THE CRISIS IN PATIENT ACCESS to emergency surgical care
FEATURES

A growing crisis in patient access to emergency surgical care
Division of Advocacy and Health Policy

Surgeon, heal thyself
John D. Zelem, MD, FACS

Anesthesiologist assistants: Making the operating room more accessible and manageable
Al Rothstein

ACS leadership in the field of sport concussion
Karen M. Johnston, MD, PhD, FACS, FRCSC

Statement on principles of patient education

DEPARTMENTS

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

Dateline: Washington
Division of Advocacy and Health Policy

In compliance...
with HIPAA’s NPI provisions—Part III
Division of Advocacy and Health Policy

NEWS

Report of the 2006 Japan Traveling Fellow
Alan Dardik, MD, PhD, FACS

Dr. Niederhuber appointed Acting Director of NCI

College launches patient education Web site

Dr. Hanlon appointed to ACS Foundation Board

Newly expanded ACS Foundation Web pages debut

On the cover: The College recently released a report on the growing crisis in patient access to emergency surgical care (see article, page 8). Photo courtesy of Punchstock.
NEWS (continued)

Outcomes research course scheduled for November 40

Carotid artery stenting outcomes data-collection tool available 40

Disparities in surgical care to be examined during Clinical Congress 42

AWS gears up to celebrate 25 years of service 42

Improving patient safety to be focus of Clinical Congress session 42

Faculty Research Fellowships awarded by College 43

Resident Research Scholarships for 2006 awarded 45

New volunteer opportunities posted on Operation Giving Back Web site 46

Register for the 2006 Clinical Congress in Chicago 46

American College of Surgeons Faculty Research Fellowships available 47

Letters 48

A look at the Joint Commission: National Patient Safety Goals 49

ACOSOG news:
Revisiting local excision of early rectal cancer
David M. Ota, MD, FACS, and Heidi Nelson, MD, FACS 50

NTDB® data points:
Who let the dogs out?
Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS 52
SYLLABI SELECT: The content of select ACS Clinical Congress postgraduate courses is available on CD-ROM. These CD-ROMs run in the PC and Mac environments and offer you the ability to keyword-search throughout the CD.

ONLINE CME: Courses from the ACS’ Clinical Congresses are available online for surgeons. Each online course features video of the introduction, audio of session, printable written transcripts, post-test and evaluation, and printable CME certificate upon successful completion. Several courses are offered FREE OF CHARGE. The courses are accessible at www.tacs-resource.org.

BASIC ULTRASOUND COURSE: The ACS and the National Ultrasound Faculty have developed this course on CD-ROM to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. It replaces the basic course offered by the ACS and is available for CME credit.

BARIATRIC SURGERY PRIMER: The primer addresses the biochemistry and physiology of obesity; identifies appropriate candidates for bariatric surgery; and discusses the perioperative care of the bariatric patient, basic bariatric procedures, comorbidity and outcomes, surgical training, and the bariatric surgical and allied sciences team, along with facilities, aspects of managed care, liability issues, and ethics.

PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons: The CD uses an interactive/lecture format to 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 financial planning for surgical practice.

PRACTICE MANAGEMENT for Residents and Young Surgeons: The CD uses an interactive/lecture format to equip residents and young surgeons with the knowledge to manage their personal surgical future, including: how to select a practice type and location; the mechanics of setting up or running a private practice; the essentials of an academic practice and career pathways; and surgical coding basics.
It is in the best interest of our profession and our surgical patients for the College to continue to become a more active player at the federal level.

What we’ve done

The College has acknowledged the importance of a presence in Washington, DC, for some time now, having established the Washington Office in 1979. At that time, this branch—what we now know as the Division of Advocacy and Health Policy—had a small staff that was mostly responsible for monitoring and analyzing legislation and educating legislators and regulators about a policy’s effect on patient care. Today, the Washington Office comprises five registered lobbyists, three regulatory analysts, a coding expert, several administrative staff, and a political action committee (PAC) manager—all ably led by Cindy Brown, Director of the division.

In addition to expanding our Washington staff, we have sought to become a more potent force in the health system reform debate. Spearheading this effort is the Health Policy Steering Committee, which ACS Regent Josef E. Fischer, MD, FACS, chairs. This committee is charged with identifying public policy issues and concerns that affect surgeons and our patients, prioritizing the issues and identifying the ones that warrant the College’s attention, developing action plans to address challenges, expanding our mechanisms for informing members and the public about our views, and developing processes for addressing legislative and regulatory issues in a timely and effective manner. This committee has been vitally important in setting the organization’s health policy agenda.

To further increase our influence on Capitol Hill, in 2002, the College’s Board of Regents agreed to establish the American College of Surgeons Professional Association (ACSPA). Because this organization has a different tax-exemption status than the College, it has had the capability to form a PAC, known as the ACSPA Surgeons-PAC. This group is ably led by Andrew L. Warsaw, MD, FACS, and includes representatives from all of the surgical specialties. The ACSPA Surgeons-PAC contributes to the campaigns of individuals in both political parties whose agenda embraces the need to achieve improvements in and the protection of high-quality care for surgical patients.
Other means that we provide to surgeons seeking to promote sound health care policies in Washington include our e-mail alerts and our Legislative Action Centers for both the federal and state levels. Through these online instruments, surgeons are able to receive timely updates on legislation and to rapidly contact their representatives and senators about the possible effects of the bills on patients and surgical practice.

**Plans for the future**

All of these initiatives have added to the College’s visibility in Washington and have allowed us to play a more active part in efforts to improve health care delivery in this nation. As the federal government continues to grapple with the range of issues related to safe, cost-effective, patient-centered health care delivery, it is imperative that we continue to build upon these successes. Hence, the College intends to launch two more projects aimed at adding value to our advocacy efforts.

First, efforts are under way to move the Washington Office to a new location near Capitol Hill. Currently, the office is a considerable distance from Capitol Hill and can barely contain our growing staff, let alone the extended surgical community. As a result, we are currently in the planning process to find and secure property within walking distance of Capitol Hill that will best serve the College’s needs and allow surgical specialty organizations and affiliated groups to come together under one roof and present a united front in Washington, DC. By having many of the surgical specialties in one central location, we will be better able to unite in addressing the issues facing the surgical profession as a whole. So, in both the literal and figurative sense, we are constructing a house of surgery in Washington, DC.

Second, we are in the process of establishing a Health Policy Research Institute to gather and analyze data on surgeons’ practices and the effects of legislation and regulations on how we deliver surgical services to our patients. This institute, which will operate under the direction of a surgeon, will serve as a “think tank” and arm us with the hard facts that we need to bring to the table during our interactions with health policymakers. Because of cost constraints and quality concerns, these individuals are becoming increasingly interested in receiving statistically sound information to assist them in their decision-making process. Hence, we will be more effective advocates when we have actual numbers to support our claims about the deleterious consequences of payment cuts, the medical liability crisis, and so on.

Given the nature of the work that the Health Policy Research Institute will carry out, I anticipate that this arm of the College will provide interested surgeons and residents with numerous opportunities to participate in the newly created ACS Scholars in Residence program. Those young people who want to be exposed to the policymaking process and grow into surgeon leaders would, no doubt, benefit from conducting research under the auspices of this institute.

As the federal government increasingly seeks to develop policies related to health care, the American College of Surgeons will continue to work vigorously to ensure that the voice of surgery and of surgical patients is heard in Washington, DC. As always, we need to hear your suggestions about the direction the College should be taking, and I encourage your involvement in federal advocacy efforts.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
On June 14, the Institute of Medicine (IOM) held a press conference to announce the release of three reports on issues related to emergency and trauma care in the U.S.: *Hospital-Based Emergency Care: At the Breaking Point*; *Emergency Medical Services: At the Crossroads*; and *Emergency Care for Children: Growing Pains*. The reports indicate that the hospital emergency departments and trauma centers across the country are severely overcrowded, emergency care is highly fractured, and critical surgical specialists are often unavailable to provide emergency and trauma care. For copies of these reports, go to [http://www.iom.edu/CMS/3809/16107/34641.aspx](http://www.iom.edu/CMS/3809/16107/34641.aspx).

ACS Regent A. Brent Eastman, MD, FACS, participated in the press conference as a representative of the College and provided the College’s views on this subject. In addition, the College released its own report, *A Growing Crisis in Patient Access to Emergency Surgical Care*. Drafted using input gathered at previous meetings with the surgical specialty societies, this document highlights the contributing factors to the emergency workforce shortage and proposes short-term and long-term solutions to the problem. The College’s report appears on page 8 of this issue of the *Bulletin*. Along with the white paper, the College has issued a national press release on the IOM report and a fact sheet on the subject in general. For more information, contact cbrown@facs.org or lmeyer@facs.org.

The American College of Surgeons, along with the American Medical Association, the American Academy of Ophthalmology, and the American College of Physicians, participated in a May 22 briefing for Senate staff. The focus of the meeting was on issues related to physician performance measurement. Frank G. Opelka, MD, FACS, who serves on the ACS General Surgery Coding and Reimbursement and Health Policy Steering Committees, spoke on this organization’s behalf. Dr. Opelka informed participants of the College’s initiatives for improving care for surgical patients and the challenges posed by efforts to design broad payment schemes that will improve quality across specialties. All participants described the progress that has been made to meet the challenge of developing new performance measures but expressed concern about the effect that potentially expensive administrative burdens could have on physician practices. For further information, contact jlewis@facs.org.

On June 1, Mark B. McClellan, MD, PhD, Administrator of the Centers for Medicare & Medicaid Services (CMS), announced the posting of information on Medicare payment for 30 common elective procedures and other hospital admissions. The new information from CMS shows the number of cases treated at each U.S. hospital and the range of payments by county for a variety of treatments provided to seniors and people with disabilities during fiscal year 2005. The listing includes information on heart operations and cardiac defibrillator implants, hip and knee replacements, kidney and urinary tract operations, gallbladder removal, and back and neck procedures.

CMS anticipates that these data will help patients make better
decisions about their care, according to Dr. McClellan. Release of this information is one part of the Administration’s effort to fulfill President Bush’s commitment to expanding Internet availability of Medicare price and quality data as an initial step toward improving access to care. For more information and to download the hospital payment information, go to http://www.cms.hhs.gov/HealthCareConInit/01_Overview.asp#TopOfPage.

CMS recently issued an update on federal reimbursement for emergency services provided to undocumented aliens. CMS notes that physicians, hospitals, and ambulance services that provide emergency health services to undocumented immigrants may not be receiving the payments available to them under the Medicare Prescription Drug Improvement and Modernization Act (MMA). That law allocates $250 million annually for fiscal years 2005-2008 to provide financial compensation to eligible providers of emergency health services. To receive related payments, surgeons must enroll with the national contractor for the program, TrailBlazer Health Enterprises, LLC. To view the CMS update, go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0633.pdf. For more information or to enroll as a provider, visit the TrailBlazer Web site at http://www.trailblazerhealth.com/ and click on the “Section 1011 Contractor Announcement” link in the “What’s New” box on the home page.

In May, Aetna, Inc. agreed to pay certain previously denied claims for evaluation and management (E/M) services that included the modifier –25. This modifier indicates that a significant, separately identifiable E/M service was performed on the same day and by the same physician as a separate procedure or service. Aetna will pay claims with dates of service as far back as May 2003 and will make changes to its claims payment software so that future claims will be handled properly. This development is an outgrowth of a class-action suit settled in Florida. The settlement included a compliance dispute resolution process that physicians used to force Aetna to make this change in its claims software. For more information, contact jharris@facs.org.

The Citizens’ Health Care Working Group recently released interim recommendations on the future of health insurance coverage. The panel was created under the MMA to provide a national public forum through which Americans could decide what type of medical coverage they should have and how it should be financed. Based on online polls, community meetings, and written comments, the group recommends the following: protection from catastrophic health costs; a “core” benefits package for all residents; integrated community health networks; more focused efforts to improve quality of care and efficiency; and new methods to provide and fund hospice, palliative, and other end-of-life care. There will be a 90-day comment period on the recommendations, with the group sending its final proposal to President Bush in September. To request more information and to send comments, send an e-mail to citizenshealth@ahrq.gov.
On June 14, the Institute of Medicine held a press conference announcing the release of three reports on issues related to emergency and trauma care in the U.S. Concurrently, the College released the following report.

