

BULLETIN

AMERICAN COLLEGE OF SURGEONS



February 2006
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CRM:

Applying aviation's model
to the OR team

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Clinical Congress

2006 Chicago, IL,
October 8-12

2007 New Orleans, LA,
October 7-11

2008 San Francisco, CA,
October 12-16

Spring Meeting

2006 Dallas, TX,
April 23-26

2007 Las Vegas, NV,
April 21-24

2008 To be announced

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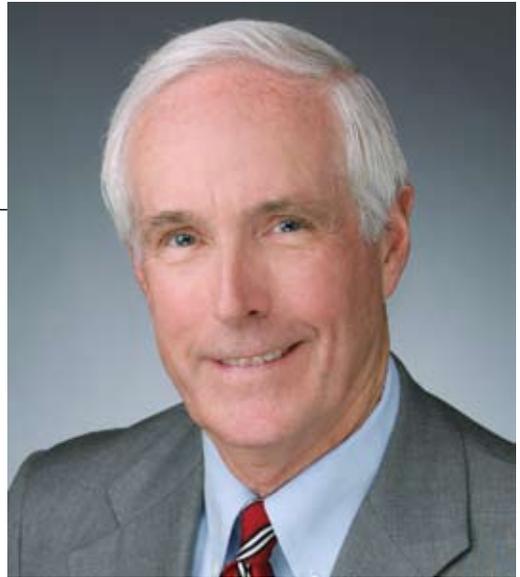
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

From my perspective



There no longer is a pot of gold at the end of the rainbow for any surgeon in practice today. No matter how hard the College works to prevent further cuts in reimbursement and to offset other factors that are having a negative impact on the work we do, reimbursement rates remain, at best, neutral, while the cost of maintaining a practice continues to rise. Young surgeons are entering the profession deeply in debt and worried about how they will pay off their loans, send their children to college, and then retire with a comfortable lifestyle. To put it mildly, surgical practice for all surgeons is far more complicated than it used to be, so we must become smarter and more sophisticated about how we run our practices and manage our personal finances.

Reimbursement

For several years now, surgeons and other physicians have dodged Medicare payment cuts by persuading Congress to intervene and replace the significant decreases with nominal increases. And just before their holiday recess the U.S. House of Representatives and the Senate passed different versions of the Deficit Reduction Act of 2005, S. 1932. Both renderings of the bill included provisions that would have averted the 4.4 percent across-the-board reimbursement cut and frozen 2006 physician payment at the same amount paid in 2005. However, the House and Senate versions of the bill varied in a number of other respects, and Congress adjourned without reconciling their disparities. At press time, Congress was scheduled to reconvene January 31, but it was unclear whether or how soon the interim Medicare payment fix would be enacted. Also uncertain was whether any legislation passed early this year would apply retroactively to services provided on or after January 1. The College and its medical and surgical specialty society partners intend to redouble their efforts in 2006 to advocate for true Medicare reforms that will bring financial predictability to surgical practices.

“ Surgical practice for all surgeons is far more complicated than it used to be, so we must become smarter and more sophisticated about how we run our practices and manage our personal finances. ”

However, this entire scenario points out how difficult the political process can be and that there is no automatic or easy fix to problems like this one, despite the vigorous best efforts of the College and other surgical and medical groups.

I should point out that the federal government is strongly considering reversing across-the-board physician pay cuts by eliminating the sustainable growth rate (SGR) component of the formula used to calculate reimbursement, and replacing the methodology with pay for performance (P4P), or value-based purchasing. The SGR sets a target for growth in Medicare spending largely on the basis of the expansion in the national economy, whereas P4P would link reimbursement to efforts to improve quality of care.

To have a positive impact on the movement to-

ward P4P, we need to continue to work diligently on developing reasonable outcomes measures for inpatient and outpatient care. Surgeons need risk-adjusted information about how their outcomes compare with those of other physicians who perform similar procedures. The Centers for Medicare & Medicaid Services (CMS) is receptive to surgeons' involvement in crafting P4P and acknowledges that we are creating a rational approach to measuring outcomes in surgery through the College's National Surgical Quality Improvement Program (NSQIP). CMS has accepted NSQIP measures and has incorporated them into its Surgical Care Improvement Project (SCIP), which the agency is likely to use in crafting P4P for inpatient surgical care. The College is also involved in the efforts of the Ambulatory Quality Alliance and its subgroup, the Surgical Quality Alliance, to develop the metrics for evaluating outpatient care.

Individual surgeons need to participate in these efforts if they want to see a potentially fairer and more reasonable approach to reimbursement emerge. They need to share and analyze their outcomes data for both inpatient and outpatient procedures, so that we can help to construct a system that focuses on quality and cost-effectiveness. If we fail to participate, we can only expect to continue to see our level of payment decline.

Practice management

In an era of growing practice expenses, it also is very important that surgeons become more knowledgeable about the "business" aspects of surgical practice and how to run their offices efficiently. The American College of Surgeons has several resources that can help in that regard.

For instance, the College offers the two CD-ROM set "Practice Management for Residents and Young Surgeons." This electronic resource—which is an outgrowth of the College's very popular manual *Practice Management for the Young Surgeon* that was published in

1995—is designed to educate and equip residents and young surgeons who have recently started practice with the knowledge to manage their personal surgical future. The CD-ROMs focus on issues such as how to select a practice type and location, how to successfully manage the mechanics of setting up or running a private practice, essentials of an academic practice, how to guide your career, and the basics of surgical coding. Another CD-ROM we've developed to meet the needs of our younger colleagues is "Personal Financial Planning and Management for Residents and Young Surgeons." This CD-ROM features an interactive course in lecture format that is designed to educate young surgeons on basic financial management skills and prepare them to manage their personal and professional financial future with a focus on issues such as debt management, successful investing, and selecting a financial advisor.

For its members of all ages, the College has offered a number of workshops focused on coding, insurance claim processing, and regulatory compliance for well over a decade. Moreover, the column "Socioeconomic Tips" appears in the *Bulletin* on a regular basis and is prepared by our Washington Office staff and our consultants in an effort to answer questions that surgeons have about billing and the efficiency of their offices. During the Clinical Congress and Spring Meeting, we offer sessions on related issues, and we support an ACS Coding Hotline (800/ACS-7911), which surgeons and their office staffs can use to get answers to questions about billing issues. And, finally, the College has contracted with Economedix, a consulting firm, to offer regular teleconferences on coding, avoiding fraud and abuse charges, and other practice management topics.

I urge surgeons and/or their office staffs to participate in all of these educational programs on a regular basis in order to gain a better understanding of how to run a cost-effective and efficient practice.

Investing

Surgeons also need to put serious thought into how they can ensure their long-term financial stability. They need tools that will help them manage their investments, plan for retirement, ensure their children's college education, and satisfy their other financial obligations. They also need to have access to high-quality life, disability, and health insurance, as well as long-term estate-planning vehicles.

The College now offers reliable life, disability, and health insurance coverage through a program underwritten by New York Life Insurance Company. In addition, we are working with Cambridge Associates of Boston, which successfully manages the College's endowment fund, to develop a proprietary investment vehicle, or mutual fund, as a benefit of membership for individuals. We anticipate that the advantages of investing in the fund will include the following: (1) professional, institutional quality management, which will allow rebalancing; (2) diversification by asset category and security; (3) favorable and convenient investment and redemption capabilities; (4) direct offering to investors without sales charges, brokerage commissions, or third-party intermediaries; (5) a payroll reduction savings program; and (6) clear and understandable reporting. Details on this new member benefit program will be announced later on this year.

The future is in your hands

The bottom line is that surgeons simply can no longer afford to ignore the business-related aspects of practicing surgery. Individual surgeons and practice groups must become more sophisticated in that regard. We need to either become knowledgeable about reimbursement, coding, investments, and so on, or we must make sure that we hire people who are highly skilled and can address these issues for us.

The College is working to provide its members with the services they will need to secure their

financial stability now and in the future. We are doing all that we can to provide you with tools and services that will help you reach that goal. However, you must be an active participant in this process by utilizing these services and incorporating them into your practice.

If you have suggestions regarding other services we can offer that will help you succeed, please share them with me or other leaders of this organization.



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.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

Congress adjourns without enacting payment fix

Just before their holiday recess, both the U.S. House of Representatives and the Senate passed the Deficit Reduction Act of 2005, S. 1932, which included provisions that would have averted the 4.4 percent across-the-board reduction in Medicare reimbursement for physician services. Instead, the legislation would have frozen 2006 physician payment at the same amount paid in 2005. However, the House and Senate versions differed in a number of respects, and Congress adjourned without reconciling these disparities. As a result, the 4.4 percent Medicare payment cut took effect January 1. Failure to gain passage of S. 1932, which addresses a broad range of spending issues, was unrelated to the Medicare physician payment provisions.

At press time, Congress was scheduled to reconvene on January 31, but it was unclear whether or how soon the interim Medicare payment fix would be enacted. Also uncertain was whether any legislation passed early this year would apply retroactively to services provided on or after January 1. The College and its medical and surgical specialty society partners intend to redouble their efforts in 2006 to advocate for true Medicare reforms that will bring financial predictability to surgical practices.

Three Fellows testify on Medicare reform

On November 17, 2005, three ACS Fellows testified at the House Energy and Commerce Committee Health Subcommittee's hearing, Medicare Physician Payment: How to Build a More Efficient Payment System. Frank Opelka, MD, FACS, a member of the College's Health Policy Steering Committee, provided testimony on behalf of this organization.

In his comments, Dr. Opelka expressed the College's concern that the 4.4 percent cut in Medicare payments that took effect January 1 will have a negative impact on surgeons' ability to practice and, in turn, on Medicare beneficiaries' ability to access needed surgical care. He further demonstrated how the Medicare payment system fails to recognize the unique nature of surgery relative to other physician services and how the methodology, which sets a universal volume target for all physician services under the sustainable growth rate, disproportionately cuts surgical reimbursement.

The subcommittee also heard testimony from two other ACS Fellows: Elizabeth Ann Davis, MD, FACS, on behalf of the Alliance of Specialty Medicine, and Duane Cady, MD, FACS, on behalf of the American Medical Association.

