promote policy solutions to ease the pressure on the nation’s emergency care safety net.

The COT, along with the Coalition for American Trauma Care, commissioned Harris Interactive to conduct a public opinion poll on the public’s awareness, knowledge, and perception of the importance of trauma care and trauma systems of care. The College hosted a congressional briefing on March 2 in Washington, DC, to officially release the poll results. Moderated by J. Wayne Meredith, MD, FACS, COT Chair, more than 60 congressional staff members attended the briefing.

On March 14, CMS announced the appointment of a new technical advisory group that includes three Fellows of the College. The College nominated or endorsed the three Fellows who were appointed to this 19-member group. The group is charged with reviewing EMTALA regulations that affect hospital and physician responsibilities in treating individuals who come to the hospital seeking treatment for a medical condition. Its goal is to help CMS develop rules that will protect individual rights while minimizing unnecessary burdens on health care providers.

In January, the Hearing Health Accessibility Act (H.R.15) was introduced. If enacted, this legislation would grant an inappropriate expansion in the scope of practice of audiologists. In response to a request from the American Academy of Otolaryngology–Head and Neck Surgery, the College sent a letter to all members of Congress, stating its strong opposition to this legislation.

Nonphysician health care professionals continue their state-level legislative efforts to expand their scopes of practice. The College and other medical organizations have participated in an advocacy “fly-in” as part of a “Surgery by Surgeons” campaign, in which representatives meet with legislative leaders and local media to educate policymakers and the public. This effort is ongoing.

The College, along with seven other physician groups, sent a letter to Congress opposing the Medicare Patient Access to Physical
Therapists Act. This legislation would provide an inappropriate expansion in the scope of practice of physical therapists. The bill would allow direct access to physical therapists without first consulting a physician.

The College has introduced a resolution directing the AMA to convene a work group with the specialties affected by the impending shortage of specialists for emergency and trauma care and those organizations closely involved in physician workforce issues. This group would be charged with developing solutions to the problem of the undersupply of specialist physicians and the future of emergency and trauma care. In addition, the AMA Surgical Caucus, now chaired by the College, will feature a panel presentation on pay for performance.

The College continues to host basic and advanced coding courses. A basic and an advanced course will be held in Chicago on July 14 and 15, respectively. Other basic and advanced courses will be held in Dallas on September 15 and 16, respectively.

The College continues its sponsorship of practice management teleconferences presented by Economedix. Courses remain on the 2005 schedule through December 14.

Journal of the American College of Surgeons (JACS)

As of May 2005, the JACS Online CME-1 Program has provided 70,000 CME-1 credits at no cost to more than 8,200 Fellows of the College. The College’s chapters would benefit from a live demonstration during their meetings so that more members could become aware of this excellent program.

Education

The Advisory Councils continue to propose educational programming for the Clinical Congress and are working to formulate programming that would increase the variety of specialties represented at the Clinical Congress. In addition, the Advisory Councils for Cardiothoracic Surgery and Urology are now proposing postgraduate courses for candidates preparing for their Board certification or recertification.

A completely new slate of didactic postgraduate courses in General Surgery will be offered at the 2005 Clinical Congress. The skills-oriented courses were designed to specifically address contemporary topics in surgery, such as the core competencies, patient safety, new procedures, and emerging technologies, as well as the nonclinical topics related to the practice of surgery.

Major changes have been made in the Abdominal Ultrasound Course, including shortening the time required to take the course. The changes should enhance the educational value of the course and reduce expenses.

The Scientific Exhibit/Poster Program has been enhanced. A moderated Poster Session will be held for the first time on Tuesday, October 18, 12:00 noon–1:30 p.m. The session will be held in the Scientific Exhibition Area and moderated by Barbara L. Bass, MD, FACS.

A new video-based education session, Movie Classics from the Past, will be presented along with an interactive session, Antireflux Surgery: Specific Challenges. An additional General Surgery video-based education session has been included.