Drafted with input gathered at meetings with the surgical specialty societies, the College's report indicates that a growing patient population and stable supply of practicing surgeons are combining with other forces to produce workforce shortages, particularly in emergency departments and trauma centers. This report also documents some of the underlying causes of what the College views as an imminent workforce crisis, including declining reimbursement, the liability climate, trends toward subspecialization, lifestyle issues, and a lack of federal or state financial support for care provided to the uninsured. In this report, the College recommends short-term and long-term solutions to the building crisis.
any changes have occurred in the surgical practice environment in the past two decades, but policy experts have given little scrutiny to the potential for unintended and undesirable effects. Even the rare policy research paper that notes how stresses in the system affect surgical patients tends to gloss over the implications of the situation. Surgeons in practice, however, have begun to take notice. While intermittent access and availability issues are becoming evident in many service areas and settings, one area raising deep concern universally is emergency care.

In March 2005 and March 2006, the American College of Surgeons hosted meetings with leaders of the surgical specialty societies to examine reports of a growing shortage of surgeons available to cover emergency departments (EDs) and trauma centers. In some specialties, the insufficient number of participants in emergency call panels has reached crisis proportions, and patients throughout the nation are feeling the impact. Furthermore, surgeons who remain in the emergency care system are experiencing professional and personal burdens that are simply unsustainable. The American Medical Association reached the same conclusions at meetings last fall and again in March of this year.

The situation is of such concern that several specialty organizations independently surveyed their members on this issue. Despite the different survey populations, the findings were remarkably similar:

- A majority of surgeons take ED call five to 10 days a month; some surgical specialists take call far more often.
- Many surgeons provide on-call services simultaneously at two or more hospitals, and a significant number say they have difficulty negotiating their on-call schedules.
- Hospital bylaws typically require surgeons to participate in on-call panels, although older individuals are often allowed to “opt out,” and they are more frequently taking advantage of this option.
- A significant number of surgeons have been sued by patients first seen in the ED, and some physicians are offered discounts on their liability coverage if they limit or eliminate ED call.

Despite earlier predictions, the number of surgeons trained through the nation’s graduate medical education system has not expanded for more than two decades. A growing patient population and a stable supply of practicing surgeons are combining with other forces to produce surgical workforce shortages, particularly in specialties with total workforce numbers in the hundreds or low thousands. Our nation’s trauma centers and EDs are feeling the most pervasive effects right now, although spot shortages are occurring in other settings and specialties as well.

The reasons for concern are clear. Patients need prompt access to definitive care when confronting a surgical emergency. But even more is at stake. Our nation’s EDs provide the one point of universal access to our health care system. They are the nation’s final safety net. Indeed, the public fully expects such access, and it is doubtful that patients realize it is eroding. Yet, policy experts and decision makers seem to be unaware of the trend, and certainly no focused efforts are under way to resolve the problem.

Equally important, our emergency care system (including the EDs, hospitals, trauma centers, and the health care professionals who compose it) forms the foundation of our nation’s response to future terrorist attacks and natural disasters. Emergency care capability has never been more important than it is in the post-9/11 world, and the need to strengthen it has never been more urgent.

The following information is an effort to document, based on the limited sources available, some of the underlying causes of this imminent crisis. Also included are proposed actions that should be explored immediately to begin addressing them. Clearly, much work remains to be done.

Overview of surgical care in the ED

According to the National Center for Health Statistics, approximately 114 million ED visits (39 per 100 people) took place in 2003, representing a 26 percent increase since 1993.¹ In
addition, nearly half of all hospital EDs reported that they were at or beyond capacity in 2005 and, as a result, were forced to divert ambulances to other facilities. The problem is particularly acute for teaching hospitals, which reported that 79 percent of their EDs were at or over capacity. Overcrowding is attributed to many factors—inpatient capacity and patient flow management among them—but frequently cited issues are the federal mandate to screen and stabilize all patients and a scarcity of on-call physicians and surgeons to provide specialty care.2

A variety of patient emergencies may require surgical care. Common reasons for surgical admissions involve: gallbladder disease; gastrointestinal bleeding; appendicitis; heart disease; aneurysm; stroke; and complications associated with procedures, devices, implants, or grafts. Patients suffering injuries from external forces, or trauma, most often require emergency surgical intervention. Trauma accounts for approximately 11.4 percent of nonpediatric and nonmaternity hospital admissions originating in the ED, according to the Agency for Healthcare Research and Quality.3

Formally designated trauma centers that function as part of a state or regional trauma care system are known to provide the highest-quality care to severely injured patients.4 Perhaps contrary to general assumptions, relatively few trauma center patients are victims of violence. According to the College’s own National Trauma Data Bank® (NTDB®), victims of motor vehicle traffic accidents represent the largest segment of patients treated in our nation’s trauma centers.5 Falls are the second most common cause of severe injury and are the most prevalent source of trauma in the elderly.

A March 2005 Harris interactive public opinion poll commissioned by the College’s Committee on Trauma and the Coalition for American Trauma Care revealed that Americans appreciate the importance of prompt access to specialized trauma care services. Nearly all respondents recognized that it is extremely (63%) or very (31%) important to receive treatment at a trauma center in the event of a life-threatening injury. In fact, most respondents (eight out of 10) believed that having a trauma center nearby is of equal or greater value than a fire or police department.6

In addition, a significant majority indicated they would be extremely or very concerned to discover that their state’s trauma system fell short of recognized standards of care. Unfortunately, a survey conducted by the Health Resources and Services Administration in 2002 found that only eight states met all the recognized criteria for a fully developed trauma care system, although 26 states met most criteria.7

Trauma systems provide an important means of ensuring access to emergency surgical care for the most severely injured patients. The trauma system model of regionalized care also holds promise for ensuring that patients receive treatment for other surgical emergencies, including those resulting from disasters. State or regional trauma systems are the bedrock for responding to disasters, whether natural or man-made, and policymakers have failed to support them with the vigor they show for other disaster preparedness and response programs.

The underlying problem:
An emerging workforce crisis

A growing shortage of surgical specialists available to cover our nation’s EDs is threatening access to prompt acute care services. While the science of forecasting physician supply and demand continues to evolve, it is apparent that previous predictions of an oversupply of specialists missed the mark. Conventional wisdom has shifted with the introduction of new peer-reviewed studies, and physician workforce analysts now project potential shortfalls in specialties that are crucial to community-based emergency care response.

Contrary to earlier assumptions, the number of surgeons trained in our nation’s graduate medical education system has remained stable for more than 20 years (see Figure 1, page 11). As a result, U.S. population growth has outpaced the supply of surgeons. Furthermore, because the elderly comprise a disproportionate share of the surgical patient population, the “graying of America” is placing even greater demands on the supply of specialists.

An analysis conducted by the Lewin Group of the American Hospital Association’s ED and Hospital Capacity Survey of 2002 showed that neurosurgeons, orthopaedic surgeons, general
surgeons, and plastic surgeons were among the specialists in short supply for ED on-call panels. A similar survey conducted by the American College of Emergency Physicians in 2005 showed that nearly three-quarters of ED medical directors believe they have inadequate on-call specialist coverage, compared with two-thirds in 2004. In that survey, orthopaedic, plastic, and neurological surgeons, as well as otolaryngologists and hand surgeons, were reported as most often being in short supply. Using conservative estimates of U.S. population growth, it is apparent that the ratio of surgeons in these specialties available to provide emergency services that Americans will need is on the decline (see Figure 2, this page).

The problem is compounded by an aging surgical workforce, which makes fewer surgeons available for ED coverage due to decreased workload capacity and retirements. In many specialties that are key to ensuring adequate emergency call coverage, approximately one-third of the practicing surgeons are age 55 or older (see Figure 3, page 12). Contributing to this shortage are provisions in many hospital bylaws that allow older physicians to opt out of ED on-call responsibilities.

Workforce shortages exist across a range of medical disciplines but generally are far more significant for surgery. The workforce in nonsurgical specialties has grown steadily over time, while the number of individuals entering surgery each year has been relatively...
stable for more than two decades. In general surgery, for example, the rate of growth is not only slower than the growth in the general population, but it is significantly lower than the rate for nonsurgical specialties, including primary care specialties. (This statement is not intended to deny the genuine issues in other areas but to clarify that the problem in general surgery is far more acute and generally overlooked.)

Other professional trends add to the problem, including the growing movement toward specialization. Program directors, professors of surgery, and other individuals who are familiar with residency matches report that approximately half of all general surgery residents go on to pursue fellowships and subspecialization. As their scope of service becomes narrower, a new and alarming trend has emerged—many surgeons no longer feel qualified to manage the broad range of problems they are likely to encounter in an ED. We can anticipate that, as hospital credentialing policies and state licensing requirements become more restrictive in coming years, this issue will be of increasing concern. Furthermore, if additional research confirms suspicions that younger surgeons are inclined to narrow the focus of their practice, the implications are even more troubling as older surgeons begin to retire.

Another important but overlooked factor is the small number of specialists produced by training programs each year. As an example, approximately 130 neurosurgery residency training positions are offered each year, far fewer than the largest medical specialty, internal medicine, which offers more than 4,700 positions. In addition, recent studies have found that the number of operative cases has generally and significantly decreased for all neurosurgery residents because of compliance with the 80-hour workweek restrictions. Considering the small number of neurosurgeons practicing in the U.S. today (approximately 3,200), the large portion of whom are older than age 55 (34%), and the time it takes to train a neurosurgeon (approximately seven years), it will be difficult to safely and adequately replace a shrinking pool of neurosurgeons participating in on-call panels.

The inadequate number of specialists providing emergency call services is taking its toll on quality of care. In a recent survey of ED administrators, 42 percent said that lack of specialty coverage in the ED poses a significant risk to patients. And, of those who indicated they would not choose their own ED as a source of care if they were seriously hurt (12%), an overwhelming majority (74%) listed the lack of specialty reinforcement as the reason.

These workforce trends must be viewed within the context of rising demand for emergency services. Sharply accelerating need is chasing declining capacity, and the result is an emerging crisis in prompt access to emergency surgical care. In the short term, we need to develop

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**Figure 3**

Percentage of emergency department surgeons age 55 years or older

These data are derived from the AMA report, *Physician Characteristics and Distribution in the US, 2006 edition*, Table 1.2.
new ways to manage our surgical resources in order to meet current needs. In the long term, we need to better understand and address the underlying causes of these problems.

**Short-term solutions**

We must develop the means to make our current emergency care system work well, despite the pressing workforce shortage. The American College of Surgeons has a long history of originating programs to improve emergency care, and we are now applying these models to new efforts to make effective use of scarce health care system resources. Examples include the following:

- The College’s publication *Resources for Optimal Care of the Injured Patient* outlines the resources hospitals must have in order to fulfill their commitment to trauma patient care at various levels. State and local authorities throughout the U.S. have used this guidebook as the foundation for trauma center designation. In addition, the College’s Committee on Trauma provides hospital consultation visits at the request of hospitals, communities, or state authorities to assess trauma care and to verify trauma center compliance with these criteria. Similar programs are conducted in collaboration with the American Burn Association to define and assess the resources required for burn treatment centers.

- The College’s *Trauma System Verification Program* provides a comprehensive, on-site trauma system review to help states and regions assess their organizational strengths and weaknesses in providing optimal care for injured patients beyond the walls of individual trauma centers. Following the Model Trauma Care System Plan that the Health Resources and Services Administration introduced in 1992, these reviews may be conducted at a multi-state, single-state, regional, county, or local level, depending on a particular system’s scope and needs.

- The Advanced Trauma Life Support® Program (ATLS®) is a series of courses offered throughout the U.S. and abroad to provide an organized approach for the evaluation and management of seriously injured patients. Now in its 25th year, this program exposes both physicians and physician extenders to proven methods of appropriately assessing and initially managing severely injured patients. The ATLS is the widely accepted “gold standard” educational program for inculcating all members of the trauma team in the common principles of emergency care and is applicable in both large urban centers and small rural EDs.

- More recently, the College initiated the *Rural Trauma Team Development Course* to help all members of the health care team provide the initial assessment and stabilization of severely injured patients. It is designed to integrate the trauma care team of a small rural hospital or clinic into a larger state or regional trauma care system, both to improve the efficiency of resource use and to ensure that injured patients receive the appropriate level of care.

The American College of Surgeons and other surgical specialty societies remain committed to developing new strategies for expanding access to urgent services. For example, we are achieving some consensus on how to apply the trauma system model so that a blueprint can be developed for better regionalizing specialty care services that may be required in an emergency situation. We believe this new structure would relieve EDs of the burden of being expected to cope with the broad range of potential surgical problems at all hours of the day and night. This strategy would be particularly appropriate for services provided by specialties with workforce numbers in the few hundreds or thousands, such as neurological and hand surgery.