CMS reduced Medicare overpayments in 2005

The Centers for Medicare & Medicaid Services (CMS) recently announced that it reduced improper payments in Medicare fee-for-service by \$9.5 billion last year. According to a CMS report released November 10, Medicare paid providers \$234 billion in fiscal year (FY) 2005, with overpayments totaling \$11.2 billion. Combined with underpayments, which were approximately \$900 million in FY 2005, the total improper claims rate was 5.2 percent, or \$12.1 billion, down from a 10.1 percent error rate and \$20.8 billion overpayment amount in 2004.

OIG reports on surgical coding issues

Most FY 2005 errors occurred in physician codes, totaling \$4.2 billion in overpayments. With respect to physician services, evaluation and management (E/M) codes accounted for the highest rate of error. Significant problems with billing for surgical dressings also were noted.

On December 12, 2005, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services posted two reports pertaining to the incorrect use of procedure code modifiers as specified by Medicare's Correct Coding Initiative.

The first report, *Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits* (OEI-03-02-00771), shows that the -59 modifier, which indicates distinct and payable procedure or service was provided to a patient on the same day as another procedure service, was used incorrectly 40 percent of the time in FY 2003. Specifically, modifier -59 was used inappropriately with 15 percent of code pairs because the services were indistinct from each other and with 25 percent of code pairs because the services were inadequately documented. The OIG also found that 11 percent of code pairs billed with modifier -59 were paid when the modifier was billed with the incorrect code, resulting in \$27 million in erroneously paid claims. The OIG recommended that CMS: (1) encourage carriers to conduct prepayment and postpayment reviews of the use of modifier -59, and (2) ensure that carriers' claims-processing systems only pay claims with modifier -59 when it is billed with the correct code.

The second report, *Use of Modifier 25* (OEI-07-03-00470), pertains to the modifier used to allow additional payment for E/M services provided on the same day as a procedure. Separate payments are allowed, as long as the E/M services are significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure. The OIG found that 35 percent of claims for E/M services allowed by Medicare in 2002 did not meet program requirements, resulting in \$538 million in improper payments.

ACS comments on databases in quality improvement

At a meeting hosted by CMS on December 8, R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, presented information about the College's clinical databases and answered questions from participants about their potential use in improving the quality of surgical care. Dr. Jones described the content and uses of information collected by the National Cancer Data Base, the National Trauma Data Bank™, and the ACS National Surgical Quality Improvement Program. Fred Edwards, MD, FACS, also participated in the meeting and provided a similar perspective on the Society of Thoracic Surgeons National Data Base and its evaluation of cardiothoracic procedures.

What surgeons should know about...

Health plan settlements

by Carol Scheele, JD, Raleigh, NC

After a decade of frustrating negotiations and failed legislative reform efforts, physician groups took their complaints about inequitable health plan policies to court, filing federal and state lawsuits against most major U.S. insurers. At press time, settlements had been reached with six health plans. As a result of these actions, physicians have received monetary compensation, and insurers have promised to reform their policies. This article attempts to answer questions surgeons may have about how these settlements affect them.

What is the nature of these lawsuits?

Physicians and their representative medical societies filed the lawsuits against health plans because of unfair payment policies, interference with medical practice, one-sided contracts, and so on. Most of the lawsuits have been consolidated in the U.S. District Court of the Southern District of Florida (Miami).

How have the medical societies been involved?

Approximately 19 state and county medical societies have filed lawsuits. Five state medical societies (California, Texas, Georgia, Florida, and Louisiana) filed lawsuits claiming that health plans were engaging in racketeering by using fraud and extortion to wrongfully deny payment to physicians. These five state medical associations were the “signatory” societies for the lawsuit settlements; other groups subsequently became “additional signatory societies,” enabling them to file complaints on behalf of their members.

Which health plans have been sued?

Defendants include Aetna, Inc.; CIGNA Corporation; Pacificare Health Systems, Inc.; United Healthcare; Anthem/Wellpoint, Inc.; Health

Net/Foundation; Coventry Health Care, Inc.; Prudential Insurance Company; Blue Cross and Blue Shield Association; numerous Blue Cross/Blue Shield plans; and Humana, Inc.

Which plans have signed settlement agreements?

At press time, the following had signed settlement agreements: Aetna/US HealthCare; CIGNA Healthcare; Health Net; Prudential; Wellpoint/Anthem; and Humana, Inc. The Prudential settlement provides funding for compliance and other advocacy initiatives on behalf of physicians but does not include monetary or prospective damage awards because the company sold its health insurance business in 1999. Plans that have not signed settlement agreements are scheduled for trial in April 2006.

How are the settlements structured?

Settlements are negotiated on behalf of all physicians nationwide. The agreements include a general release of prior claims and allow physicians to opt out of the agreement. Physician contracts must incorporate certain provisions of the settlement agreements, and certain business practices must be changed by specified dates. The settlements typically retain more favorable clauses in physician contracts and pending and existing state laws and regulations.

The health plans that have settled pay all litigation costs, and the provisions apply to all patients unless otherwise stated.

What types of relief do the agreements provide to physicians?

The settlements reached with Aetna, CIGNA, Health Net, Anthem/WellPoint, and Humana contain the following components of interest to surgeons:

- *Prospective relief:* Reform health business

practices to simplify physician office administration

- *Disclosure requirements:* Transparency in claims processing, medical necessity requirements, and other policies and processes
- *Monetary damages:* Some cash payments for monetary damages to physicians and physician foundations
- *Compliance and dispute process:* Several mechanisms to enforce agreements related to compliance and dispute processes

What are some examples of settlement agreement business requirements?

The settlement agreements are not identical, but some similarities exist, including:

- *Payment rules.* Certain Current Procedural Terminology (CPT)* code combinations and modifiers (-25, -57, and -59) must be paid when adequately documented; evaluation and management codes may not be downcoded; and modifier -51 exempt, add-on, and indented codes must be handled as specified in CPT guidelines.
- *Consistency and disclosure of payment rules.* Payment rules become more consistent across health plan products, and plans must disclose reimbursement edits and claims adjudication rationales.
- *All-products clauses.* Health plans are generally prohibited from requiring participation in all product line.
- *Assignment of benefits.* Four agreements have specific requirements regarding the plan's obligation to honor valid assignments of benefits for nonparticipating physicians.
- *Gag clauses prohibited.* Health plan administrators are restrained from inhibiting free communication between physicians and their patients.
- *Refund restrictions.* Refunds must be paid within specific time limits.
- *Medical necessity determination.* Clinical guidelines must be based on scientific evidence; a clinical definition of "medical necessity" has been established.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2005 American Medical Association. All rights reserved.

Will physician-member committees monitor and advise the health plans?

Yes. The agreements call for the health plans to establish physician advisory committees (PAC) to review national policies as well as redundant claims, payment, and medical necessity disputes. Details about the Aetna and CIGNA PACs are posted at www.aetna.com/provider/physician_advisory.htm and www.cigna.com/health/provider/medical/procedural/advisory.html, respectively.

What if a plan fails to comply with the settlement agreement?

A compliance dispute process has been established to enforce payment issues, payment policies, and other substantive provisions of the agreement. A compliance dispute facilitator will be assigned to each settlement agreement. If this individual cannot negotiate an agreement, the complaint may be referred to a compliance dispute officer, who will mediate or arbitrate the case. If no resolution is possible at this point, the case may be referred back to the court.

The agreements also provide for an independent review of billing disputes separate from the compliance dispute process. After exhaustion of appeals, billing disputes are heard by an independent organization with coding expertise. Its decision is binding and is passed on to the PAC. A similar mechanism has been established for resolving medical necessity disputes.

What are some examples of disputes?

- Contracts with key provisions that do not comply with the settlement agreement
- Failure to pay the -25 modifier
- Refund demands outside the time limits
- Failure to pay add-on codes
- Enforcement of "all products" clauses or practices in violation of the settlement agreement

continued on page 31

Ms. Scheele is associate general counsel for the North Carolina Medical Society in Raleigh.

Error reduction through team leadership:

Applying aviation's CRM model in the OR



by **Gerald B. Healy, MD, FACS, Boston, MA; Jack Barker, PhD, Miami, FL;**
and **Capt. Gregory Madonna, Ft. Lauderdale, FL**

Over the past several years, efforts have been initiated to bring the crew resource management (CRM) model used in aviation into the operating room. The expectation is that this approach will improve patient safety in the surgical environment in the same way it has increased passenger safety for the major airlines. A catalyst for this movement was the Institute of Medicine report, *To Err Is Human: Building a Safer Health System*,* released in 2000. Indeed, that report specifically suggested that one possible means for reducing error in the medical setting would be to implement formal training in teamwork analogous to the CRM construct.

Many health care organizations are incrementally bringing CRM into the medical community. For example, the Joint Commission on Accreditation of Healthcare Organizations includes team training as a key element of its comprehensive patient safety plan, and the American College of Surgeons has presented general sessions and postgraduate courses on applying the aviation model in the operating room (OR) at its last two Clinical Congresses. In addition, several medical centers are attempting to institute this model. Some of these institutions are turning to consulting firms composed of individuals who were involved in introducing CRM to aviation, including Mach One Leadership, the agency established by Jack Barker, PhD, and Capt. Gregory Madonna. They both have extensive experience in developing applying team training skills for high-performance civilian and military flight

*Kohn LT, Corrigan JM, Donaldson MD, eds. *To Err Is Human: Building a Safer Health System*. Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academy Press; 2000.

crews. They both currently work for a major U.S. airline.

This article explains the relevance of CRM, describes the cultural changes necessary to apply CRM in the OR, and shows how it is being adopted in various settings. The authors anticipate that this article will stimulate discussion about applying the team training approach in surgery.

Why team training?

The theory behind team training and CRM is that complex systems break down not because of flaws in their engineering, but rather because the people operating within the system fail to interact in a manner that ensures efficiency and good outcomes. In aviation, for example, airplanes continued to crash throughout the middle decades of the last century not because the aircraft were unsafe, but because the flight crews were not always coordinating their efforts.

Given this observation, psychologists were hired in the 1970s to analyze the behavior of flight crews. They found that often somebody on the team had spotted a potential problem but was afraid to speak up. Based on these findings, the psychologists and the leaders of several of the large airline companies determined that flight crews needed to take the following actions: (1) flatten the hierarchy; (2) empower the junior team members to voice their concerns if they saw something was amiss; and (3) train senior team members to listen to the perspectives of the rest of the crew and to view questions as signs of simple, honest concern or a need for clarification rather than insubordination or doubts

about the leaders' ability. With input from the psychologists involved, various techniques were developed to improve team interaction, so that the talents and insights of the entire crew were being used to their full potential.