Two Surgical Forum sessions on Quality, Outcomes, and Costs, and a separate Research in Surgical Education Session will be presented as a result of the increase in abstract submissions in these categories. The Surgical Forum Committee will sponsor two general sessions: Biomaterials and Biosensors, and Grant Writing Symposia for New Investigators.

Enrollment in the Surgical Education and Self-Assessment Program (SESAP) 11 concluded in October 2004. SESAP 12 was redesigned and the content categories made congruent with the content categories of the Recertification Examination of the American Board of Surgery. A new category on Ethics and General Competencies was added. The CD-ROM for SESAP 12 was enhanced and the CME verification process was streamlined. SESAP 12 was released in October.
The audio companion for SESAP 12 has been launched and various parts of the audio companion will continue to be released during the SESAP 12 release period (2004-2007). Development of SESAP 13 has commenced and is proceeding well. (See article about the development of SESAP on page 52 of this issue of the Bulletin.)

Web casts of various sessions have been made available from the 2002, 2003, and 2004 Clinical Congresses and the 2004 and 2005 Spring Meetings. Charles D. Mabry, MD, FACS, is the course director for two new CD-ROM interactive courses, Personal Financial Planning and Management for Residents and Young Surgeons and Practice Management for Residents and Young Surgeons.

A new course, Surgeons As Effective Communicators, which was launched in May 2005, includes interactive sessions that focus on the application of principles of effective communication to complex surgical situations. The course offers planned and impromptu opportunities for attendees to participate in standardized scenarios that involve communication challenges in a variety of clinical and nonclinical settings. Each attendee is videotaped and receives feedback.

Another course, Surgeons As Leaders, was launched in April 2005 and is designed for surgeons who currently serve in leadership positions or aspire to such positions in the university-based environments. The focus of the course is effective leadership to handle clinical and administrative challenges in a variety of surgical settings.

Case Log System

The College has designed a Case Log System to support the practice-based learning and improvement activities of individual surgeons. The Case Log System will help surgeons monitor their outcomes and benchmark this information with risk-adjusted outcomes data and best evidence to identify gaps in performance and areas for improvement.

The Case Log System is designed to facilitate surgeons’ efforts to begin collecting their patient information and outcomes data in an ongoing and systematic fashion. In addition to assisting surgeons in identifying learning needs, the outcomes data would help surgeons meet the requirements of Step IV of the Maintenance of Certification Program of the American Board of Medical Specialties.

The Case Log System was demonstrated to the Regents. Entries require less than one minute, can use any language, and import from Excel to eliminate the need to make duplicate entries. It is anticipated that the system will be released later this year.
Postgraduate courses to address palliative care, diagnosis of anal cancer

The American College of Surgeons and its Division of Education invite attendees of this year’s Clinical Congress in San Francisco, CA, to consider two postgraduate courses of current interest.

Pain Management and End-of-Life Care will be chaired by Geoffrey P. Dunn, MD, FACS, Erie, PA. The goal of this course is to provide surgeons with the information necessary for basic competency in the management of acute and chronic pain and the treatment of terminally ill patients, consistent with the American College of Surgeons’ Statement of Principles of Palliative Care (Bull Am Coll Surg. 2005;90:34) and required by the Medical Board of California. The course will begin on Tuesday, October 18, and will continue on Wednesday, October 19. The fee for this 12-credit course is $490.

Prevention and Early Diagnosis of Anal Cancer: The Use of High-Resolution Anoscopy to Treat Anal High-Grade Squamous Intraepithelial Lesions and Bowen’s Disease will be chaired by Mark L. Welton, MD, FACS, Stanford, CA. Strategies for managing patients in the office and in the operating room will be presented, followed by a series of practical demonstrations, including a slide show designed to emphasize the recognition of lesions. This six-credit course will be held on Wednesday, October 19, and includes a 90-minute workshop component. The fee is $375 and registration is limited to 24 participants.

Additional information regarding course registration and travel to San Francisco may be obtained by visiting the ACS Web site at http://www.facs.org/clincon2005/index.html.

Socioeconomic tips (from page 30)

Out penalty. After that date, their premiums will increase by 1 percent for each month they delay participation.