In addition, the ATLS and Rural Trauma Team Development Course models could be applied to develop and implement protocols that allow physicians and surgeons in the ED to better assess whether conditions and injuries would best benefit from immediate, definitive specialty care or stabilization and treatment the following day, thereby lessening the demands on specialists on call.

Of course, the profession cannot address all of the contributing causes on its own; the federal government will need to intervene as well. Together, we can strengthen our nation’s emergency care system. In the short term, we will work with Congress to reauthorize and appropriate funds for the Trauma Care Systems Planning...
and Development Act, a program administered by the Health Resources and Services Administration that aims to ensure that state and regional systems of care are operating throughout the nation to provide prompt access to surgical care that severely injured patients need. We also will work with policymakers to help ensure that an emergency surgical workforce is identified and prepared to assist in the event of a national terrorist attack or natural disaster.

**Forces shaping the workforce crisis**

The single most important factor shaping the surgical workforce issue today is declining reimbursement. Physician concerns center not only on reimbursement for the emergency services themselves, which frequently are uncompensated, but also on insurance payments for procedures that comprise a major component of elective practice. These payments have been declining steadily over the past two decades. Related issues, such as the disruption that late-night emergency care causes to a surgeon’s routine practice schedule and the lifestyle impact of frequent on-call service, undermine surgeons’ willingness to take call.

As a recent report from the Center for Studying Health System Change.
System Change noted, surgical specialists are more likely than other specialists or primary care physicians to provide charity care, probably because of their emergency on-call responsibilities (see Figure 4, page 14). Yet, the number of both surgeons and other physicians who are providing charity care is decreasing, a trend the center attributes to declining practice incomes, which make it more difficult for physicians to subsidize unpaid care.

NTDB data confirm that surgeons bear the significant brunt of uncompensated care provided to severely injured patients. According to data compiled from more than 1.5 million patient records at 565 U.S. trauma centers, “self-pay” is the largest single payment category for trauma center patients (21%), followed by Medicare (17%), with Medicaid not far behind (11%) (see Figure 5, page 14). And, while hospitals may draw upon special federal and state financing streams to offset the costs of providing care to patients with little or no health insurance coverage, physicians and surgeons may not.

Furthermore, as Table 1 (right) illustrates, Medicare payments for many operations that elderly patients most often require are considerably lower than they were in the 1980s. These are actual, national average payment amounts, with no adjustment for inflation between 1989 and 2006. Payment levels for services frequently provided to injured patients in the ED have not fared much better, as shown in Table 2 (right). Because many private insurance plans and Medicaid programs use the Medicare physician fee schedule as the basis for their own payment arrangements, these trends are reflected throughout the health care system. Again, the overall decline in practice income makes it difficult for surgeons, most of whom are in solo and small group practices, to shoulder the burden of caring for patients who are unable to pay. According to information that the Centers for Medicare & Medicaid Services recently released, the Medicare reimbursement situation will only worsen as the sustainable growth rate system produces further across-the-board payment reductions, amounting to an additional 39 percent in the next nine years.

All specialties have concerns about the Medicare payment system, but its flaws are especially problematic for surgical specialists. As Medicare data show, medical services generally are growing at a rate that allows many specialists to offset per-service payment reductions by increasing service volume. However, the volume rates for surgical procedures are not growing—in fact, for many surgical services, volume is actually shrinking. So, not only are the overall payment cuts not offset, but, under the sustainable growth rate system, the increasing number of services provided by other physicians is actually causing the reductions.
Some surgeons are exhibiting market responses to these pressures, some of which affect access to emergency services. Certain surgeons have been forced to minimize financial disruptions to their practices by subspecializing in narrow fields dominated by elective procedures. In some cases, those surgeons who narrow their scope of services are able to omit hospital-based care from their practices, making them unavailable for emergency on-call panels. According to a survey conducted by the American College of Emergency Physicians, 51 percent of ED directors in 2005 reported deficiencies in on-call coverage because specialists left their hospitals to practice elsewhere. Hospital ED administrators report these specialists frequently relocate to ambulatory surgery centers (31%).

In other cases, surgeons may eliminate risky or less profitable services from their practices. For example, a recent survey of neurosurgeons revealed that 38 percent now limit the types of procedures they perform. Of those, 57 percent have eliminated pediatrics, 13 percent no longer provide services related to trauma, and 11 percent no longer perform cranial procedures. For other surgical specialties with elective patients requiring hospital resources, one option has been to form their own specialty facilities equipped to provide only a limited range of nonemergency procedures.

Also affecting the availability of surgical care in EDs are liability issues unique to emergency care. Part of the growing reluctance to take call is because of a genuine concern that ED patients will sue. Surveys by the American College of Surgeons and the American Association of Neurological Surgeons/Congress of Neurological Surgeons revealed that more than one-third of respondents had been sued by a patient who was first seen in the hospital ED. A 2005 hospital ED administration survey also lists “malpractice concerns” as the principal factor discouraging specialists from providing ED coverage. Furthermore, because liability premiums have outpaced payments for their services, some surgeons have concluded that they simply cannot afford the added liability risk for a largely uninsured patient population.

In addition, younger surgeons, who often take the on-call shifts at trauma centers, are leaving states with the most severe liability problems. For example, according to the Project on Medical Liability in Pennsylvania, funded by the Pew Charitable Trust, “Resident physicians in high-risk fields such as general surgery and emergency medicine named malpractice costs as the reason for leaving the state three times more often than any other factor.” Furthermore, an American Hospital Association study found that more than 50 percent of hospitals in medical liability crisis states now have trouble recruiting physicians, and 40 percent say the liability situation has resulted in less physician coverage for their EDs. The crisis has even forced the closure of trauma centers in Florida, Mississippi, Nevada, Pennsylvania, and West Virginia at various times in recent years.

Specialties that have experienced particularly high premium increases—including neurosurgery, orthopaedics, and general surgery—are also among those that provide services emergency patients most frequently require. According to a report from the General Accounting Office, soaring medical liability premiums have led specialists to reduce or stop on-call services to hospital EDs, seriously inhibiting patient access to emergency surgical services.

Declining payments from all sources, a large burden of uncompensated care being provided in EDs, escalating practice overhead and medical liability premium costs, and new practice patterns that are causing some surgeons to narrow their breadth and limit inpatient care are combining to produce an unfortunate result: the pool of surgical specialists from which to draft an emergency call schedule is being drained.

**Long-term solutions**

Many of the solutions the surgical profession has identified for these problems are enormous in scope and envelop the structure of our health care system and the interests of many stakeholders. Certainly, it is time for researchers and policymakers to begin addressing these difficult issues, bearing in mind that no stakeholder has more to lose than the surgical patient. Hence, it is time that surgeons and policymakers initiate changes that are currently feasible to address the underlying causes.
Federal and state laws do little to encourage surgical specialist participation in emergency on-call panels. The Emergency Medical Treatment and Labor Act (EMTALA), for example, was signed into law in 1986 as an effort to address the problem of patient-dumping by hospital EDs. The law grew both in scope and complexity for a number of years and was often interpreted in such a restrictive sense that it imposed untenable burdens on specialists providing emergency coverage. Although the federal government has taken steps to address some of the law’s most serious weaknesses, specialists tend to view EMTALA as a mandate to provide uncompensated care around-the-clock, and the law is widely believed to be a primary factor behind practice behavior changes that are taking surgeons away from hospitals and EDs. In addition, the American College of Emergency Physicians noted in a recent report that EMTALA may actually encourage uninsured patients to seek ED care in increasing numbers because they are aware of the federal mandate to provide screening and stabilizing care.22

The College pledges to work with regulators to continue refining laws such as EMTALA to remove disincentives for specialists to provide emergency care.

State insurance laws also unintentionally contribute to the problem of uncompensated trauma and emergency care. One such statute, known as the Uniform Accident and Sickness Policy Provision Law (UPPL), permits health insurers to deny coverage for trauma care for alcohol- or drug-related injury. The original intent of the UPPL was to free sober drivers from paying the medical bills of those who drive while intoxicated. However, the result is that surgeons receive no compensation for services provided to insured patients, who often require care in the middle of the night. Although a few states have repealed their UPPLs in recent years, most still have them on the books.

Indeed, it is important to remember that there are few mechanisms that can be used to provide compensation to surgeons and other specialists who care for the uninsured or patients who are covered by programs like Medicaid, which traditionally provide low reimbursements. Unlike hospitals, surgeons do not have access to Medicare’s “disproportionate share” payment program, and most states that collect funds for trauma and ED care through special driver’s license fees, traffic violation fines, and so forth, funnel the money to institutions rather than to physicians.

A variety of mechanisms for improving the reimbursement issues that underlie the problem must be pursued. Of course, the federal government needs to take on the formidable task of comprehensively addressing the ever-growing number of Americans without health insurance. Moreover, the current Medicare payment system that is producing negative annual updates for all physician services, regardless of their unique value or spending trends, must be reformed.

The College will continue to work at the state level to eliminate UPPL laws that deny reimbursement for care provided to insured patients, as well as develop new strategies to provide physicians with access to the financing mechanisms available to facilities that provide uncompensated care.

At the federal level, we believe the government should support EMTALA’s mandate that physicians provide care for the uninsured of emergency department patients by providing some tax relief for these services. Such a tax credit or deduction could be based on overhead costs as determined in the Medicare physician fee schedule. Alternatively, the government could adjust the practice expense “pools” it develops for each specialty in determining overhead costs in the Medicare fee schedule by taking into account the impact of uncompensated care on those costs, as it has for emergency medicine. Finally, we believe Medicare should support those hospitals that have resorted to paying stipends to ensure on-call coverage by recognizing these costs when determining changes in hospital market basket or updates under the prospective payment system, as it does for critical access hospitals.
care provides 5 percent bonus payments to physicians who practice in physician scarcity areas. Unfortunately, the program appears to work better for primary care physicians than for specialists, largely because bonus payments are based on the location where services are rendered. Surgeons who care for sparse populations tend to provide their services either in regional hospitals or office buildings near those institutions. As a result, the actual site of service may be outside a physician scarcity area, even though the vast majority of the population being served resides in such an area. Another program provides 10 percent bonuses to physicians who render services in health professional shortage areas, but that program applies only to primary care and mental health providers.

Similarly, federal programs geared toward recruiting more physicians to provide care in underserved areas tend to favor primary care and certain nonphysician providers. The National Health Service Corps, for example, provides scholarships and medical school loan repayments to health professions students in return for a period of service in an urban or rural health professional shortage area. Again, no such program is available to surgeons and other specialists.

We will work with Congress to create a health professions support program to cover medical school debt for young surgeons providing surgical care in community or rural hospitals/trauma centers. We also will work with policymakers to refine current laws pertaining to physician scarcity areas so they may more effectively encourage surgical specialists to provide care in areas where demand is greatest.

Even federal programs providing limited medical liability protections for volunteer physicians tend to favor office-based care rather than treatment for the uninsured in the nation’s EDs. The Volunteer Protection Act, for example, applies only to individuals serving in not-for-profit organizations. In addition, Public Health Service Act section 224 provides Federal Tort Claims Act protection for services provided to patients of community health centers. However, because the focus is on community health centers, these protections only apply to primary care and office-based services. Surgeons who provide care to patients referred by community health centers receive no protections under the statute.

All medical and surgical specialty organizations support enactment of comprehensive, common sense, medical liability reforms. Until a comprehensive and nationwide solution emerges, however, interim steps addressing the most immediate concerns should be considered. For example, policymakers can limit exposure to medical litigation and provide qualified immunity for EMTALA care by bringing these mandated services under the Federal Tort Claims Act. Similar strategies may be pursued on the state level.

One federal program intended to ensure prompt access to surgical care for severely injured patients was established in the Trauma Care Systems Planning and Development Act of 1990 mentioned previously. Administered through the Health Resources and Services Administration, in the past several years this program has distributed $31.4 million in funds to all 50 states and five territories for the purpose of developing state and regional trauma care systems. But today, even with this influx of federal funds, the nation’s trauma systems remain incomplete, and, unfortunately, only one-fourth of the U.S. population lives in an area served by a trauma care system. Furthermore, efforts to reauthorize the program failed in 2005, no funds were appropriated for 2006, and the President’s fiscal year 2007 budget proposes its elimination—all despite the fact that in 1999 the Institute of Medicine called on Congress to “support a greater national commitment to, and support of, trauma care systems at the federal, state, and local levels.”