It is important to note that the empowerment of team members in no way reduces the captain's authority or accountability. One person and one person only remains the final authority on how to complete a flight. However, the captain encourages all team members to contribute their skills and knowledge and applies their input in a very disciplined way. Key methods for drawing out the talents of team members include preflight briefings, the regular use of standard operating procedures (SOPs), checklists, and the creation of an environment that encourages constant team interaction.

Briefings

The briefings before flights or procedures provide the ideal forum for building a team dynamic that allows everyone to work together, both when carrying out routine tasks and tackling unexpected problems. Briefings serve the following purposes:

- They clarify who will be leading the team so that others know to whom to look for guidance.
- They open lines of communication among team members, ensuring that everyone can contribute his or her unique knowledge base to the task, and thereby set the tone for the upcoming procedure. Protocols, responsibilities, and expected behaviors are discussed and reinforced, so that possible misunderstandings are avoided.
- They prepare the team for the flow of the procedure, clarifying what is expected to happen and when.
- They provide opportunities to discuss potential contingency plans and the means for resolving any unusual circumstances.
- By delineating expectations, they reduce disruptive or unexpected behaviors.

In aviation, preflight briefings are conducted several different times and among various teams and subunits. Upon arrival at the aircraft, the pilots and flight attendants discuss such issues

as potential delays, turbulence, and security. Before takeoff, the pilots and flight attendants separate to discuss their unique duties. Whenever a new member enters the dynamic, that person is briefed so he or she fully understands the situation and can solidify a place on the team.

These briefings have proven highly effective in creating a strong team dynamic. They open lines of communication and reinforce each team member's understanding of his or her role in the mission. They eliminate the sort of confusion that may lead to a critical situation.

Could these briefings be of any use in the OR, and if so, how? Expanding a timeout into a more comprehensive briefing could be very useful in terms of bringing the entire operative team together as a unit. The team members might discuss and review any potential complications, the patient's risk factors and operative history, the anticipated stages of the procedure, and the coordination of switching to alternative procedures should the need to do so arise. This sort of discussion will serve to clarify each team member's responsibilities and ensure that everyone is able to anticipate how the operation will proceed.

SOPs and checklists

Two additional tools that help to guarantee a safe and productive outcome for the entire team include following SOPs and using checklists.

In aviation, the SOPs are the routine activities and processes carried out because they have proven in the past to result in smoother, safer flights. Many procedures and protocols have been formally outlined in manuals, and everyone is expected to know and follow these standards and to question the behavior of those individuals who fail to comply. In surgery, they would likely be the best practice guidelines that are emerging from evidence-based research. These guidelines still allow for individual technique but also ensure that critical steps are completed in a way that has worked in the past—no wild freelancing and no need for another team member to wonder, "What's that person doing now?"

To ensure that many of the steps defined

through the SOPs are carried out, the flight crew goes through a checklist at important stages of the process. Checklists ensure that everything that needs to get done does, in fact, get done. More importantly, they create a team dynamic that empowers junior members to speak up. They can, in effect, say, “Hey, boss, nothing personal, but the checklist says we need to do this step now. OK?”

Could checklists add to the operative experience as well? We believe that checklists can serve a valuable purpose in the OR. Some surgeons may claim these instruments amount to “cookbook medicine.” If the function of checklists were to provide step-by-step descriptions of procedure that had to be followed to the letter, these individuals would be correct. But that is an inaccurate description of the checklists to which we are referring. Checklists could be used in the operating theater as part of preoperative preparation to ensure that all the necessary resources—such as prostheses, anesthetics, and antibiotics—and equipment are on hand before the procedure begins. By making certain everything is in place before a procedure, surgical teams may increase the efficiency of an operation.

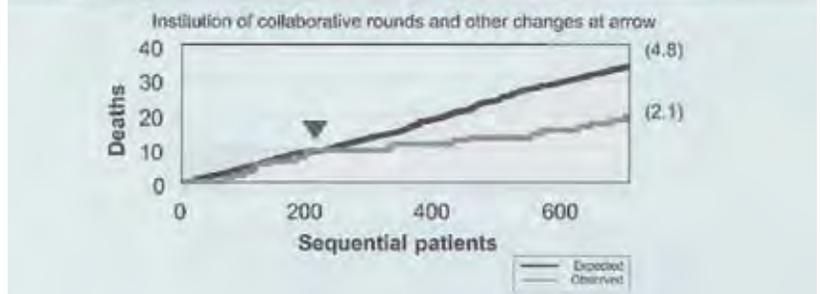
Applications in surgery

The staff at Mach One Leadership have observed and interacted with members of the health care industry and believe the dynamics in aviation and surgery are strikingly similar. Both are high-risk professions carried out within highly complex systems populated with intelligent, type-A personalities.

The CRM training model in aviation has proven to instill leadership skills that lead to improved team interactions, fewer errors, and better staff morale. As a result, commercial flight has become safer and more cost-effective.

A dramatic example of how CRM has helped

Operative mortality for Concord Cardiac Surgery, Jul. 6, 1998, to Oct. 4, 2001



Following implementation of collaborative rounds, mortality of Concord Hospital’s cardiac surgery patients declined significantly from expected rates. Uhlig, Brown, Nason, Camelio, Kendal. *Joint Commission Journal on Quality Improvements*. 28(12), December 2002. Note: Other changes include institution of leadership training.

to save lives can be found in the efforts of the crew aboard a United DC-10 that crashed in 1989 during a flight between Denver, CO, and Chicago, IL. While at cruising altitude, the center engine of the three-engine craft exploded, sending shrapnel through the skin of the plane, disabling all three hydraulic systems, and rendering the flight controls useless. The airplane was rendered virtually inoperable, but the crew members quickly applied their leadership skills, coalesced into a single unit, and guided the aircraft into a crash landing, sparing 170 lives.

Dr. Healy is otolaryngologist-in-chief, Children’s Hospital, Boston, MA. He is the Chair of the Board of Regents.



Both the crew and the National Transportation Safety Board attributed the positive outcome of that incident to CRM training.

In health care, the concept of CRM training is still relatively new. Concord Hospital, in Concord, NH, began incorporating some of these concepts into its cardiac surgery program a few years ago and has experienced improvement on a number of levels (see figure, page 13). The unit lowered mortality rates among surgery patients, and patients and families began reporting greater satisfaction with the care rendered. Meanwhile, the hospital staff reported greater work satisfaction and said the training enabled them to make decisions that led to enhanced patient safety and outcomes. Improved staff morale is believed to result in lower rates of turnover, which is certainly a concern given the current nursing and other workforce shortages.

The intensive care unit (ICU) at the Johns Hopkins Hospital has instituted the use of checklists to ensure that patients receive appropriate treatment at the right time. Since the checklists were instituted, patient stays in the ICU have been reduced an average of two days.

In fall 2003, Children's Hospital in Boston, MA, began implementing CRM in its Department of Otolaryngology. Initially, the Mach One staff sent surveys to the surgeons in the department, asking for their reactions to and expectations of this sort of training.

The Mach One staff then presented several interactive sessions for all the professionals

who serve on operative teams. During these workshops, teams sought to resolve situations in which effective communication can make the difference between a successful versus a negative outcome. Junior members of the operative team were trained in how to safely and respectfully approach senior members to discuss their concerns, while the attending surgeons were trained in how to listen to the input from the other team members but continue to serve as the final authority and decision maker.

Next, the Mach team observed the performance of those individuals who had completed the course and provided one-on-one coaching regarding how to handle specific situations.

In the subsequent phase, the Mach staff sought to determine whether CRM training had any effect on rates of infection and other quality- and safety-related issues. A key feature of team training is that it represents a fundamental shift in the culture of patient safety that requires a long-term commitment to nurturing the desired behaviors. In that light, we are working to find agents of change within the institution who will continually reinforce the CRM principles and instill these concepts in the next generation of surgeons.

Surgeon reaction

The initial reaction to CRM training at Children's Hospital and other institutions has tended to run the gamut. Some people embrace it immediately, whereas others take umbrage with the notion that someone's "going to tell me how to run my OR." Nonetheless, once they start to participate in the process and realize its benefits, most surgeons become energized and feel relieved that they no longer "have the whole world on their shoulders" and can rely on the rest of the team. In fact, at Children's Hospital, reaction has been universally positive.

Fixed versus formed crews

One common assertion among surgeons is that if they worked with the same operative team all the time, it would be easier to gel as a unit and anticipate each others' strengths, weaknesses, needs, and expectations. They de-



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duce that “fixed” teams, comprising the same members from case to case, are more effective than “formed” teams composed of individuals selected to work on specific cases and would negate the need for team training.

However, a number of studies conducted in aviation—both in the military and the private sector—have shown that fixed crews actually were more likely to make mistakes, particularly on routine flights, possibly because the comfort level is just a bit too high. Flying together for extended periods of time leads to complacency and more human factor-related accidents.

Nonetheless, the teams that had the worst flight outcomes were newly formed flight crews working together for the first or second time. Therefore, the studies would indicate an increase in performance as crews complete several missions together; then, after a period of high performance, a terminal phase of diminishing effectiveness sets in.

Similar complacency is likely to infiltrate the OR when teams have worked together for extended periods of time. Likewise, teams composed of individuals who are unfamiliar with each other may need to take extra care in preparing to perform a procedure. Formed crews, which are typical in major medical centers, may actually experience the best outcomes. The caveat is that teams formed of randomly selected individuals must take steps to ensure synergy through the use of comprehensive briefings, evidence-based protocols, and CRM-like team training.

Conclusion

The continuing emphasis on quality improvement and error reduction in surgery make implementing CRM in the health care environment a virtual necessity. CRM has shown to improve team cooperation and outcomes. Furthermore, there are several financial issues to consider. If the government moves forward with establishing a pay-for-performance system that would link higher reimbursement to better outcomes, CRM may result in greater financial stability. In addition, fewer errors and improved outcomes would reduce the clinical costs associated with having to redo procedures and lower the risk

of costly medical liability claims that, in turn, drive up the cost of liability insurance.