What will happen to the current drug cards?

They will expire when a person’s drug coverage becomes effective or on May 15, 2006, whichever occurs first.

How might patients obtain more information about the drug benefit plan?

For help with prescription drug plans, patients may contact Medicare by telephone at 800/MEDICARE (for TTY users, 877/486-2048) or visit www.medicare.gov. They may also get help at their State Health Insurance Assistance Program. However, make note that comparative information about plans will not be released until October 2005.

For help with prescription drug costs, patients may contact the Social Security Administration at 800/325-0778 (for TTY users, 800/325-0778) or visit www.socialsecurity.gov. They may also contact their local Medicaid office.
Farming may date back to more than 23,000 years ago, as evidenced by the seed-collection habits of the people of Israel in the Stone Age. Over the millennia, farming has gone through monumental changes. Farm implements once constructed of sticks and rocks have become technologically advanced marvels of engineering. Farmers use high-speed Internet with live Doppler radar, hybrid and genetically engineered seeds, advanced-formula fertilizers, and sophisticated machinery. These advances have resulted in a substantial increase in yield per acre over the past several farming generations. In spite of these successes, the future of farming in the U.S. is in jeopardy.

As harvest time approaches in the heartland, those individuals who have devoted their lives to feeding the people of the U.S. need to be thanked. There are more than 2 million farms in the U.S. with an average size of 460 acres. Most of these farms are primarily family-run operations that may have been in the same family for generations. However, a worrisome statistic is that the average age of the U.S. farmer is 54.3 years. The proportion of farmers aged 55 and older has risen from 37 percent in 1954 to 61 percent in 1997. Presently, more than one quarter of farm operators are 65 years or older. The aging of the U.S. has now made its way to the farm.

As the National Trauma Data Bank™ reported last month in the Bulletin, elderly individuals have decreased physiologic reserve and suffer more serious consequences from a traumatic event than their younger counterparts suffer. According to the National Agricultural Safety Database (http://www.cdc.gov/nasd/index.html), a project funded by the National Institute of Occupational Safety and Health, one in nine farmers aged 55 and older had been involved in a tractor rollover, and workers older than 55 years accounted for approximately half of all farming deaths. In the records contained in the NTDB Annual Report 2004, there
are more than 7,000 records listing “farm” as the site of injury. Using the external cause of injury code (E code) 919.0 to extract farm machinery-related injuries, there are 1,382 records. The graph on the previous page depicts the relationship between age and number of deaths related to farm machinery.

Economic forces are wreaking havoc on the U.S. farmer. U.S. farming exports are decreasing and subjected to heavy tariffs while there is an increase in imports of cheaper foreign foods. Couple this with the graying of the heartland and the lack of interest in farming among younger generations, and soon there will be no one down on the farm.

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.

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**CALL FOR SUBMISSIONS**

**The Committee for the Forum on Fundamental Surgical Problems**

**The American College of Surgeons**

For the 2006 61st annual Surgical Forum published in the Journal of the American College of Surgeons

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**Accepted abstracts**

*will be presented at:*

American College of Surgeons

- Clinical Congress • 8-12 October 2006
- Chicago, IL

**Who**

- Young surgical investigators (principal investigator is first named author).
- Up to ten (10) co-authors allowed.

**What**

- 250 maximum word abstract that presents a concise summary of research done and in progress, but not presented or published previously. Title must be brief; body of abstract must include Introduction, Methods, Results, Conclusions. One-page table may be submitted separately (see Author Instructions on Web site) if absolutely necessary; table does not count toward the 250 maximum word count.

**When**

- Abstracts accepted from November 1, 2005, through March 1, 2006.

**Where**

- Online submissions ONLY: http://www.facs.org/sfabstracts. Abstracts may not be presented in advance of the Surgical Forum program in October or manuscripts published in whole or in part before the abstract submission.

- **Final Decision:** May 2006 (principal author will be contacted).
- **Format:** Follow Author Instructions, Online Submission.
- **Questions:** kkoenig@facs.org or: 312.202.5336.