In addition to advocating the reauthorization of the Trauma Care Systems Planning and Development Act, we will work with policymakers in the future to expand this concept to other surgical emergencies, including those resulting from natural or man-made disasters. We also will explore improvements in
Lastly, it is vitally important that policy researchers and policymakers gain a greater understanding of the forces that are undermining our nation’s emergency care system. Studies of the growing uninsured population, for example, must expand their focus beyond the important but narrow issue of chronic disease management and begin considering the implications for access to high-quality acute care services for all Americans. The American College of Surgeons is committed to initiating this dialogue and will continue its collaboration with representatives of all surgical specialties to improve our understanding of the problems confronting surgical practice today and to develop innovative solutions to resolve them.

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11. Online survey conducted by the American College of Surgeons, February 2006.

AUGUST 2006 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
SURGEON,

HEAL THYSELF

by John D. Zelem, MD, FACS,
Booneville, MS
becoming healthy” has been a buzzword since the 1990s. Thanks to the baby boomers, who have started the trend, we have seen a considerable increase in our awareness of health. There has been a tendency to reverse the paradigm from the treatment of diseases to their prevention. In his book *The Next Trillion,* Paul Zane Pilzer, a world-renowned economist, predicted that wellness will occupy an additional one-seventh or “next trillion” of our economy. He also states that wellness is the industry in which the fortunes of the new millennium will be created. We as surgeons and physicians, who have been monitoring the health and wellness of our patients, need to start taking a better look at our own health and wellness.

We as a profession are being watched by our family, our friends, our colleagues, and, especially, our patients. Knowledge is caught, not taught—in other words, our actions speak louder than words. Our patients want to make sure that we not only talk the talk but also walk the walk. We need to be the model for our patients to follow and free ourselves of the old philosophies and old thinking, “Do as I say, not as I do.”

**The process of becoming healthy**

We live in a society of immediate gratification: enjoy now, pay later. I call this a “credit card mentality.” At the same time, the media are overwhelming consumers with advertisements for losing large amounts of weight in short periods of time and getting that six-pack abdomen in just six to eight weeks. But, of course, under most conditions, these proclamations are physically impossible. The manufacturers of these products also realize that fact because one might notice their disclaimer in very small print, either in the advertisement or on television: “Results not typical.” The shorter period of time in which a person makes those changes, the higher the chance that that person will go back to his or her former state in just as short a period of time. This also sets the participant up for failure with unrealistic expectations. The only thing that the seller is interested in is making some money, not a person’s continued success. We as physicians must be aware of this deception both for ourselves and our patients.

The reality is that becoming healthy is a process, just as learning how to walk was a process. It is not an overnight miracle. A person cannot cheat or shorten a process. A surgeon cannot create a surgical wound one day and expect it to be healed with perfect tensile strength in one week. There is a process to wound healing.

As recipients of this magazine continue to read this article, they are either becoming healthy or unhealthy. It is like standing on a set of stairs—one may either go up or down but cannot stand on the same step. Many of us have let our health go because we have been so busy going through medical school, residency, and busy hours in our practice. We, as well as our patients, have a tendency to react to crisis, not the subtle hints we receive every day. We don’t address our health until that medical crisis arises. Then we eat differently, exercise more, and lose some extra weight.

**Getting started**

There are two ideas to keep in mind while considering the content of this article. The first idea is, “The definition of insanity is doing the same thing every day, expecting different results.” We are guilty of this in all aspects of our lives, not just our health. Many people believe that they can change results with their old habits and actions but, if they continue to do what they have always done, they will continue to get what they have always gotten. The other phrase is: “If you want to make some changes in your life, you have to make some changes in your life.” Change is often uncomfortable because we are so secure in our comfort zones, but change is good. It is part of the process. We will not make the changes that we need to make to improve our health and

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*VideoPlus, 2001. ASIN: B0006RX28E*
lives if the reasons for doing so are not important enough.

So how does one get started? First of all, a person needs to know why he or she wants to become healthy. I had my reasons: I was overweight and had hypertension and lots of coronary calcifications. I wanted to be able to spend more time with my kids in a much healthier body. We all must determine, “What is our reason, our why?” What are the consequences of not attaining a healthy life? If the reasons for getting healthy are not important enough to the person, it will never happen. That person will not be able to get to the next step: making some commitments.

So now that a person knows why he or she wants to become healthy, what kind of commitments is that person willing to make? It is already well known that surgeons are capable of making and keeping commitments, as they have already gone through the grueling process of becoming a physician/surgeon. That took sacrifice and courage to go for it and complete it. Surgeons had to make many changes in their life, schedule, social life, sleep pattern, and study habits. The surgeon had to stretch, and he or she did it because the “why” was important enough. Even though there wasn’t always a lot of time, there was a way for the surgeon to find time to do the things that he or she wanted to do, like a social engagement, time with a spouse, time with kids or family, and so on. There was commitment. Isn’t health worth it? Patients and family will know if a surgeon is not committed to his or her own health.

A person’s ideas about maintaining a healthy life may be the same that I considered. I have seen so many people, myself included, who start off a new, more healthful approach to life with a bang and fizzle out in a very short time. People quit. They quit their jobs, relationships, professions, exercising, reading, studying, and so much more. A surgeon cannot possibly be responsible for them, but that surgeon can be for himself or herself.

A variation of the so-called Pareto principle is the 20/80 rule: 20 percent of people will be responsible for 80 percent of the results. That principle applies to all aspects of life, not just health. If a person’s reason for becoming healthy is important enough, that person will find the way to push forward.

### Habits

The best way to keep to commitments is to develop good habits. Here is a poem from an unknown author that best describes habits:*

I am your constant companion.  
I am your greatest helper or heaviest burden.  
I will push you onward or drag you down to failure.  
I am completely at your command.  
Half the things you do might just as well be turned over to me and I will be able to do them quickly and correctly.  
I am easily managed—you must merely be firm with me.  
Show me exactly how you want something and after a few lessons I will do it automatically.  
I am the servant of all great people and, alas, of all failures, as well.  
Those who are great, I have made great.  
Those who are failures, I have made failures.  
I am not a machine, though I work with all the precision of a machine plus the intelligence of a person.  
You may run me for profit or run me for ruin—it makes no difference to me.  
Take me, train me, be firm with me, and I will place the world at your feet.  
Be easy with me and I will destroy you.  
Who am I?  
I am habit.

*Available at http://www.motivateus.com/stories/ycc.htm

### Four seasons analogy

I like to take this point and put it into what I call a “four seasons analogy.” Winter is an “intuitive” season—it is cold and not much physically gets accomplished then, but it is a time of thinking and planning. For example, consider the farmer who is getting ready for his next planting. He may get the seeds and the fertilizer ready and plan where the crops will go. In the winter season, we
also do our planning, get our thoughts in order, maybe set some goals, and make the decision to get started.

Spring is the “get started” season. This is the time when we are out of the gate with great enthusiasm and energy. Whatever we are doing, whether it be for our health or otherwise, there is no stopping us. The farmer is preparing the soil, planting the seeds, making the rows straight, and fertilizing and watering the early crop. In both situations, great amounts of energy are being expended with excitement. Challenges are handled with relative ease; we are headed toward our goals.

Summer is the “meet your wall,” or “life happens,” season. This is the season when the challenges really start to happen and maybe even increase. We don’t see a lot of results yet and begin to wonder if what we are doing is really working. The farmer may see a drought, too much rain, too hot, too cold, too many weeds, a poor crop, or animals and pests destroy the plants. A surgeon may find that work gets busier, and there are family problems, illness, or any other challenge that life brings along. The farmer doesn’t give up on his crop. Should a surgeon give up on what he or she is trying to achieve? This is the season when most people quit. They don’t have the drive and reserve to dig deep down to continue plodding along to get to fall, the harvest.

Yes, fall is the harvest season. This is the point at which we begin to reap the results. The continuous efforts that have been invested are now starting to pay off. Some of the toughest challenges have been weathered, and we are beginning to be where we want to be. This stage is not the end, though. As mentioned before, a person cannot stay here—he or she will either go forward or slide backwards.

Here is an important point to keep in mind. Many people quit during the summer of their journey. They are not experiencing the results they are looking for, or they cannot overcome their challenges. They did not know how long summer would be. When they quit, they did not know how close they were to their fall, their harvest, their results.

Maintaining a healthy lifestyle

There are two components to completing this “process”: goal setting and finding a mentor. Some goals must be set and written down. A person needs to know where he or she wants to be if that person wants to be able to recognize when he or she gets there. I am sure that many people remember being on a long trip as a child and asking, “Are we there yet?” That child had no idea where the family was going, how long it would take, and what it would look like when he or she got there. That is why goals must be set—so all these unknowns are addressed.

Lastly, don’t do it alone. A person going through this process should find a mentor, someone who has already done what is set to be accomplished and is very successful at it. In the area of health, it may be a person’s physician, a personal trainer, a nutritionist, or another health care professional. Find someone with comparable experience and follow his or her direction and advice. A person will pay a pro to improve a golf or tennis game, so why not find a pro for improving health? A mentor should guide the goal-setting process initially.

Remember this: becoming healthy is a process, and it is an ongoing journey. Learn to enjoy the journey, for, believe it or not, the success of achieving these goals is not in attaining them, it is the process of becoming who or what a person needs to become while doing it.

The principles presented here apply not only to becoming healthy but to all aspects of life. They are achievable. I know, for I have done everything here that I recommend to you, the reader. I am not anyone special, just a person with renewed passion for personal health and wellness.

n the early 1990s in Cobb County, GA, the Atlanta suburb of Marietta was experiencing explosive growth. And at Wellstar-Kennestone Hospital, the growing pains were starting to show.

“The volume of patients was skyrocketing,” recalls Steven Oweida, MD, FACS, a vascular surgeon at Kennestone. “The increase in patients, combined with a shortage of anesthesia providers, was straining the system, especially when it came to anesthesia delivery. The hospital had been exclusively using anesthesiologists, until it became clear that it needed to look at physician extenders to offer a more efficient level of care that met the hospital’s standards.”

Even today, surgeons can sometimes be at the mercy of the anesthesia provider shortage. As the number of operations and sites where they are performed increase, it is critical for surgeons to be able to perform when and where they choose without being hampered by a lack of anesthesia providers. Operating rooms can temporarily shut down. If they don’t, sometimes tired, overworked anesthesia providers are forced to be on the case.

Anesthesiologist assistants (AAs) allow the surgeons more access to the operating room and less guessing as to when they are doing the surgery.
This is why AAs are becoming the solution of choice for both the shortage and quality issues. For example, today there are 22 anesthesiologists, 18 AAs, and one certified registered nurse anesthetist (CRNA) on staff at Kennestone. The cardiac team has four anesthesiologists and six AAs.

Dr. Oweida says, “You can either throw bodies at the problem, or you can use the best anesthesia provider available. Now they are giving us the right AA and the right anesthesiologist. We receive a better work ethic and results from the AAs than even from the marginal anesthesiologists we once had to work with because of the shortage. We have noticed that our patients are getting a better level of care.”

The change Kennestone has experienced is not unusual for the growing AA profession. AAs are helping to solve the anesthesia provider shortage as their numbers are increasing.

“It expands the flexibility and versatility of the anesthesia department,” says Terrence Fullum, MD, FACS, chairman of the department of surgery at Providence Hospital in Washington, DC. “Certainly in this era of anesthesia shortages, that is one of the areas we have evaluated and used.”

“I immediately realized the AA’s strong adjunct to the anesthesiologist, with their ability to start lines, work the magic of induction, and so on,” according to Dr. Fullum, who performs advanced laparoscopic and bariatric surgery. “The AAs know the protocols and are great at patient assessments. This enhances the anesthesiologist’s ability to safely supervise more than one case at a time.”

In most states, AAs are supervised by anesthesiologists in the same manner as CRNAs: one anesthesiologist for every four nonphysician providers.

**Growing in numbers**

Currently AAs work in 15 states and the District of Columbia, 10 through licensure, and six through delegatory authority, meaning they are specifically requested by hospitals or physician anesthesiologists. Their jobs are interchangeable with the CRNAs, with the difference being a nursing degree for the CRNAs—who in certain circumstances can work without an anesthesiologist—and the emphasis on the anesthesia care team (ACT) for the AA.

“Anesthesiologist assistants have always been and will continue to be trained to work in the ACT model of patient care,” says Ellen Allinger, president of the American Academy of Anesthesiologist Assistants. “As such, AAs are the only anesthesia professionals who work solely within this team concept.”

The ACT concept was initially approved by the American Society of Anesthesiologists in 1982. It is defined by the ASA as properly trained and credentialed professionals who have certain aspects of anesthesia care delegated to them while concurrently being medically directed by an anesthesiologist.