We hope that this article has dispelled some common misconceptions regarding use of aviation’s CRM training model and encourages surgeons to consider how they might adapt this model in their institutions and offices. In an increasingly complex industry, we believe that surgeons will ultimately need to function as and view themselves as leaders of high-performance teams. To effectively lead a group of highly specialized, knowledgeable workers, one needs focused and formal training targeted toward that dynamic. We hope to develop a way of approaching our work that improves patient safety and outcomes. ^Ω

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Voluntary quality reporting program initiated for physicians

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On October 28, 2005, the Centers for Medicare & Medicaid Services (CMS) announced the launch of a physician voluntary reporting program (PVRP) as part of the agency's ongoing efforts to improve quality in health care. This article is intended to increase surgeons' understanding of the PVRP, including an overview of its purposes, means of implementation, and potential problems and benefits for participants.

Background

The development of the PVRP is CMS' most recent step toward implementing its quality initiative, first announced in November 2001 by Tommy Thompson, then-Secretary of the U.S. Department of Health and Human Services. The program began in April 2002 with the nursing home quality initiative, which set quality measures for those facilities that agreed to participate in a pilot project. The nursing home measures were applied nationally in November 2002. CMS then extended the quality initiative to home health agencies and hospitals in 2003. In 2004, the initiative was further expanded to include dialysis facilities that treat patients with end-stage renal disease and to primary care physicians. Hence, the PVRP is the first physician-centered quality improvement program from CMS available at the national level.

The PVRP allows physicians to report quality measures through the claims system. Participating physicians also may register to receive confidential feedback on their performance, including a comparison to regional, state, and national performance levels. The feedback reports are intended to allow physicians to gauge their success in identifying patients on whom to report data and in determining their quality performance for selected conditions.



The quality measures will be reported at the practice level through tax identification numbers. Although participation is not tied to payment at this time, it could easily be transformed into a pay-for-performance system. Therefore, physicians are advised to carefully monitor the program not only in terms of their own participation, but also with an eye on the relevance and effectiveness of the initial measures.

The measures

CMS originally released a set of 36 measures for reporting, but after additional physician input, CMS reduced the number of measures to 16. On December 27, a new starter set of quality measures was released. Of the 16 initial measures, only five are surgery-related, two of which are specific to coronary artery bypass graft surgery. The three remaining surgical measures are receipt of autogenous arteriovenous fistula in end-stage renal disease patients requiring hemodialysis, antibiotic prophylaxis in surgical patients, and thromboembolism prophylaxis in surgical patients.

Most of the PVRP measures center on primary care services, including control of diabetes mellitus, heart failure, and end-stage renal disease. Other areas addressed include depression and assessment of elderly patients for falls.

The five surgical measures in the PVRP examine processes rather than outcomes. The program does include outcome measures for primary care physicians, such as control of hemoglobin A1c (less than or equal to 9%), low-density lipoprotein (less than 100 mg/dl), and high blood pressure (less than 140 systolic and less than 80 diastolic) in patients with type 1 or type 2 diabetes. Because the program is not risk-adjusted, the number of outcome measures included is limited.

Reporting

The most common source of clinical data for quality measures is retrospective chart abstraction, but CMS found this method too burdensome for the initial phase of the program. The PVRP measures will be submitted using “procedure” codes, known as G-codes, to report clinical data through the claims processing system. G-codes are part of the Healthcare Common Procedure Coding System (HCPCS) and consist of an initial “G” fol-

lowed by four numbers. G-codes will be reported on the claim form in addition to the required Current Procedural Terminology (CPT)* code. It is important to understand that G-codes are not substitutes for CPT codes, are not associated with a separate fee, and are ineligible for compensation from CMS. The submission of G-codes is voluntary, and, therefore, claims will be paid regardless of whether a G-code is provided.

CMS considers the G-code system a temporary method of data collection until electronic clinical data submission becomes possible through electronic medical records. As health information technology becomes more widely available and accepted, risk-adjusted outcome measures can be implemented.

G-code measurements

Under the current system, each quality measure has multiple corresponding G-codes. The physician reports the G-code that represents the clinical service furnished. Each measure has a numerator, which is the G-code, and a denominator, which is the population being evaluated. An example of a PVRP measure is as follows:

Measure: Antibiotic prophylaxis in surgical patient

- *Numerator:*

- G8152: Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin).

- G8153: Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin).

- G8154: Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure.

- *Denominator:*

- Specified CPT codes.

CMS has stated that physicians may select which measures they will report. At press time, the feedback report physicians will receive was still in draft form, but preliminary information suggested that for each measure, CMS will col-

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2005 American Medical Association. All rights reserved.

lect information on the number of patients with the relevant condition and patients with a G-code reported to generate a reporting rate, as well as the number of patients in the denominator and numerator to generate a performance rate.

Uses of the data

CMS has stated that information obtained through the PVRP will *not* be available to the public. However, physicians should bear in mind that this program is modeled on the hospital voluntary reporting project, which ultimately evolved into public reporting in the form of CMS' hospital compare program.

Selection of measures

CMS defines an effective measure for performance measurement, quality improvement, disease prevention, and public reporting as "valid, reliable, evidence-based, and relevant for consumers, clinicians, and purchasers."[†] Various physician and quality care organizations, including the National Quality Forum (NQF) and the Ambulatory Care Quality Alliance (AQA), endorsed segments of the initial 36 measures. The revised set of 16 measures is based on measures endorsed by the NQF and the AQA that will also be used by the Quality Improvement Organization (QIO) programs. Surgical specialties were not heavily involved in the development of the PVRP.

The revised set of measures includes improvements to the denominator of three surgical measures. The CPT codes in the denominators were redefined for receipt of autogenous arteriovenous fistula in end-stage renal disease patients requiring hemodialysis, use of internal mammary artery in coronary artery bypass graft surgery, and preoperative beta-blocker for patients with isolated coronary artery bypass graft. In addition, problematic surgical measures were removed from the initial set for further study.

The College and other physician groups are working with the Physician Consortium for Performance Improvement (PCPI), NQF, AQA, and CMS to develop measures that are relevant to surgical care. In 2006, the College and its partners will progress to developing surgical

measures, and the PCPI will begin studying and developing additional surgical measures with the College as their lead organization. The 20 measures that were removed from the initial set will be further defined, and new quality measures will be phased into the PVRP as they are developed and approved.

Problems and challenges

The PVRP instructions are incomplete, and the omissions could pose challenges to the submission of data. CMS has agreed to revise the instructions but has given no timetable for doing so. Sources of trouble that the physician community has called to the attention of CMS include the following:

- The instructions direct physicians to insert the procedure code as the first item on a claim and to follow it with the G-code on the next line without a corresponding charge. The instructions do not explain whether other fields on the line item should be included, such as the date of service or diagnosis code.
- The instructions are incomplete on whether the G-code can be reported on a claim that is separate from the one containing the CPT code for the primary procedure.
- Many of the surgery-related measures are written as hospital-related measures. For instance, the antibiotic prophylaxis measure states "patient documented to have received antibiotic prophylaxis..." rather than "documentation that physician ordered antibiotic prophylaxis..."
- The current instructions include a list of CPT codes for the surgery measures that are arbitrary, omitting many relevant procedures. CMS has promised to make the list more complete.
- The measure for receipt of an autogenous arteriovenous fistula in end-stage renal disease patients has a major flaw. Eligible patients are those who are already receiving dialysis. Because an autogenous arteriovenous fistula has to mature before use, patients will have documentation that they received both an autogenous arteriovenous fistula and some other form of venous access. The current G-codes do not account for this situation, and physicians would have to report two G-codes for one measure.

continued on page 40

[†]Centers for Medicare & Medicaid Services. *CMS Manual System: Pub 100-19 Demonstrations*. Washington, DC: U.S. Department of Health & Human Services; 2005.

Political crisis and access to health care: A Nepalese neurosurgical experience



by Karim Mukhida, MD, Toronto, ON

War and the burden of illness

War and violent conflict are recognized as public health problems responsible for an important proportion of global morbidity and mortality.^{1,4} The number of armed conflicts has been increasing since the Second World War⁵ and the World Health Organization (WHO) estimates that, since then, there have been 160 wars with an associated 24 million deaths.¹ There are currently 1 billion people living in countries where a civil war is ongoing or likely to develop.^{5,6} The health effects of war extend beyond those directly injured in conflict and beyond the period of actual conflict.^{7,8} Approximately 90 percent of these casualties are civilians, partly as a result of the conflicts' exposure of civilian populations to conditions that lead to ill health: the disruption of economic networks and social services, the displacements of populations, and impaired resource distribution.⁷⁻¹¹

In addition, destruction of health-related infrastructure—such as clinics, laboratories, and water treatment and electrical systems—limits access to medicines and increases the risk of infectious disease transmission and malnutrition.^{7,12} Resources tend to be used on military concerns rather than health promotion,¹³ and health research and policy formulation are impaired.^{10,14} As Pederson notes, conflicts also have effects on communities' "social and cultural fabric" that are difficult to measure quantitatively.¹⁵ The Global Burden of Disease Study^{2,16} reports that the overwhelming majority of this public health burden is in the developing world, which is not surprising given the risk factors for armed conflict, including rapid demographic changes and populations' unequal access to resources and political power.¹

Conflict and neurosurgery in Nepal

During a three-month international health residency—an elective neurosurgery rotation at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu in 2004—I witnessed the effects of armed conflict on the provision of neurosurgical services. TUTH is a 426-bed tertiary care center and one of only three hospitals in Nepal

that offer neurosurgical services. Nepal is one of the economically poorest countries in the world—38 percent of the population lives below the national poverty line.¹⁷ The life expectancy at birth is only 60.1 years, up to 15.1 percent of which is lost because of poor health¹⁸; the infant mortality rate is 62 per 1,000 live births¹⁹; and only 27 percent of the population has access to adequate sanitation facilities.²⁰

Accessing neurosurgical care in Nepal is challenging even under the best of circumstances.²¹ Travel to the Kathmandu Valley, where the country's neurosurgical centers are clustered, is especially difficult for the 90 percent of the country's population living in rural areas. Travel to those hospitals often means a journey of several days, including walking or being carried by a family member to the nearest bus stop or airstrip.²² At U.S. \$12 per capita,¹⁸ government expenditures on health care are low in Nepal, and almost no private health insurance exists. The costs of neurosurgical treatment at TUTH, which includes those for medications and medical supplies, are therefore expensive for many families, considering that the gross national income per capita is only U.S. \$238, and a computed tomography scan of the brain and craniotomy cost U.S. \$29 and U.S. \$36, respectively. Furthermore, neurosurgical resources are sometimes lacking and need to be improvised. For example, modern spinal instrumentation standards to Canadian neurosurgical centers are too expensive for the hospital's budget and instrumentation is instead done using rods and wires purchased at local hardware stores by patients' family members.

The delivery of neurosurgical care at TUTH is made more difficult by Nepal's ongoing political and civil unrest. Since February 1996, the Communist Party of Nepal (Maoist) has been engaged in a People's War against the government. The conflict has been marked by the deaths of more than 10,000 people as a result of the violence, as well as bombings and protests.²²⁻²⁶ In the six days around Christmas 2004 alone, 106 people—including government soldiers, police officers, Maoist rebels, and civilians—were killed, and Kathmandu was blockaded from the rest of the country because barricades were set on all the main highways in central Nepal, hindering the transport of medical supplies and foodstuffs.

Opposite page: Protesters gather in the streets in Kathmandu.

The disappearances of thousands of people after abductions by Maoist rebels or detentions by security forces and reports of torture inflicted by both sides of the conflict have attracted the concern of Amnesty International and Human Rights Watch.²⁷⁻²⁸ The redistribution of government expenditures resulting from the increasing costs of national security has been at the expense of the health sector: only 5 percent of central government expenditures are allocated to health compared with 8 percent for defense.¹⁷

Patients' access to neurosurgical care at TUTH has been consequently adversely affected. In the rural and mountainous areas of Nepal, which have been the worst affected by the conflict, the frequent highway security checks, road blocks, and threats of violence associated with Nepal's political problems combine to make the journey to the urban neurosurgical centers longer and more difficult. The Nepal Safer Motherhood Project²⁹ assessed the conflict's effects on the accessibility of obstetric care in rural Nepal and found that the conflict has exacerbated preexisting barriers to seeking, reaching, and obtaining health care.

Transport at night is restricted because of curfews, and emergency funds established to help patients defray the costs associated with treatment and travel to hospital are no longer accessible or have been looted by Maoists.²⁹ Even travel to TUTH for patients in urban Nepal has been affected. For example, intermittently between April 1 and July 1, 2004, 15 days of "bandh," or general strikes, were called in the Kathmandu Valley. Usually ordered by the Maoists, these strikes entailed the closing of all businesses and schools and the prohibition of vehicular traffic, with the threat of violence to those who did not comply.

Bandh days were quiet in the hospital. The outpatient department—for which the queue to purchase tickets to see physicians begins early in the morning and features hundreds of patients waiting outside the clinic doors in the hallways—was unusually vacant. Operations were delayed or canceled. Many patients could not make it to the hospital because no public transport was available. Streets in Kathmandu that usually would be jammed with people were empty. A hospital bus drove around the city to

collect physicians, nurses, and other hospital staff in the mornings and again in the afternoon to drop them back home. Some physicians rode their motorcycles to work on bandh days but were careful to cover their license plates for fear they could be identified and later targeted for their lack of compliance with the strike.

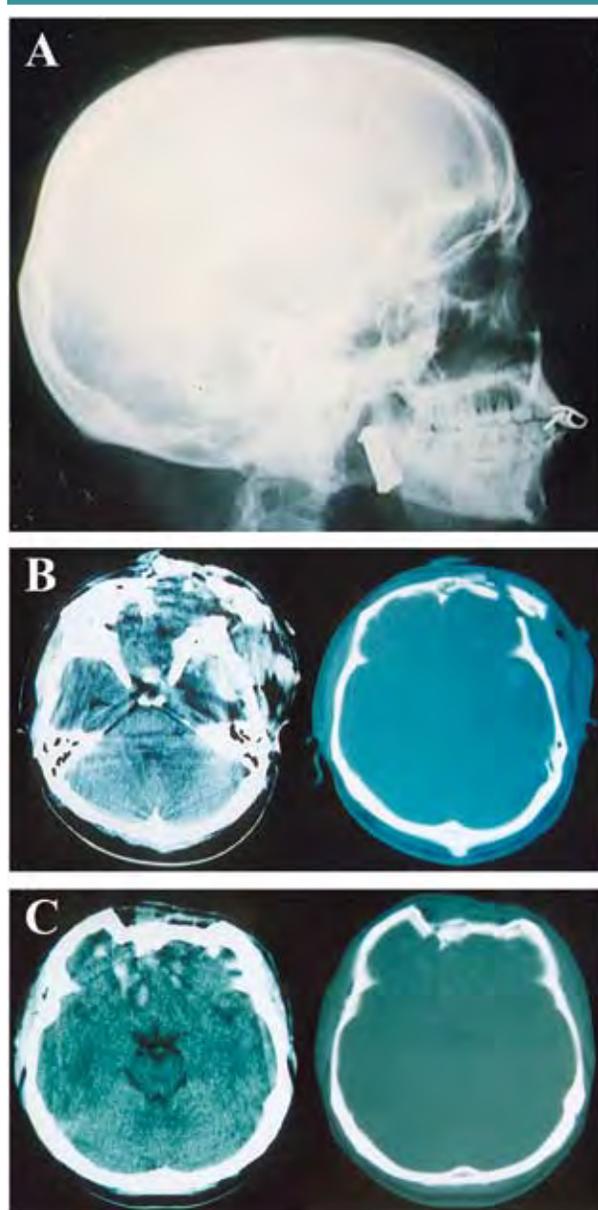
The conflict's effects on the health care system's human and fixed capital also have hindered rural patients' abilities to obtain referrals for specialty surgical services, such as neurosurgery, which are available only in the Kathmandu Valley. According to the Nepalese Ministry of Health, in rural Nepal, more than 1,000 community health service centers have been destroyed during the conflict. More than one dozen health care workers have been killed as a result of the violence.³⁰ According to the U.S. Agency for International Development and the Nepal Health Services Support Program, many more health care professionals have left their posts because of harassment, extortion, and threats by Maoists and security forces, despite appeals by Amnesty International and the International Society of the Red Cross.^{29,31}

The conflict-associated reduced access to neurosurgical services resulting from travel logistics or the inability to access primary care physicians for appropriate referrals to the urban neurosurgical centers has important implications for outcomes for neurosurgical emergencies, such as trauma. Recent scientific, evidence-based reports have shown that improvements in outcome can be achieved by prompt resuscitation or primary treatment and transport of patients to dedicated trauma and neurosurgical centers.³²⁻³⁶

Neurosurgical services were also affected by the conflict through the admission of victims of violence. Police officers have represented an especially large number of the casualties of violence, and more than 1,200 have died since the conflict began. Patients requiring surgery at TUTH included those with gunshot and bomb blast injuries (see photos, page 22). From the end of March to the end of June 2004, of the nine neurosurgical procedures performed for trauma (20% of the operative caseload), two were related to political violence.

More generally, the conflict has hindered health professionals' ethical rights to practice medicine without prejudice. A November 2001 Ministry of

Health directive required physicians to inform security officials of any wounded individuals seeking medical care. Physicians who provided



Victims of political violence admitted to the neurosurgery service at TUTH suffered from a variety of injuries, including gunshot (A, B) and bomb blast (C) injuries to the head.

treatment without appropriate government notification violated the directive, which itself was contrary to the ethical standards of the World Medical Association, and were subject to prosecution.^{25,26,37} Indeed, one physician was detained in isolation for 19 days. The directive has also dissuaded civilians caught in the crossfire between government security and Maoist forces from reporting and seeking treatment of conflict-associated wounds. The Centre for Victims of Torture in Kathmandu reports that as many as 20,000 civilians have not sought medical attention for wounds because of fear of being wrongly accused of collusion with Maoist rebels.³⁷

Peace through health: Peace for Nepal?

The failure of the resumption of peace talks between the Nepalese government and Maoist rebels in January 2005 and King Gyanendra's dismissal of government, assumption of direct government control, and declaration of a state of emergency on February 1, 2005, suggests that restoration of peace in Nepal through political means alone may be elusive. Perhaps the best avenue for improvement of the delivery of neurosurgical care as well as health care in general in Nepal will be through health workers. This has been the basis of the "peace through health" framework, which maintains that health professionals' roles in conflict situations include not only the treatment of casualties of violence, but also participating in peace-building and peace-making processes.^{8-11,38,39}

Although peace through health principles has been systematically used for more than two decades, and a variety of international organizations—such as the World Medical Association and Physicians for Global Survival, and charters, such as the Ottawa Charter for Health Promotion—have recognized peace as a prerequisite for health, efforts to shape these ideas into a subdiscipline for health professionals have only begun recently.^{9,10} The foundations for the discipline were laid at an international conference at McMaster University, Hamilton, ON, in 2001¹⁰ and the completion by students of the world's first university course there in 2004.⁹

Santa Barbara and MacQueen have outlined that physicians can enhance peace by acting through the health care system, such as by pro-

moting health-related superordinate goals that transcend those of the conflicting parties and advocating for equitable health care delivery, and by acting on the war system, such as by promoting understanding of war as a public health problem and participating in conflict resolution.¹¹

Peace through health principles is not a new concept to Nepal. Physicians and surgeons in Nepal were active participants in the 1990 revolution that brought an end to the absolute monarchy and enabled the establishment of a parliamentary constitutional monarchy.⁴⁰ Dedicated to a principle of “health for all,” Nepalese physicians’ voices were heard in the democracy movement through a variety of actions by alerting the media about the government’s use of bullets prohibited by the Geneva Convention and participating in hunger strikes.⁴⁰

Physicians have also provided itinerant services to bring health care to populations in remote Nepal that have been most affected by the conflict, and consequently among the least able to travel to the capital for tertiary care. Between 1990 and 1995, for example, ophthalmologists from Kathmandu have conducted almost 100 free “eye camps” (mobile ophthalmology clinics), screened more than 60,000 patients, and performed more than 6,300 surgical procedures.⁴¹ Currently at Tribhuvan University, pro-democracy slogans painted on the medical students’ residences demonstrate that Nepalese politics is very much on the minds of many in the health care community.

The peace through health framework offers surgeons in developed countries the opportunity to help in conflict-affected developing countries like Nepal. This is possible by raising awareness of the surgical and public health consequences of armed conflicts as well as through participation in international surgery activities as sponsored by nongovernmental organizations like the Canadian Network for International Surgery,⁴² International Committee of the Red Cross,⁴³ the Foundation for International Education in Neurological Surgery,²¹ and Orthopaedics Overseas,⁴⁴ or through professional organizations like the Canadian Association of General Surgeons, which formed the Liaison Committee for the Advancement of Surgical Services in the Developing World.⁴⁵ Our colleagues overseas deserve our support. 