The ACT concept is considered to be the optimal mode of patient care and has been supported by a study that states: “Medical direction by an anesthesiologist was associated with lower mortality and failure-to-rescue rates.”

In another, more recent study, Vila and colleagues reviewed Florida state records, looking at death and injury rates following similar surgeries in ambulatory surgery centers, and compared them to surgeries performed in physician offices.

“We found that the injury and death rate in offices was 10 times higher than in ambulatory surgery centers,” Dr. Vila says. “There were insufficient data from the physician offices to specifically determine the presence of a care team practice. However, the death reports did indicate that an anesthesiologist was present in only 15 percent of the office deaths. These results were suggestive that the presence of an anesthesiologist would decrease the likelihood of an adverse event.”

Ms. Allinger emphasizes that these studies show the importance of the anesthesia care team concept. “Surgeons are assured that when working with an AA, there will always be an anesthesiologist also involved in the anesthetic care of their patient.”


“With the ACT, the patient is assured that, with the anesthesiologist plus the AA, there are two anesthesia providers,” says Rob Wagner, AA-C, MMSc, RRT, director and assistant professor at the new AA program at Nova Southeastern University in Ft. Lauderdale, FL. “With the anesthesiologist and surgeon, there are two medical doctors. It is the highest standard of patient care.”

**Education and training**

AAs are baccalaureate-degreed professionals with an education built on the pre-med prerequisite, just like the anesthesiologist.

At the new AA master of health science program at Nova Southeastern University, the anesthesiologist plays a major role in teaching the academic courses and training the AAs in the clinical setting. It’s the clinical environment where the AA experiences first-hand the concept of the ACT.

“The AAs are trained from the get-go to be part of the anesthesia care team,” says Mr. Wagner.

In fact, as a recent article in *Anesthesiology News* points out, AAs are involved in more complicated surgical procedures today, meaning even more choices for surgeons.

Dr. Oweida points out, “AAs understand the dynamics of complicated patients when you clamp the aorta, working on the carotid artery. They are good at responding medically and keeping the patient as physiologically stable as possible. Our number-one complication in vascular surgery is heart problems, so if you have somebody good at cardiac anesthesia, you will have better outcomes. [AAs] are gifted at many things and responses.”

“They are trained to do more complex surgeries, like a ruptured aortic aneurysm, or anesthesia for heart and liver transplants,” says Mr. Wagner. “AAs are trained in every surgical specialty involving anesthesia. That encompasses all surgical procedures, from plastic surgery, obstetric surgery, cardiac surgery, to neurosurgery.”

More well-trained AAs are becoming available as more AA schools open, filling positions and helping solve the shortage of providers, specifically the lack of nurse anesthetists.

The opening of the Nova Southeastern University program, along with the program at South University in Savannah, GA, doubles the number of existing AA programs in the past three years. The trend to open more AA schools will most likely continue as more states license AAs.

That means more efficient delivery and the highest quality of medical care with the anesthesia care team.

“AAs, in my view, definitely have had an impact on positive outcomes,” Dr. Oweida says. “We know that cases are getting more and more complicated in the ORs. The more providers, and the better trained and the more multidisciplinary they are, the more positive the outcomes you will have.”

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Mr. Rothstein works in public relations for the American Academy of Anesthesiologist Assistants, which is headquartered in Tallahassee, FL.
The last few years have provided an explosion of data and interest in the sport concussion field. In 2001, the Journal of the American College of Surgeons was the first to publish a comprehensive approach to this injury, describing a method of evaluation that encompassed everything from clinical history and evaluation; research methods, including new imaging and functional magnetic resonance imaging (MRI) technologies; and concussion rehabilitation and prevention. Although sport concussion is not a surgical problem per se, surgeons have often been involved in the medical management of elite and professional teams, are often on the sidelines as parents or coaches for amateur players, and indeed may be or may have been talented athletes themselves. Traditionally surgeons have shown leadership in management of head injury and certainly trauma surgeons and scientists have an interest in this area—and athletes are an excellent study population for particular injuries.

Recent advances have solidified this involvement with the 2nd International Concussion in Sport meeting in Prague in November 2004, followed by simultaneous publication in four journals of the conclusions and recommendations from that meeting. Moreover, compared with the first meeting, which was held in Vienna, Austria, in 2001, representation from surgeons in general, and Fellows of the American College of Surgeons in particular, had grown—for example, Edward Laws, MD, FACS, then-President of the ACS, gave a keynote presentation, and Graham Teasdale, MBBS, FACS(Hon), honored the group with his special perspective on head injury. Participants included representatives from the neurosciences, sport medicine professionals, coaches, athletic therapists and physiotherapists, sport psychologists, neuropsychologists, and equipment manufacturers. Such unprecedented interaction among diverse groups led the way for a consensus document revolutionizing the management of concussion in sport.

In addition to the important areas prioritized from the first meeting, including sideline evaluation and imaging and return to play issues, new strides were made in development of clinical history, preseason medical concussion stations, concussion rehabilitation and sport psychology in concussion, and new research techniques, including functional MRI. The concept of simple versus complex concussion was elucidated and the important issues of pediatric concussion and cognitive exertion explored. In addition to the document, the new sideline evaluation card for the Sport Concussion Assessment Tool was developed; both are downloadable and free of charge for widespread use at www.cjsportmed.com or www.bjsportmed.com. Also noteworthy, the mandate to educate was identified as a...
high priority, setting a standard of care not seen before.

All these developments were accomplished with the support and endorsement of the world’s largest sporting bodies, namely, the International Ice Hockey Federation, Federation Internationale de Football, and the International Olympic Committee.

As part of the education initiative, the ACS once again contributes to setting the bar high. Long a part of the neurosurgical world, Think First, a not-for-profit, injury-prevention organization, has now taken on the task of concussion education. Think First Canada, under the leadership of Charles Tator, MD, PhD, FACS, FRCSC, has recently launched the Concussion Road Show, a public education program that aims to educate players, coaches, primary care physicians, therapists, and the public about the main issues related to concussion. This event is sponsored by Manulife and travels to various venues on weekends. Event participants provide presentations and written materials and lead a question-and-answer interaction with the audience. In addition, the Think First Web site (www.thinkfirst.ca) now has a concussion portal with free, downloadable information packages for coaches, parents, players, physicians, and the public. Growing interest in this program was evidenced by the Committee on Trauma Prevention’s meeting at the 2005 Clinical Congress in San Francisco, CA, where M. Margaret Knudson, MD, FACS, committee chair, identified ongoing discussion and updates on the concussion issue as important parts of the annual agenda.

ACS surgeons are in the concussion scrum. And although concussions are not a surgical field, they present an opportunity to advance the traditionally surgical field of head injury.

References


**Dr. Johnston** is a neurosurgeon/concussion consultant in the departments of neurosurgery, kinesiology, and physical education, and director of the concussion program at the McGill Sport Medicine Centre, McGill University, Montreal, QC.
The critical role of patients and their significant others as integral members of surgical teams is essential to delivering optimum and safe surgical care. Active involvement of patients as partners in care can increase compliance and decrease complications through early identification of risks. The American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education have both emphasized the important role of patients within the context of the core competencies.\textsuperscript{1} Patients need to possess the requisite knowledge and skills to contribute effectively to their care, and patient education is key in this regard.

The American College of Surgeons supports the Patients’ Bill of Rights\textsuperscript{2} and the recommendations of the Institute of Medicine,\textsuperscript{3} which have underscored the rights and responsibilities of patients to fully participate in their care. Patients need to be provided with education to help them in decisions regarding their operations and to help them effectively participate in the surgical experience and contribute to their continuing care. Patient education materials should be based on contemporary principles of surgical education and evidence-based medicine and tailored to the specific needs of the individual patient.

The ACS supports the following:

- Assessing the individual needs of each patient and focusing specifically on various cultural, gender, age, and literacy issues
- Designing and implementing individually tailored, scientifically sound patient education that addresses the essential domains of knowledge, skills, and attitudes; focuses on coping mechanisms; and assesses achievement of educational objectives through valid and reliable methods
- Utilizing appropriate methods to involve the patient and confirm the patients’ comprehension during the process of obtaining informed consent
- Providing instructions to patients and their signifi-
cant others that are comprehensive and address home care skills, pain management, dietary recommendations, lifestyle modifications, follow-up care, and symptoms and signs that need to be brought to the attention of the surgeon and the surgical team

• Improving the ease of access to accurate patient education information from the ACS and other professional organizations

• Collaborating with other professional organizations on approaches to enhance patient education and sharing of relevant and easily comprehensible educational materials

• Evaluating the impact of patient education on patient care using well-designed scientific methods

• Promoting the science and practice of patient education

References


In compliance...

with HIPAA’s NPI provisions—Part III

by the Division of Advocacy and Health Policy

We are now more than halfway through the two-year period for physicians to obtain and begin using a national provider identifier (NPI) as required by the Health Information Portability and Accountability Act (HIPAA). Physicians must have and begin using the NPI on claims forms submitted on or after May 23, 2007. (Small insurers may take up to one additional year to begin using the NPI.)

The deadline is not as far away as it may seem. While the Centers for Medicare & Medicaid Services (CMS) is emphasizing prompt issuance of the NPI, the prudent surgeon or staff member will consider the possibility of a six- to nine-month delay in getting a NPI. Furthermore, implementing the NPI will be a complicated and lengthy process that primarily will be the responsibility of individual physician practices. We urge all Fellows who have yet to obtain and implement a NPI to begin the process as soon as possible.

New developments

This article reviews some of the basics involved in obtaining a NPI, which were discussed in this column in June 2005 and November 2005, and presents some additional material. New developments include the following:

• Group practices with a significant number of physicians may now apply for individual NPIs for all their physicians using a single electronic file in a CMS-specified format. The group must ask each physician for permission to obtain his or her NPI. We anticipate that many Fellows will be in practices that use this method for submitting applications. More information can be obtained from the CMS Web site at http://www.cms.hhs.gov/NationalProvIdentStand/ and at https://nppes.cms.hhs.gov.

• A new Medicare physician enrollment application that went into effect May 1 requires the submission of a NPI with the application. The application is available through the CMS Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll.

• Large providers must determine whether they have components, or “subparts,” requiring their own NPI. This concept is explained at http://www.cms.hhs.gov/NationalProvIdentStand. Click on “Medicare NPI implementation” at the left.

• CMS urges all Fellows to include all existing identifying numbers, not just Medicare numbers, on the application. When reporting a Medicaid number, also report the state issuing the number. Existing, or legacy, numbers are needed to develop crosswalks to aid in the transition to the NPI.

• The paper form CMS-1500 has been modified to accept a 10-digit NPI. A period of time will be allotted during which either the new or the old CMS-1500 may be used, but, as of press time, the dates of the transition had not yet been announced.

Applying for a NPI

Physicians may apply for a NPI in one of three ways: a Web-based application process available at https://nppes.cms.hhs.gov; a paper application...
available at that same Web site or by calling 800/465-3203; and, as explained previously, groups may file electronically in a CMS-specified format. CMS says it takes approximately 20 minutes to complete an individual application, and physicians who apply online may get a NPI in minutes.

When applying, physicians must designate the code for their specialty on the application, by either consulting a list of codes at http://www.wpc-edi.com/codes/taxonomy or by writing the specialty on the application. In the latter instance, the proper code will be assigned as part of the NPI issuance procedure. For several specialties, such as hand surgery and plastic surgery, more than one code is available. General surgeons are simply recognized by the specialty of “surgery” and use the code 208600000X. Please consult the November 2005 issue of the Bulletin (available at the CMS Web site) for detailed information on selecting a code.

**Implementing the NPI**

It will take an extended period of time to implement the NPI, and physician offices will play a major part in its success. After a NPI is assigned, it must be furnished to everywhere that legacy numbers have been placed, meaning, essentially, each organization that touches a claim and each office, hospital, laboratory, and so on to which a physician refers patients. Practices will need to determine when to start displaying the NPI on various documents, such as patient referrals and insurance claims.

Medicare has announced its implementation schedule (see box, this page). It also has announced a preference for surgeons sending both the NPI and the legacy number to Medicare for a period of time. In fact, both numbers must be used through October 1, 2006. If a problem arises with the NPI, Medicare will use the legacy number rather than deny the claim. Medicare is using the NPI on claims, claim status responses, remittance advice notices, and eligibility response electronic transactions. Medicare is also working with other payors to encourage them to use the same implementation policies and schedule.

**More information**

Check Web sites for more information about the NPI and its implementation. The CMS Web site has become very robust and is full of information about the NPI. In addition, check with large insurance plans and local organizations, such as state medical associations, to see if they have any information available.