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FIRE-SAFE CIGARETTES: REDUCING THE HAZARDS OF SMOKING

by Robert G. Sise and M. Margaret Knudson, MD, FACS, San Francisco, CA

As the leading cause of fatal fires in the U.S., cigarettes are responsible for one-fourth of all fire deaths. In 2002 alone, lit tobacco products caused an estimated 14,450 residential fires; 520 deaths; 1,330 injuries; and \$371 million in residential property damage.¹ Each year, cigarette fires cost the nation more than \$6 billion in services and lost productivity.²

Although only 4 percent of all residential fires are reportedly caused by smoking materials, the fire fatality rate resulting from smoking is nearly four times higher than the overall residential fire rate, and injuries are more than twice as likely (see table, next page). Smoking fires typically occur in the early morning when victims are asleep and affect both smokers and nonsmokers alike, particularly children and the elderly. Upholstered furniture, trash, and bedding are the materials most frequently ignited by cigarettes, and these fires often occur in multifamily dwellings. Among the human factors that contribute to this problem, the majority of lit tobacco fires were caused when the smoker fell asleep.¹

Traditional cigarettes burn continuously even when unattended. A fire-safe cigarette is designed to extinguish itself when not actively smoked. On June 29, 2004, New York State enacted the world's first law requiring that cigarettes include

design alterations to make them fire safe. The law mandated that all cigarettes sold in the state meet the fire-safe cigarette standards established by the American Society for Testing and Materials. Under these standards, a cigarette can only be classified as fire safe if, when placed lit on a stack of test filler paper, it does not cause any weight loss of the stack (that is, it does not ignite the paper). When lit and left unattended, fire-safe cigarettes will not burn intensely for the amount of time necessary to ignite the majority of household fabrics. A standard cigarette, when not smoked, may smolder for up to two hours. This is more than the amount of time required for an upholstered chair, for example, to burst into flames. On the other hand, a fire-safe cigarette extinguishes itself in approximately five minutes. A common design employed by cigarette companies to reduce ignition potential is to use paper with specially designed rings along the cigarette that slow the

**2002 loss measure
for residential smoking fires**

Loss measure	All residential fires	Residential fires caused by smoking
\$ loss/fire	11,832	14,478
Injuries/1,000 fires	35.9	87.7
Fatalities/1,000 fires	6.5	25.1

Source: National Fire Protection Association

burning when they are not puffed.³ On October 1, 2005, a nationwide law in Canada mandated that all cigarettes sold must be fire safe. Similar legislation has recently been passed in Vermont and California.

A preliminary analysis of the effect of the New York cigarette law recently has been published.⁴ Although it is too soon to demonstrate any reduction of fires, death, and injuries caused by smoking as a result of the new law, it is gratifying to note that New York cigarette brand averaged 10 percent of full-length burns, as compared with 99.8 percent for California and Massachusetts brands. This reduced ignition propensity was achieved by cigarette paper banding. In addition, cigarette sales and prices were not affected by the New York standards. Importantly, after testing for over 20 toxic smoke constituents, there was no evidence of significant changes in toxicity with the new design.

In summary, mandating safer cigarettes can have an immediate impact on the morbidity and mortality stemming from cigarette fires. Physicians in states without such laws are encouraged to become advocates for this cigarette redesign at the state and national levels. To learn more about how to play an active role in the campaign, a downloadable advocacy kit is available on the Phoenix Society for Burn Survivors Web site at www.phoenix-society.org. Legislative updates are available from the Trauma Foundation Web site at www.firesafecig.org.

The authors would like to acknowledge Andrew McGuire and the members of the Trauma Foundation in San Francisco for their assistance in preparing this

document and for their continued advocacy to reduce the burden of burn injury. □

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Mr. Sise is a research assistant with the San Francisco Injury Center.



Dr. Knudson is professor of surgery, University of California, San Francisco, and Chair of the ACS/COT Subcommittee on Injury Prevention and Control.



Statement in support of legislation regarding fire-safe cigarettes

The following statement was prepared by the Subcommittee on Injury Prevention and Control of the ACS Committee on Trauma and approved by the Board of Regents at its October 2005 meeting.

Recognizing that cigarette smoking is a major hazard, the American College of Surgeons supports aggressive efforts to educate the public on the dangers of using tobacco products and the subsequent high costs of this serious but preventable problem. The College also recognizes, however, that this educational effort remains a difficult challenge that may never be totally resolved. Because fires caused by cigarettes can cause serious burn injuries and deaths, the American College of Surgeons supports efforts and legislation aimed at preventing burn injuries associated with cigarettes.

- Cigarettes are the leading cause of fatal fires in the U.S. and are responsible for one-fourth of all deaths caused by fires.
- Annually, cigarette fires kill approximately 1,000 people and injure 3,000 more.
- Fires caused by cigarettes cost the nation over \$6 billion dollars each year.
- Unlike deaths caused by smoking and related illnesses, most cigarette fire fatalities occur among non-smokers, including children and firefighters.
- The majority of casualties caused by cigarette fires can be prevented by simple cigarette redesign.
- Fire-safe cigarettes are designed to decrease the burning power of cigarettes that are not being puffed.
- When lit and left unattended, fire-safe cigarettes will not burn intensely for the amount of time necessary to ignite the majority of household fabrics.
- The American Society for Testing and Materials (ASTM) has established fire-safe cigarette standards using the National Institute of Standards and Technology Center for Fire Research model.
- In June 2004, Gov. George Pataki and legislators in New York State enacted the world's first law requiring that all cigarettes sold in that state to be self-extinguishing. The law is intended to reduce the number of fires started by careless smokers. Other states are expected to follow with similar legislation.

Therefore, the American College of Surgeons encourages all physicians to advocate for fire-safe cigarette legislation nationwide.

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Dr. Starzl named National Science Laureate

Thomas E. Starzl, MD, PhD, FACS, of Pittsburgh, PA, has been awarded the 2004 National Medal of Science. A Fellow since 1966 and the 1995 recipient of the College's Jacobson Innovation Award, Dr. Starzl, professor of surgery at the University of Pittsburgh School of Medicine, is known worldwide for having performed the world's first liver transplant in 1963 and the first successful liver transplant in 1967.

He has worked throughout his career on controlling organ rejection and understanding disease processes, but most recently "has made important discoveries about immune tolerance, which have completely changed the face and conventional paradigms of transplant immunology."*

*National Science Foundation. President announces 2004 Medal of Science winners [press release]. Available at: http://www.nsf.gov/news/news_summ.jsp?cntn_id=104602&org=olpa&from=home. Accessed December 19, 2005.

Dr. Starzl receives this award specifically "for his unique contributions to basic and applied science that resulted in the emergence of organ transplantation as a widely available treatment."*

Established in 1959, the Medal of Science is the highest honor for science in the U.S. It is administered by the National Science Foundation on behalf of the president and honors individuals for "pioneering scientific research in a range of fields, including physical, biological, mathematical, social, behavioral, and engineering sciences, that enhances our understanding of the world and leads to innovations and technologies that give the United States its global economic edge."†

†White House. Recipients of the 2004 National Medal of Science and 2004 National Medal of Technology [press release] Available at: <http://www.whitehouse.gov/newsreleases/2005/11/20051114-5.html>. Accessed December 19, 2005.



Dr. Starzl

The recipients of the National Medal of Science were announced in November 2005. The medals will be presented by Pres. George W. Bush at a White House ceremony in the near future.

Trauma meetings calendar

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

- **Trauma and Critical**

Care 2006, March 20–22, Las Vegas, NV.

- **Trauma and Critical Care 2006—Point/Counterpoint XXV**, June 5–7, Williamsburg, VA.

Complete course informa-

tion can be viewed online (as it becomes available) through the American College of Surgeons Web site at: <http://www.facs.org/trauma/cme/traumtgs.html>, or contact the Trauma Office at 312/202-5342.

Clowes Career Development Award given

The 2006 George H.A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award was granted to Yolonda L. Colson, MD, PhD, assistant professor of surgery, Brigham and Women's Hospital, Boston, MA, for her research project entitled The Mechanism of Facilitating Cell Induced Regulatory T Cell Networks.

The Clowes Award, which pro-

vides support for promising young surgical investigators, is sponsored by The Clowes Fund, Inc., of Indianapolis, IN, and is in the amount of \$40,000 for each of five years, beginning July 1.

Information regarding the scholarships, fellowships, and awards offered by the College appears on the College's Web site, www.facs.org/memberservices/research.html.



Dr. Colson

2006 International Guest Scholars selected

Ten International Guest Scholarships for 2006 were awarded by the Board of Regents during the 91st annual Clinical Congress in San Francisco, CA. This program enables talented, young academic surgeons from countries other than the U.S. or Canada to attend and participate in the activities of the Clinical Congress, then to tour surgical institutions of their choice in North America. The program is administered by the College's International Relations Committee. The requirements for applicants for the 2007 International Guest Scholarships will appear in a future edition of the *Bulletin*. They are also posted on the College's Web site at www.facs.org/memberservices/research.html.

The 2006 International Guest Scholars are as follows: Wendy A. Brown, MBBS, PhD, FRACS, Prahran, Australia; Jeong-Hwan Chang, MS, PhD, Gwang-ju City, South Korea; Mehmet Hacıyanli, MD, Izmir, Turkey (Abdol Islami Scholar); Luis Humberto Lopez, MD, Leon, Mexico; Julio

Cesar Morales, MD, Guatemala, Guatemala; Sarder A. Nayeem, MBBS, Dhaka, Bangladesh; Ronnie T. P. Poon, MBBS, MS, FRCS (Ed), FACS, Hong Kong, China;

Hernan P. Sacoto, MD, Cuenca, Ecuador; Zsolt Toth, MD, Pecs, Hungary; and Ashish Wakhlu, MS, MCh, Lucknow, India.

2006 ACS Japan Traveling Fellow selected

Alan Dardik, MD, PhD, FACS, assistant professor, section of vascular surgery, Yale University School of Medicine, New Haven, CT, has been selected as the 2006 ACS Japan Traveling Fellow. Dr. Dardik will participate in the annual meeting of the Japan Surgical Society in Tokyo, Japan, March 29–31, 2006. He will attend the Japan Chapter meeting during that event and will then travel to several surgical centers.

Requirements for the 2007 Traveling Fellowship will be published in an upcoming issue of the *Bulletin*. They will also be posted on the College's



Dr. Dardik

Web site at www.facs.org/memberservices.research.html.