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### Medicare implementation

<table>
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<tr>
<th>Date claim reaches Medicare</th>
<th>Medicare will accept claims with a NPI, but a legacy Medicare number must also be on the claim</th>
<th>Medicare will accept claims with a NPI and/or a legacy Medicare number</th>
<th>Medicare will accept only the NPI</th>
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<tr>
<td>Now through October 1, 2006</td>
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<td>October 2, 2006–May 22, 2007</td>
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<td>May 23, 2007, and thereafter</td>
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The goals of my visit to Japan, as I had originally envisioned, were to attend the annual meeting of the Japan Surgical Society in Tokyo, to stimulate additional scientific exchange and friendship with my current scientific collaborators, and to evaluate the training and outcomes of two Japanese surgical fellows who had previously spent time in my laboratory. The two weeks spent in Japan not only accomplished these goals but also exceeded my expectations by introducing me to new colleagues and fostering new collaboration.

I arrived in Tokyo before the Japan Surgical Society meeting to visit two institutions there. My first visit was to Tokyo Medical and Dental University, where I was hosted by Takehisa Iwai, MD, PhD, chairman of the department of surgery. I attended several conferences, including a weekly postoperative conference; I was impressed by the high standard of resident preparation and presentations. The drawings of the extensive lymph node dissections for gastrointestinal tumors were most impressive, as was the extensive use of laparoscopy for benign breast disease. I had the opportunity to have in-depth discussions with Dr. Iwai—regarding his mounting evidence that Buerger’s disease may have a hematologic, not vessel, origin—and with Eiji Kaneko MD, PhD, regarding his clinical trial of circulating peripheral mononuclear cell injection for critical limb ischemia. The opportunity to watch Dr. Iwai and Norihide Sugano, MD, PhD, perform a femoral-popliteal bypass was exciting and enabled the comparison of operating techniques as well as the similarities and differences in the Japanese and U.S. operating rooms.

I next visited Tetsuro Miyata, MD, PhD, who hosted my visit to the University of Tokyo. I saw the outpatient clinic, the inpatient wards, and the vascular laboratory. Dr. Miyata and I discussed vascular surgery research, and he introduced me to his chief resident, Kota Yamamoto, MD. All of us hope...
that Dr. Yamamoto will come to my laboratory for an experience in basic science research.

The annual meeting of the Japan Surgical Society opened with its council dinner. I was warmly welcomed by Masatoshi Makuuchi, MD, PhD, president of the society, and was seated with Dr. Makuuchi’s friends and colleagues, including Junji Machi, MD, PhD, and Guido Torzilli, MD, PhD. I was then introduced to the members of the society as the representative of the American College of Surgeons. Afterwards, I was congratulated by many surgeons for the honor of being selected the Japanese Traveling Fellow; the wonderful feeling of camaraderie and friendship between surgeons of different cultures was almost surprising but greatly appreciated.

The annual meeting was held at the Tokyo International Forum, a very large and architecturally spectacular venue. I particularly enjoyed the poster sessions and the opportunity to discuss surgery with Japanese colleagues. As part of the Surgical Forum, I presented a discussion of the importance of vascular training on outcomes after carotid endarterectomy. This talk generated much discussion and went well past my allotted time. It was quite interesting to see how Japanese surgeons are dealing with the increasing numbers of patients with carotid stenosis, which has a much lower incidence there than in the U.S.

I also gave a presentation, hosted by Drs. Iwai and Miyata, about the most recent results of carotid stenting and comparison of outcomes of carotid stenting and endarterectomy. Mr. Toshihito Seto, of LeMaitre Vascular, arranged for Prof. Izumi Nagata to be the discussant of my talk. Professor Nagata is the chairman of neurosurgery at the Nagasaki University School of Medicine and the most prestigious performer of carotid stenting in Japan. We had a lively and wonderful discussion of the similarities and differences between Japanese and U.S. practice in the management of carotid disease.

During my week in Tokyo, I was also able to visit the Asakusa shrine, see the Kabuki theatre, walk down the Ginza, and visit the very busy Tsukiji fish market; although I saw the Tokyo Dome, I had just missed opening day of baseball season. The cherry blossoms were in full bloom and spectacular; Kitanomaru Park was a par-
particularly nice place to see the flowers alongside the native Tokyo residents.

My next destination was the northern island of Hokkaido. Masae Haga, MD, PhD, who had spent a year in my laboratory, attended the Tokyo meeting and accompanied me on the airplane ride to Asahikawa, the snow-covered, second-largest city in Hokkaido. I was hosted by Tadahiro Sasajima, MD, PhD, whom I had met in the U.S. and had already visited earlier in the week in Tokyo. Dr. Haga and Hidenori Asada, MD, PhD, who also spent time in my laboratory, showed me around Asahikawa Medical College. We saw several postoperative patients; I was impressed by some of the creative ways that vacuum-assisted closure devices were used.

I took the train to Sapporo for my visit to Hokkaido University. My host was Toshiya Nishibe, MD, PhD, who had spent many years there; the former chairman of the department, Keishu Yasuda, MD, PhD, already retired, and his successor, Yoshiro Matsui, MD, PhD, had not yet settled in. I saw the inpatient wards and was able to see many similarities with our hospitals. It was snowing in Sapporo but I was still able to see the collegiate campus of Hokkaido University and several of the city sites, including the Sapporo tower.

My next stop was Hiroshima. I flew there, accompanied by Mr. Seto. I was able to get together and spend some time with Akimasa Yamashita, MD, PhD, who also spent a year working in my laboratory.

However, the main purpose of my visit to Hiroshima was to see the world heritage site of the A-bomb memorial, which was quite moving. I was also able to visit the nearby Miyajima Island, a beautiful site with a famous tori in the water. From Hiroshima, I traveled by shinkansen—the bullet train to Sapporo.
train—to Nagoya, the third-largest city in Japan.

My visit to Nagoya was busy. I first visited Aichi Medical College, where I was the guest of Takashi Ohta, MD. Although he was busy, given his recent election as president of the hospital, we spent some time together discussing vascular surgery in Japan and the U.S., as well as potential for future collaboration. I was also able to spend some time with Hiroyuki Ishibashi, MD, and accompanied him to the operating room to watch a repair of an abdominal aortic aneurysm.

At Nagoya University, I was hosted by Kimihiro Komori, MD, PhD, FACS. We spent time discussing our research projects and mutual interests. Dr. Komori introduced me to several of his residents, including Dai Yamanouchi, MD, who may also spend some time in my laboratory in the future. My colleague, Masayoshi Kobayashi, MD, PhD, and I spent time discussing our mutual interests and future projects.

Motomi Ando, MD, PhD, hosted my visit to Fujita Health University and invited me back to Japan next year for the annual vascular meeting. I scrubbed in on a femoral-popliteal bypass case with Dr. Nishibe and Yuka Kondo, MD, PhD; our hands danced together, across cultures and languages, as surgeons working together for a patient. This was really the highlight of my trip.

In Nagoya, I was able to visit the Toyota Auto Museum, the Tokugawa Art Museum, and Nagoya Castle, which were all surrounded by the wonderful cherry blossoms.

My visit to Japan was very busy but wonderful, with seven institutional visits in addition to the Japan Surgical Society meeting. I found my Japanese colleagues to be wonderful hosts and eager to discuss all aspects of surgery, from clinical work to basic science research, and from the larger picture to fine details. Their passion to pursue excellence is clear in every endeavor that they undertake.

I thank my Yale partners, Bauer Sumpio, MD, PhD, FACS; Richard Gusberg, MD, FACS; and James Wong, MD, FACS, for covering my absence and encouraging me to capitalize on this opportunity. I thank my wife, Susan, and my children, Ian, David, and Kevin, for letting me go for such a long time without them and, as usual, without complaint.

And I greatly thank the American College of Surgeons for allowing me to serve as the representative both of the society and of our country. This fellowship was a great honor and a wonderful stimulus of enthusiasm for surgery, academics, and research.

Dr. Dardik is assistant professor, department of surgery, Yale University School of Medicine, New Haven, CT, and attending surgeon at the VA Connecticut Health Care Systems, West Haven, CT.
Dr. Niederhuber appointed Acting Director of NCI

On May 31, Andrew von Eschenbach, MD, FACS, submitted his resignation as Director of the National Cancer Institute (NCI), effective June 10. He will continue to serve as Acting Commissioner of the U.S. Food and Drug Administration and as a senior advisor to the U.S. Department of Health and Human Services Secretary Michael Leavitt while he awaits confirmation. John E. Niederhuber, MD, FACS, has been designated Acting Director of the NCI effective immediately upon Dr. von Eschenbach’s resignation.

A distinguished surgeon and researcher with strong ties over many years to the NCI as an outside advisor and grant reviewer, Dr. Niederhuber became the NCI’s Deputy Director for Translational and Clinical Sciences in September 2005. Just before his recruitment to the NCI, he chaired the National Cancer Advisory Board. His extensive academic and research career in the cancer field has included positions at the University of Michigan, Johns Hopkins University, and Stanford University. Most recently, he was director of the Comprehensive Cancer Center at the University of Wisconsin.

Dr. Niederhuber has been a Fellow of the College since 1976 and has served on the Committee for the Forum on Fundamental Surgical Problems and in leadership positions on the Commission on Cancer, serving as its Vice-Chair from 1988 to 1989 and as Chair from 1989 to 1990.

For more information about Dr. Niederhuber’s appointment, visit http://www.cancer.gov/aboutnci/acting-director-appointed.

College launches patient education Web site

Patients as Partners in Surgical Care—a new patient education Web site developed by the American College of Surgeons to help surgical patients and their families become informed about their operation and surgical care—is now live at http://www.facs.org/patienteducation/.

In collaboration with surgical and professional organizations, the National Library of Medicine, and the National Institutes of Health, the College has developed this online resource that will provide current information about surgical procedures, diseases, tests, medications, pain management, national guidelines, and interactive education. Features include links to health news, the National Library of Medicine’s PubMed, and other patient education and professional resources. A “surgeon search” feature is also part of the site.

Patients as Partners in Surgical Care is an excellent, current source of patient education information for surgeons and other health care professionals. For more information, contact kheneghan@facs.org, or read the related article in the June 2006 issue of the Bulletin at http://www.facs.org/fellows_info/bulletin/bullet.html.
The ACS Foundation has announced the appointment of C. Rollins Hanlon, MD, FACS, of Chicago, IL, to its Board, effective June 9.

Through this appointment, Dr. Hanlon replaces Oliver H. Beahrs, MD, FACS, who passed away in January.

An ACS Fellow since 1953, Dr. Hanlon is a fixture in the College’s leadership. From 1957 to 1959, he was a Governor and from 1967 to 1969, he was a Regent. Dr. Hanlon then served as Director of the College from 1969 to 1986, followed by his term as ACS President from 1987 to 1988. Since that time, he has continued to provide guidance to the College in his role as Executive Consultant.

Dr. Hanlon is a thoracic surgeon who received his medical degree from Johns Hopkins University in Baltimore, MD, in 1938, and performed his internship there in 1939. Dr. Hanlon’s first surgical residency was at the Cincinnati General Hospital in Ohio, followed by a surgery fellowship at the University of California, San Francisco. Dr. Hanlon also served in the U.S. Navy (1944-1946), then returned to Johns Hopkins for another surgical residency (1947-1948).

An honorary member of numerous national and international organizations, Dr. Hanlon has received many prestigious awards. In 2004, he and his wife, Margaret H. Hanlon, MD, received the Distinguished Philanthropist Award from the ACS Fellows Leadership Society.

The American College of Surgeons Foundation underscores the vital role that surgeons play in benefiting society by enhancing and extending life for patients of all nationalities, creeds, and economic levels. Through charitable donations, the Foundation endeavors to help surgery continue to advance and make a positive difference in people’s lives for many generations to come.

Newly expanded ACS Foundation Web pages debut

Explore the newly expanded Web pages of the American College of Surgeons Foundation on the College’s Web portal eFACS.org to discover extensive information regarding various means of contributing to the work of the College while receiving significant benefits and recognition of support for our important missions.

On the Foundation’s Web pages,
you will find abundant informational material and interactive pages allowing for private, customized gift benefit calculations and their impact on your financial management goals. Visit the ACS Foundation pages at http://www.facs.org/acsfoundation/.

Outcomes research course scheduled for November

The Surgical Research Committee of the American College of Surgeons will sponsor the second biennial Outcomes Research Course, November 17–19, at College headquarters in Chicago, IL.

Although the course is intended primarily for surgeon researchers, its flexible curriculum and interactive format are designed to meet the interests of investigators with varying skills and experiences. Novices will learn the key concepts of outcomes research, including how to work with and interpret data. Surgeons with previous experience in outcomes research will get direct feedback on their work and practical advice from leaders in the field.

The course emphasizes the core concepts of outcomes research and its practical applications to important questions facing surgeons and surgical practice.

The first day provides a broad overview of the field, primarily in lecture format.

On the second day, participants may choose among several skills laboratories, according to their backgrounds and primary research interests. Breakout sessions provide the opportunity for participants to get feedback on their ongoing work or study proposals from experts in the field. And finally, on the third day, selected course faculty will present their own research in progress in interactive sessions, allowing participants to “get under the hood” of the work of established investigators.

In addition to advancing surgeons’ skills in clinical epidemiology and statistical analysis, the course will cover external funding strategies and other career development aspects specific to surgical outcomes researchers.

Participation is limited, and priority will be given to members of the College. Register by September 1 to take advantage of the early sign-up discount. Visit http://www.facs.org/cqi/src/outcomesres.html for additional information about the course, a preliminary course schedule, course fees, and a registration form. Questions may be directed to Mary Fitzgerald at 312/202-5319, or e-mail mfitzgerald@facs.org.

Carotid artery stenting outcomes data-collection tool available

The Society for Vascular Surgery (SVS) has developed Vascular Registry—the first Web-based tool to collect and analyze data on carotid artery stenting (CAS) and carotid endarterectomy. The data collected help facilities meet the CAS reimbursement standards set by the Centers for Medicare & Medicaid Services.

The SVS took the lead in developing the program because it is committed to collecting long-term outcomes data to evaluate new treatments. Vascular Registry allows correlations among practitioners, procedures, comorbidities, and outcomes. This efficient program collects stenting and open-repair data, compares site-specific CAS baseline risk factors and complication rates with those at peer institutions, and allows a facility to download data for analyses beyond CAS compliance.

To learn more about this cost-effective program, visit www.VascularWeb.org or call 800/258-7188.
The American College of Surgeons presents

ACS Coding Today

Claims coding reference and education database

ACS CodingToday features:

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

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

Special discount pricing: Only $199 for the first user, $50 for each additional user—a $590 value!
Disparities in surgical care to be examined during Clinical Congress

An examination of the crucial issues concerning the nature of disparities in surgical health care for disadvantaged populations will be the focus of an important general session to take place on Thursday, October 12, during this year’s annual Clinical Congress in Chicago, IL.

Cosponsored by the College’s Committee on Diversity and the Surgical Research Committee, Understanding and Reducing Disparities in Surgical Care will feature five national leaders in the field who will address the following topics: Current evidence and observations about disparities in surgery, social and behavioral strategies for reducing disparities in the use of surgery, racial disparities in surgical outcomes and growing evidence that minority patients have poorer outcomes because they are treated in lower-quality hospitals, and research and potential policy solutions for reducing such disparities.

For more information, contact Molly Clear at 312/202-5325, or mclear@facs.org.

AWS gears up to celebrate 25 years of service

Thirty years ago, few women even considered becoming physicians, let alone surgeons, because there were not many role models to encourage female students to enter the medical profession. However, as a result of the guidance and advocacy offered by organizations like the Association of Women Surgeons (AWS), women now make up more than 50 percent of medical students and 20 percent of physicians, and a growing number are choosing the field of surgery.

In recognition of this growing trend and in celebration of its 25th anniversary, the AWS will host a black-tie gala on Friday, October 6, just before the 2006 American College of Surgeons Clinical Congress in Chicago, IL. Kathryn D. Anderson, MD, FACS, President of the College, will be the featured guest speaker at a dinner celebrating the occasion, and other eminent woman surgeons will be highlighted as AWS takes a retrospective trip through the history of women in surgery. An educational program will follow on Saturday, October 7.

For more information or event details, visit www.WomenSurgeons.org or e-mail info@WomenSurgeons.org. The association is headquartered at 5204 Fairmont Ave., Ste. 208, Downers Grove, IL 60515; tel. 630/655-0392.

Improving patient safety to be focus of Clinical Congress session

An examination of the crucial issues concerning patient safety in the operating room will be the focus of an important general session to take place on Thursday, October 12, during this year’s annual Clinical Congress in Chicago, IL.

Sponsored by the College’s Committee on Patient Safety and Professional Liability, Improving Patient Safety in the Operating Room will help the surgeon understand the character, frequency, and importance of systems errors in the operating room. Ways for surgeons to become involved in the development of patterns of behavior that mitigate this problem will be presented. For more information, contact Molly Clear at 312/202-5325, or via e-mail at mclear@facs.org.
Faculty Research Fellowships awarded by College

The ACS Board of Regents awarded 10 Faculty Research Fellowships for 2006 in February. These two-year fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty and carry grants of $40,000 per year from July 1, 2006, through June 30, 2008. Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the College.

The recipients are as follows:

**Alfredo Quinones-Hinojosa, MD**, assistant professor, Johns Hopkins University, Baltimore, MD.

*Research project:* Migration of human neural stem cells in vitro and in vivo.

*Fellowship:* The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons, which is named to honor Dr. Martin, founder of the College.

**Brian S. Zukerbraun, MD**, assistant professor, University of Pittsburgh, Pittsburgh, PA.

*Research project:* The use of carbon monoxide to prevent circulatory collapse from hemorrhage.

*Fellowship:* The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care, which honors the late Dr. Carrico.

**Isabelle Bedrosian, MD**, assistant professor, M.D. Anderson Cancer Center, Houston, TX.

*Research project:* Predicting complete response after chemoradiation in patients with rectal cancer.

**Dev M. Desai, MD, PhD, FACS**, assistant professor, Duke University Medical Center, Durham, NC.

*Research project:* Glycogen storage disease-1a as genetic disease model of hepatocellular carcinoma.

**Christopher Skelly, MD**, assistant professor, University of Chicago, Chicago, IL.

*Research project:* Prevention of arterial restenosis utilizing a neurovirulence-attenuated herpes simplex-1 virus.

**Peter F. Nichol, MD, PhD**, assistant professor, University of Utah, Salt Lake City, UT.

*Research project:* Molecular
and cellular mechanisms of duodenal development and atresia.

**Robert L. Grubb III, MD,** assistant professor, Washington University, St. Louis, MO.

*Research project:* Oncogenic tyrosine kinases impart treatment resistance to tumor cells by suppressing Bcl-xL.

**Robin D. Kim, MD,** assistant professor, University of California, San Francisco, CA.

*Research project:* Strategies against TNF-related proliferative signaling in hepatocellular carcinoma.

**Chester J. Koh, MD,** assistant professor, University of Southern California, Los Angeles, CA.

*Research project:* Regeneration derived from multipotent stem cells.

**Dennis A. Wigle, MD,** assistant professor, Mayo Clinic, Rochester, MN.


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

Resident Research Scholarships for 2006 awarded

Six American College of Surgeons Resident Research Scholarships for 2006 were awarded by the Board of Regents in February 2006. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of $30,000 for each of two years, beginning July 1, 2006. Unless otherwise noted, scholarships are sponsored by the Scholarship Endowment Fund of the College.

The recipients are as follows:

Patrick S. Tawadros, MD, resident in surgery, University of Toronto, Toronto, ON.
Research project: Mechanisms of macrophage activation following oxidative stress. The scholarship is sponsored by Wyeth Pharmaceuticals.

David J. Kaczorowski, MD, resident in surgery, University of Pittsburgh, Pittsburgh, PA.
Research project: Mechanisms of TLR4-mediated inflammation in hepatic warm ischemia reperfusion.

Sumona V. Smith, MD, resident in surgery, Emory University, Atlanta, GA.
Research project: Role of syndecan-1 in aortic aneurysm formation.

Tammy T. Chang, MD, PhD, resident in surgery, University of California, San Francisco.
Research project: The molecular and cellular basis of enhanced three-dimensionality and sustained proliferation of
hepatocytes in simulated microgravity.

Steven C. Gribar, MD, resident in surgery, University of Pittsburgh, Pittsburgh, PA. Research project: The role of the gap junction protein connexin 43 in the pathogenesis of necrotizing enterocolitis. The scholarship is sponsored by Ethicon, Inc.

Kristin M. Noonan, MD, Hospital of the University of Pennsylvania, Philadelphia, PA. Research project: The genetic basis of congenital diaphragmatic hernia. (Research to be performed at Massachusetts General Hospital.) The Scholarship Endowment Fund of the American College of Surgeons was established in 1965 to provide income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are invited. Fellows interested in making gifts to fund these vital programs are encouraged to contact the ACS Development Office at 312/202-5376.


New volunteer opportunities posted on Operation Giving Back Web site

The Foundation for International Education in Neurological Surgery invites actively practicing, retired, and resident neurosurgeons to participate in neurosurgical teaching, both clinical and didactic, at 17 established locations in Central America, South America, Africa, and Asia. In addition, the Defense Medical Readiness Training Institute needs qualified instructors to teach Advanced Trauma Life Support® at Combat Casualty Care at Fort Sam Houston, San Antonio, TX, throughout the year. Currently, assistance is being sought for the weekends of September 8–10 and September 22–24. Domestic volunteer opportunities are also available in Virginia Beach, VA, at the Beach Health Clinic and in Brunswick and St. Marys, GA, through the Coastal Medical Access Program.

For more information on these and other surgical volunteerism opportunities, visit the Operation Giving Back Web site at http://www.operationgivingback.facs.org. Be sure to register for a “My Giving Back” account when you visit the site.

Register for the 2006 Clinical Congress in Chicago

Register today for the 2006 Clinical Congress, to be held October 8–12, in Chicago, IL. The registration form is available in your Program Planner, which you should have received in the mail. You may also go to the College’s Web site, www.facs.org, to register. Registration is open to all physicians and individuals in the health care field. Registration includes a name badge, program, and entrance to the exhibits and all sessions other than postgraduate courses. Registered attendees may purchase postgraduate tickets based on availability. Advance registration is strongly encouraged.

The registration deadline for international registrants is August 7. The deadline for U.S. and Canadian registrants is August 21. Registrations received and postmarked after the deadlines will be billed according to the pricing structure published on the registration form.
American College of Surgeons
Faculty Research Fellowships available

The American College of Surgeons is offering two-year Faculty Research Fellowships, through the generosity of Fellows, chapters, and friends of the College, to surgeons entering academic careers in surgery or a surgical specialty. The fellowship is to assist a surgeon in the establishment of a new and independent research program. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years—July 1, 2007, through June 30, 2009—to support the research.

General policies covering the granting of the American College of Surgeons faculty research fellowships are as follows:

• The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty 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. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

• This award may be used by the recipient for support of his/her research or academic enrichment in any fashion that the recipient deems maximally supportive of his/her investigations. The fellowship grant is 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.

• Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s scholarships administrator to request approval of the additional award.

• The College encourages the applicant to leverage the funds provided by this fellowship with time and monies provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.

• Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

• The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

• A minimum of 50 percent of the fellow’s time must be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

• The recipient is expected to attend the Clinical Congress of the American College of Surgeons in 2009 to meet with the Scholarships Committee, to present a report to the Surgical Forum, and to receive a certificate at the Annual Business Meeting of Members.

One of the fellowships is named to honor Franklin H. Martin, MD, FACS, founder of the American College of Surgeons. Another fellowship is named to honor C. James Carrico, MD, FACS, and is designated for research in trauma and critical care.

The closing date for receipt of applications is November 1, 2006. Application forms may be obtained upon request from Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or from the College’s Web site, www.facs.org.
The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the “From my perspective” columns written by Executive Director Thomas R. Russell, MD, FACS.

Health courts
Thank you to Dr. Griffen for the courage to offer our membership an opportunity to read about special health courts, one of the viable alternatives to the destructive disorder of the current tort system. The current medical malpractice system has created a toxic work environment for honorable physicians. It fails to provide fair and just compensation for the vast majority of patients who sustain injury as a result of medical error, it is exorbitantly expensive and inefficient in delivering compensation to harmed individuals who are able to access the system, it sends conspicuously random messages regarding liability to those who provide medical services, and at the same time, it is sadly effective in providing disincentives to the spirit of cooperation and open communication that are necessary to the success of quality improvement initiatives.