Nominations sought for Jacobson Promising Investigator Award

The American College of Surgeons is accepting nominations for the second Joan L. and Julius H. Jacobson II Promising Investigator Award, to be selected in 2006. This award has been established to recognize outstanding surgeons engaged in research advancing the art and science of surgery and who have shown through their research an early promise of significant contribution to the practice of surgery and the safety of surgical patients. The award amount is \$30,000, to be given at least once every two years. The College's Surgical Research Committee administers the award.

Award criteria

- Candidate must be board-certified in a surgical specialty and must have completed surgical training in the last three to 10 years.
- Candidate must be a Fellow of the American College of Surgeons.

- Candidate must hold a faculty appointment at a research-based academic medical center (military service position included).

- Candidate must have received peer-reviewed funding such as a K-Series Award from the National Institutes of Health (NIH), Department of Veterans Affairs, National Science Foundation, or Department of Defense merit review to support his or her research effort.

- Nomination documentation must include a letter of recommendation from the nominee's department chair. Up to three additional letters of recommendation will be accepted.

- Only one application per surgical department will be accepted.

- Nomination documentation must include a NIH-formatted bio-sketch and copies of the candidate's three most significant publications.

- Nominee must submit a one-page essay to the committee

explaining why he or she should be considered for the award, and discussing the importance of the research he or she has conducted/is conducting.

The recipient may be required to prepare and give a presentation on his or her research at the annual ACS Clinical Congress following receipt of the award.

Nomination procedures

Nominations are accepted at any time. To be considered for the award in 2006, submissions must be postmarked or e-mailed no later than March 17. Compile the necessary documentation listed above for award criteria and submit it electronically via e-mail to mfitzgerald@facs.org. Nominations may also be submitted on a CD-ROM and mailed to: Mary T. Fitzgerald, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

For additional information, e-mail mfitzgerald@facs.org or call 312/202-5319.

WHAT SURGEONS SHOULD KNOW ABOUT, from page 9

How can I get help filing a dispute?

Any signatory medical society or compliance dispute facilitator assigned to a particular health plan may evaluate a dispute and complete the requisite paperwork. A list of signatory medical societies, contact information for compliance dispute facilitators, and the form are available at www.hmosettlements.com.

Where can I find out more?

For more information, surgeons may want to visit www.milbergweiss.com and www.physiciansfoundation.org, or call the College at 312/202-5000 and ask to speak with the State Affairs staff. 

Franklin Martin: “The founding father”

by Rodney A. Mannion, MD, FACS, Michigan City, IN

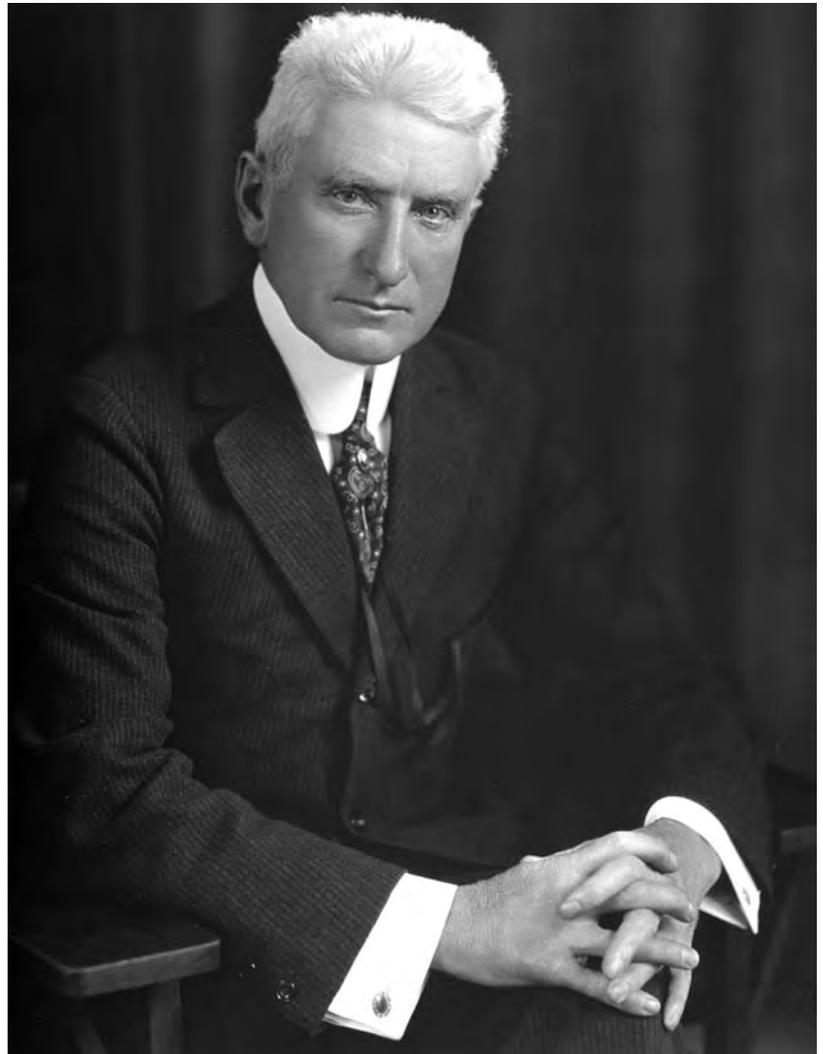
Editor’s note: In 2005, the *Journal of the American College of Surgeons* celebrated its 100th anniversary. Following is a condensed biography of the founding of the College and the Journal.

Franklin Martin, MD, is considered by some historians to be the grandfather of North American surgery. Certainly he excelled in almost every aspect of organizational and editorial leadership so necessary to lift the practice and teaching of the surgical specialty cherished by Fellows. From the 1880s through his founding of the American College of Surgeons in 1905, and until his death on March 7, 1935, Dr. Martin was an inspiring leader, and one worth emulating.

Dr. Martin grew to manhood in seemingly idyllic, if somewhat strained financial, circumstances in Wisconsin. His father joined the Union Army and was killed in 1862, which led Dr. Martin to be a devout patriot his entire life. His mother and the extended family, who lived along the Rock River, raised him well. He was very mentally quick and had a unique ability to recall details.

Dr. Martin spent three years at Chicago Medical College, followed by Northwestern University, and a two-year internship at Mercy Hospital.

The State Street office where Dr. Martin set up his prac-



Dr. Martin

tice slowly became popular with rich and poor people. He concentrated his practice on gynecology, published in the *Journal of the American*

Medical Association and other magazines, and gradually prospered.

Early on, Dr. Martin’s penchant for professional leader-

ship came to the fore and he spearheaded the South-Side Medico-Social Society, which met in the homes of many young, prominent physicians in the area. His scientific forte was the use of galvanizing electrodes to ameliorate uterine bleeding, prevalent at this time before the advent of safe hysterectomy. He was an adroit surgeon who performed early operations in patients' homes and used the antiseptic—and, later, the true aseptic—methods. Dr. Martin became known by name, and William J. Mayo, MD, would frequently visit Chicago to watch Dr. Martin operate and to discuss cases.

Ted Donnelly, a friend of Dr. Martin, was a publisher who encouraged him to start a much-needed journal for the surgical profession. In 1905, *Surgery, Gynecology & Obstetrics* was launched. The editorial board—headed by Dr. Martin as managing editor—was composed of prominent men such as Nicholas Senn, MD, John B. Murphy, MD, and Drs. William and Charles Mayo. Though the journal was slow in

gaining circulation, it eventually became quite successful. In 1994, it was renamed the *Journal of the American College of Surgeons*.

In 1912 and 1913, Dr. Martin leveraged his high standing in the profession, which resulted in founding the American College of Surgeons. This succeeded the amorphous Clinical Congress of Surgeons of North America, despite vociferous opposition, especially among surgeons on the West Coast. Dr. Martin was very interested in participating in the cause against fee splitting and poorly prepared, poorly schooled, and unethical surgeons—both ideals still framing the tenets of today's College.

In addition, the dark blue and scarlet robes worn at the yearly Convocation began with Dr. Martin at the College's first Clinical Congress. At this meeting, five prominent surgeons—including Sir Rickman Godlee and Dr. William Halsted—received honorary Fellowship, and Dr. Martin was named Secretary General of the College. He did not become

College President until the 1928-1929 term.

Dr. Martin's credits also include political and military activities. Before World War I, Dr. Martin was immersed in the bureaucracy of Woodrow Wilson's administration. Because his maternal grandfather, Alexander Carlin, had been a lifelong, intensely partisan Democrat, this was a natural situation for Dr. Martin. He was also chair of the General Medical Board during World War I and was decorated for his military service.

The information contained in this brief discussion of Dr. Martin, plus a wealth of additional information, is available in a two-volume autobiography, *The Joy of Living: An Autobiography* (Garden City, NY: Doubleday, Duran & Company, Inc.; 1933. ASIN B0006AM7AK).

This book deserves to be read by all surgeons who wish to practice ethical surgery.

Dr. Mannion is recently retired from the active clinical practice of urology.



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Disciplinary actions taken

The Board of Regents took the following disciplinary actions at its October 15, 2005, meeting:

- A general surgeon from Brunswick, GA, was censured after being charged with violation of Article VII, Sections 1(f) and (i) of the *Bylaws* for providing expert witness testimony that was found to be false and/or misleading regarding the standard of care.

- Charles Keith Lee, MD, a thoracic surgeon from Kansas City, MO, was expelled from the College. He had been charged with violation of Article VII, Sections 1(f), (h), and (i) of the *Bylaws* following allegations that he misrepresented his credentials while testifying as an expert witness.

- An orthopaedic surgeon from Washington, DC, was placed on probation following charges that he violated Article VII, Sections 1(b) and (f) of the *Bylaws*. This surgeon's Fellowship status will remain on probation until he has a full and unrestricted medical license; full and unrestricted surgical privileges in an accredited hospital; and his practice pattern has been reviewed and approved by the Central Judiciary Committee. The action was taken following disciplinary action by the Maryland State Board of Quality Assurance and the New York Department of Health after he was found to have engaged in unprofessional conduct in the practice of medicine.

- Jayant M. Patel, MD, a general surgeon from Portland, OR, was suspended from the College. Dr. Patel's Fellowship was placed on probation with conditions in June 2001 following charges that he violated Article VII, Section 1(b) of the *Bylaws* when his license to practice medicine in the State of Oregon was restricted because of multiple adverse patient outcomes. More recently, his Fellowship was placed on immediate temporary suspension pending investigation of whether he has an active license to practice medicine.