Decades of band-aid applications, that is, tort reform initiatives, have led us to the current unsustainable and unconscionable chaotic conditions that we encounter at the interface of medicine and law. We can’t expect those who are grounded in adversarial ethics (the operative ethical foundation of effective tort law) to lead us out of this crisis. It will take the commitment of leaders who recognize that we need to adopt a new paradigm, one founded in cooperative ethics (the foundation of effective medicine), in order to better serve our nation. Special health courts represent a move away from the adversarial drama of dueling experts trying to convince a lay jury, usually selected on the basis of unfamiliarity with medicine, of an applicable standard of care—often where only practice guidelines and no true standard of care exists. Fairness and justice are not hallmarks of the current malpractice environment, and by design they cannot emerge from reforms to this failed area of tort law. Thank you for the courage to speak publicly of one of the available alternatives.

Dan F. Kopen, MD, FACS
Forty Fort, PA

What students should be learning
I read with interest the article “Transitions in surgical training: The path to surgical leadership in the making of a ‘good’ surgeon” (Bull Am Coll Surg. 2006;91[4]:27-33). The authors are obviously well versed and writing from a fresh perspective of experience. Though I enjoyed the comments about the importance of establishing and maintaining bedside procedures and clinical skills, developing leadership skills, and making competent decisions quickly and under stressful situations, I was disappointed to see that the authors did not emphasize the necessity of having a thorough working knowledge of surgical anatomy, surgical embryology, and anatomical complications of surgery.

The change in focus in the medical school curriculum and residency training program is an issue that has concerned me for quite some time. Though new technologies and advances in medicine have necessitated a knowledge of microanatomy and microsurgical techniques, the resident of today is not receiving adequate teaching in surgical anatomy and surgical embryology.

I believe it’s time the pendulum shifted back to teaching our students the fundamentals of gross anatomy and instilling a solid foundation on which to build. After all, surgeons can and will make many unnecessary and fatal mistakes if they don’t know surgical anatomy.

John E. Skandalakis, MD, FACS
Atlanta, GA

Who was Robert Hurlbut?
Congratulations to Charles M. Ferguson, MD, FACS, for his illuminating article about a little-known surgeon whose untimely death kept him from becoming part of the ACS history. Dr. Ferguson’s painstaking research into records from various individuals and archival repositories brings to light an unsung hero.

For those interested in pursuing similar research into records of former ACS members, the ACS Archives retains case records as submitted by a few selected applicants for ACS Fellowship status from the 1930s and 1940s. Prizes were given during those years for the best-presented case records, some of which are even presented in multiple volumes. Some prize-winners included the following: Woodard Beacham, MD (first president of ACOG), 1951; Richard Bennett, MD, 1935; Truman Blocker, MD (president of University of Texas Medical Branch), 1940; Robert Buxtom, MD, 1944; Ian Fraser, MD, 1942; A.R. Judd, MD, 1942; Lewell King, MD, 1942; David Latham, MD, 1943; Nolie Mumey, MD, 1935; and John Orndoff, MD, 1941.

Besides revealing details on the training and experience of these surgeons, the case records from that period illuminate trends in surgical practice and procedures over the century and demonstrate the very high regard these applicants had for membership in the ACS.

Susan K. Rishworth
ACS Archivist, Division of Member Services

Military medical think tanks
I read with great interest the recent article by Drs. Eiseman and Chandler, calling for closer ties between the College and military medicine (Time to lend a hand:
A proposal for a military medical think tank. *Bull Am Coll Surg.* 2006;91(5):8-11. As a graduate of the Army War College and faculty member of the Uniformed Services University, I have been only too aware of the revolution in military affairs (RMA), which the authors so aptly call to the fore.

There is currently a RMA in military medicine as well. New paradigms are required to deal with the ever-changing battle conditions, such as planning for the participation of nongovernmental organizations. Of particular note is the current Army-wide program transforming the field medic into a competent emergency medical technician.

I am sure there are many ways the College’s expertise could be leveraged to ensure state-of-the-art medical care to our soldiers in the field and the provision of humanitarian care in austere environments. Creating a new acronym (of which the Army is so fond)—RMA2, the revolution in military medical affairs—could certainly be the initial push.

Brian T. Nolan, MD, FACS
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A look at the Joint Commission

National Patient Safety Goals

Surgeons play an important role in establishing and achieving the Joint Commission’s National Patient Safety Goals. These goals focus on critical areas where patient safety can be improved through specific actions by surgeons and other health care professionals—for example, a new goal for 2007 encourages patients to be involved in their own care as a safety strategy. This goal applies to licensed independent practitioners, including surgeons.

The 2007 goals for hospitals are as follows:
- Improve accuracy of patient identification
- Improve effectiveness of communication among caregivers
- Improve safety of using medications
- Reduce risk of health care-associated infections
- Accurately and completely reconcile medications across the continuum of care
- Reduce the risk of patient harm resulting from falls
- Encourage patients’ active involvement in their own care as a patient safety strategy
- Identify safety risks inherent in the patient population (applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals)

The Joint Commission’s 2007 National Patient Safety Goals for Ambulatory Care and Office-Based Surgery also include a goal on reducing the risk of surgical fires.

Each goal has a subset of requirements. For example, the goal on encouraging patients’ active involvement in their own care includes the following requirement: “Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.”

The goals are updated every year. New goals and requirements may be introduced, whereas others may be retired. For example, based on high compliance rates, the Joint Commission retired the following two goals in 2006:
- Improve the safety of using infusion pumps
- Improve the effectiveness of clinical alarm systems

To establish the goals and requirements, the Joint Commission turns to an expert panel of physicians, nurses, pharmacists, and other patient safety experts. This panel reviews compliance data, the latest research and literature, and other resources. Then it formulates a list of proposed goals and requirements for the following year and conducts an online field review, or public comment period, through the Joint Commission’s Web site. This field review provides surgeons, their professional societies, and others an opportunity to shape the panel’s recommendations and, ultimately, the goals’ final makeup.

Each month, this column will focus on activities of the Joint Commission that are relevant to surgeons. For more information on the Joint Commission and to sign up for Joint Commission e-mail newsletters and announcements, visit [www.JointCommission.org](http://www.JointCommission.org).
ACOSOG news

Revisiting local excision of early rectal cancer

by David M. Ota, MD, FACS, Durham, NC, and Heidi Nelson, MD, FACS, Rochester, MN

Organ preservation is highly desirable for cancer patients who present with early disease. Lumpectomy and postoperative radiation therapy is a paradigm for other organ sites. Early stage rectal cancer is defined as ultrasound T1 or T2 and was the subject of enthusiasm for transanal local excision of distal rectal cancer followed by postoperative radiation therapy. However, a 20 percent local recurrence rate was reported for T2 rectal cancers that were locally excised and treated with postoperative radiation therapy.* Because a 20 percent local recurrence rate for T2 rectal cancer is high, local excision is being done less frequently.

The search for a conservative surgical approach to treating T2 rectal cancer remains. Consider the following hypothetical patient encounter. A relatively obese 58-year-old man presents with rectal bleeding and a biopsy-proven 2.0 cm diameter distal rectal adenocarcinoma. The patient has read about an abdominoperineal resection (APR) and a permanent colostomy and is interested in sphincter preservation. Transrectal ultrasound shows that this is a T2 lesion with no mesorectal adenopathy and chest X ray and computed tomography scan show no evidence of regional or distant disease. So far, this is good news for the patient.

On the digital rectal exam, the distal edge of the tumor is 2 cm above the anorectal ring and 5 cm from external anus by rigid proctoscopy. When discussing treatment options with the patient, including APR, he indicates he is not very enthusiastic about a permanent colostomy. He is relatively young, has good health, and is concerned about sexual function. A low anterior resection and low rectal anastomosis, either by stapler or coloanal method, is another possibility, but in a relatively obese man, this will require two surgeons, a long operation, and a possible positive tumor margin at the distal end of the resected rectum. You are not enthused about this prospect. You and the patient search for another option.

The American College of Surgeons Oncology Group (ACOSOG) offers such an option. Z6041 is a new protocol that offers a different strategy for the conservative surgical approach to early distal rectal cancer. Preoperative chemoradiation therapy for T3 and T4 rectal cancer results in significant tumor regression and affords surgeons the opportunity to offer low anterior resection for patients who might otherwise require an APR and postoperative chemoradiation therapy. Z6041 adopts this preoperative therapeutic approach to induce tumor regression before a transanal local excision.

This is a clever and novel approach. Locally excising a 2.0 cm diameter T2 rectal cancer through a transanal approach does not offer the best exposure and it is a challenge to obtain a 1 cm mucosal margin around a 2 cm tumor. However, if a pre-treatment regimen can induce tumor regression so that a 2.0 cm tumor becomes a residual ulcer smaller than 0.5 cm, the prospect of a complete tumor-free local excision of the rectal cancer becomes higher. In fact, one of the important maneuvers in this trial is to endoscopically tattoo the rectal cancer site before preoperative chemoradiation therapy is started. One of the challenges of preoperative therapy for early rectal cancer is that tumor regression can be so significant that identifying the tumor site during the local excision procedure can be difficult if there is a complete clinical re-

gression and no residual ulcer.

Z6041 is a phase II nonrandomized trial that requires 85 patients. The preoperative chemoradiation therapy for Z6041 consists of capecitabine (Xeloda) and oxaliplatin with 54 Gy pelvic radiation therapy. Both agents are commercially available. Toxicity will be monitored closely. Local excision will be performed approximately four to six weeks after completion of chemoradiation therapy. The primary endpoint of the trial is tumor-free survival at three years. Other endpoints include negative margins in the resected specimen, pathologic complete response in the excised tissue, and quality of life and anorectal function records.

ACOSOG needs your participation in Z6041. If you have patients with early ultrasound staged T2 distal rectal cancers and want to offer your patient an option to APR or low anterior resection and low rectal anastomosis, we urge you to consider this novel treatment approach for your patients. This ACOSOG protocol offers a local excision approach to ultrasound T2 rectal cancers and patient accrual into this protocol from multiple institutions is critical. Only through this evidence-based approach can surgeons evaluate the safety and effectiveness of new surgical approaches to rectal cancer. Your participation and enrollment of patients is crucial to determine if preoperative therapy followed by local excision is effective in local control of this disease. The synopsis and entire protocol are available on the ACOSOG Web site, www.acosog.org.

For more information about becoming an ACOSOG member, contact Helen Harbett at harbet001@notes.duke.edu. For enrollment questions, contact Beth Martinez at marti025@surgerytrials.duke.edu, Dr. David Ota at david.ota@duke.edu, or Dr. Heidi Nelson at nelsonh@mayo.edu.

Dr. Ota and Dr. Nelson are ACOSOG Group Co-Chairs.
NTDB® data points

Who let the dogs out?

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

Every year, 2 percent of Americans, almost 5 million people, suffer dog bite injuries, according to the Centers for Disease Control and Prevention. This leads to 800,000 injuries requiring medical attention and overall losses associated with dog bites exceeding $1 billion per year. In a seven-year period during the 1990s, the number of dogs in the U.S. rose by 2 percent while the number of bites increased by 33 percent. Unfortunately, children are the most frequent targets, with the majority of attacks happening at home or in a familiar place, and more than three-fourths of the dogs belong to the victim’s family or a friend.

Vicious dog attacks have become a common occurrence in the news. Almost weekly, somewhere in the U.S., reporters are covering these events, singling out one or two breeds as evil killers. Although pit bull mixed breeds and rottweilers are the top two breeds most likely to kill and seriously maim people, fatal attacks over the past 30 years have been attributed to dogs from at least 30 breeds.

Why does man’s best friend turn on him? A dog that is treated harshly or trained to attack may bite a person. A dog of any breed can be turned into a dangerous dog. Often the owner is responsible for this type of behavior, not the breed nor the individual dog. An owner who is responsible can win the respect and love of a dog no matter what breed it may be. Any individual dog may be a good, loving pet even though its breed may be likely to bite. Irresponsible owners may create unsafe situations with their pets, placing others in jeopardy even though the breed is considered tame.

To examine the occurrence of these injuries in the National Trauma Data Bank® Dataset 5.0, we used cause of injury code E 906.0, dog bite. There were 2,493 records with 1,798 being discharged to home, 324 to acute care/rehab, 172 to nursing homes, 37 other, and 162 deaths. These data are depicted in the figure on this page. This group of patients had an average length of hospital stay of over five days, an intensive care unit length of stay of one and one-half days, and an average injury severity score of 9.8.

Dogs are lovable and obedient animals when treated with respect and love. Acting kindly and maintaining a sensible environment will minimize the risk of dog bites. Then the public will not have to worry about “who let the dogs out.”

Throughout the year, we will be highlighting these data through brief monthly reports in the Bulletin. The full NTDB Annual Report Version 5.0 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.