Restoration of Dr. Patel's full Fellowship privileges will be considered when he has a full and unrestricted medical license; full and unrestricted surgical privileges in an accredited hospital; and his practice pattern has been reviewed and approved by the Central Judiciary Committee.

- An otolaryngologist-head and neck surgeon from Sayre, PA, had his full Fellowship privileges reinstated following a period of probation when he fulfilled the requirements of having a full and unrestricted medical license; full and unrestricted privileges in an accredited hospital; and having his practice pattern reviewed by the Central Judiciary Committee.

The probation was imposed following charges that he violated Article VII, Section 1(b) and (f) of the *Bylaws* when his license to practice medicine in

the State of Pennsylvania was restricted.

• • •

Following are the disciplinary actions that may be imposed for violations of the principles of the College:

- *Admonition*: A written notification, warning, or serious rebuke.

- *Censure*: A written judgment, condemning the Fellow's or member's actions as wrong. This is a firm reprimand.

- *Probation*: A punitive action for a stated period of time, during which the member

- (a) loses the rights to hold office and to participate as a leader in College programs

- (b) retains other privileges and obligations of membership

- (c) will be reconsidered by the Central Judiciary Committee periodically, and at the end of the stated term

- *Suspension*: A severe, punitive action for a period of time, during which the Fellow or member, according to the membership status,

- (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs

- (b) is subject to the removal of the member's name from the yearbook and from the mailing list of the College

- (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a

Fellow of the American College of Surgeons

(d) pays the visitor's registration fee when attending College programs

(e) is not subject to the payment of annual dues

When suspension is lifted, the

Fellow or member is returned to full privileges and obligations of Fellowship.

• *Expulsion:* The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith

returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons, and may not participate as a leader, speaker, or panelist in College programs.

ACS Career Opportunities

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Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings

October 15-16, 20, 2005

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

American College of Surgeons Professional Association (ACSPA)

As of August 23, 2005, the College's political action committee (ACSPA-SurgeonsPAC) had raised \$421,000 toward its \$500,000 goal for the 2005 fundraising year, which ended November 30. As of August 15, 2005, \$213,000 had been pledged to the PAC via the telephone fundraising campaign.

Of 215 U.S. members on the Board of Governors, 104 (48%) contributed to the PAC for an average contribution of \$376. This represents a 15 percent increase over the number provided in the June report.

In 2005, the ACSPA-SurgeonsPAC organized 11 political fundraiser events.

American College of Surgeons (ACS)

Statements

The Board of Regents approved the recommendation of its Committee on Ethics to withdraw ST-7, Statement on Ethics in Patient Referrals to Ancillary Services. The statement was published in 1989 in response to the Stark legislation, which attempted to define the circumstances under which it was appropriate for a physician to refer patients to ancillary health service facilities in which the physician had a financial interest. The statement has become outdated partly because of revisions to the legislation over the past 15 years.

The Board of Regents approved a Statement in Support of Legislation Regarding Fire-Safe Cigarettes. Recognizing that cigarette smoking is a major health hazard, the College supports aggressive efforts to educate the public on the dangers of using tobacco products and the subsequent high costs of this serious but preventable problem. Fires caused by cigarettes can cause serious burn injuries and deaths, and the College supports efforts and legislation aimed at preventing burn injuries associated with cigarettes. The statement was developed by the Committee on Trauma Subcommittee on Injury Prevention and Control; it appears in this issue of

the *Bulletin* (page 27) and will be posted on the College's Web site at a later date.

Finance Committee

On the recommendation of the Finance Committee, the Board of Regents approved a business plan and start-up funding for a proprietary mutual fund benefit. The fund would be designed to serve as one component of a surgeon's investment program and could be used for retirement and nonretirement savings. It is anticipated that the fund will debut at the 2006 Clinical Congress in Chicago, IL.

The Board of Regents also approved the Finance Committee's recommendation to provide \$1.7 million for 2007 scholarship funding. In addition, the Board approved the recommendation that the Scholarships Committee work with the ACS Foundation to develop a process to expand opportunities.

ACS Foundation

On September 1, 2005, the Internal Revenue Service approved the ACS Foundation's application for tax-exempt status under section 501(c)(3) of the Internal Revenue Code. Contributions directed to the ACS Foundation are now officially tax deductible.

As of September 14, 2005, gifts and pledges in the amount of \$262,772 had been received. This represented an increase of \$128,551 over the same period in 2004.

Selected Readings in General Surgery

The Board of Regents accepted the gift of *Selected Readings in General Surgery (SRGS)* from Robert N. McClelland, MD, FACS, founder and editor-in-chief. Under the College, this outstanding resource would be taken to the next level through integration and linking with existing educational programs. Educational guidance and advice would be provided to further enhance the product and create new programs based on *SRGS*. In addition, *SRGS* would be linked to the Surgical Education Self-Assessment Program, integrated into the Fundamen-

tals of Surgery Resident Curriculum, used in practice-based learning and improvement activities, and promoted as a special resource to meet maintenance of certification requirements.

ACS Iran Chapter

The Board of Regents approved the formation of an ACS Chapter in Iran. The ACS Iran Chapter is the College's 33rd international chapter.

Advocacy

Efforts to develop physician pay-for-performance (P4P) programs for Medicare and in the private sector have intensified tremendously in recent months, and many specialties are unprepared. The College worked with the surgical specialty societies to draft a framework for developing P4P systems for surgery. This document has served as the basis for joint responses to P4P proposals developed on Capitol Hill and by Medicare. In addition, the College joined the steering committee of the Ambulatory Quality Alliance, a group of payors, patients, employers, federal officials, and medical and surgical organizations that is addressing P4P implementation issues.

The College continues to support advocacy efforts of particular interest to the surgical specialties on the state and federal levels. In addition, many resources have been devoted to the five-year review of work under the Medicare physician fee schedule.

In a letter to Rep. Nancy Johnson (R-CT), Chair of the Ways and Means Subcommittee on Health, the College has stated its support of H.R. 3617. H.R. 3617 is focused solely on establishing a P4P model for Medicare physician payments. H.R. 3617 would provide a payment increase of 1.5 percent for Medicare physician payments in 2006 and would repeal the sustainable growth rate and replace it with payment updates based on the Medicare Economic Index in 2007 and all future years. As a result, H.R. 3617 would guarantee payment increases for all physicians in 2006 and, in future years, most likely guarantee increases

even for physicians who fail to meet their quality measures.

In July, the Senate Appropriations Committee approved its funding legislation for the Departments of Health & Human Services, Labor, and Education for fiscal year 2006. In response to a College-initiated coalition letter of support for the Health Services & Resources Administration's (HSRA) Trauma-EMS (Emergency Medical Services) program, which garnered signatures from 23 other organizations, included in this bill is \$3.4 million for the HSRA Trauma-EMS program, as well as \$20 million for Emergency Medical Services for Children (EMSC). The companion House bill does not contain any funding for trauma, but does provide \$19 million for EMSC.

Also in July, the College, along with 32 other organizations, signed a letter in strong support of S. 760, the Wakefield Act. This bill would reauthorize the EMSC program for an additional five years with an annual funding level of \$23 million.

College and American Trauma Society representatives met in August. The purpose of the meeting was to urge the Bush Administration to include the Trauma-EMS program in its fiscal year 2007 budget, due in February 2006.

The Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group (TAG)—composed of 19 members, including four ACS Fellows—met June 15–17. TAG was created to provide advice and recommendations to the Centers for Medicare & Medicaid Services (CMS) concerning regulations related to EMTALA and their application to hospitals and physicians. In comments submitted to TAG, the College strongly urged the advisory committee to reject any legislative or regulatory efforts to require surgeons to take call as a condition of Medicare participation or as a stipulation to obtain hospital privileges. TAG subsequently voted to recommend that CMS not require physicians to serve on-call as a condition of Medicare participation. During its next meeting, TAG will consider additional proposals to address the shortage of on-call specialists and will continue to examine other related EMTALA issues.

For a second time, the College partnered with 11 other medical organizations to participate in an exhibit at the National Conference of State Legislatures annual meeting. With more than 5,000 state legislators, government officials, and other policymakers in attendance, this meeting provides a “one-stop” grassroots advocacy forum on a wide range of issues with the dominant theme being medical liability reform.

Education

The 2006 Spring Meeting will be held in Dallas, TX, April 23–26. The program is being planned by the Advisory Council for General Surgery in collaboration with the Division of Education and the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). The College's Spring Meeting will precede the SAGES meeting. The Excelsior Surgical Society/Edward D. Churchill Lecture will be delivered on Monday, April 24. Two special joint programs co-sponsored by the College and SAGES will be presented on Wednesday, April 26. A number of sessions specifically directed at surgical residents will be presented in collaboration with the Resident and Associate Society.

The first year of collaboration between the College and SAGES on the Fundamentals of Laparoscopic Surgery (FLS) program was very successful. The joint launch of the program was in April 2005, and sales of FLS since this launch have been brisk.

A task force on surgical palliative care has been very successful in developing and implementing state-of-the-art educational programs to enhance palliative care in surgery. A one-day seminar was held in May 2005. It was well received, and a follow-up seminar is planned for 2006.

Journal of the American College of Surgeons (JACS)

The JACS Online continuing medical education (CME)-1 program continues to provide CME-1 credits at no cost. To date, this program has awarded more than 72,000 credits.

Surgery News

Feedback from members of the College who are receiving *Surgery News* continues to be very positive. A PDF (portable document format) version of the newspaper is available via the College's Web site. If the newspaper reaches the break-even point, it will be possible to expand the print circulation in the future to include all members of the College.

Operation Giving Back (OGB)

OGB was officially introduced at the 2004 Clinical Congress and had a busy and exciting year in 2005. Relationships have been established on the domestic and international fronts, volunteer resources have been researched and compiled, the online Web resource has been revised and expanded, and work has been initiated with the ACS Committee on Resident Education toward the creation of volunteer opportunities for residents.

In response to the ravages of Mother Nature, the program was extended well beyond its primary mission when it mobilized surgeons

in response to two major natural disasters, Hurricanes Katrina and Rita. The Web site quickly adapted to serve as a means of conveying timely and pertinent information on everything from points of contact for responding to continuity of care for affected patients. The immediate and overwhelming response of ACS members is clear and compelling evidence of the need for information on how to assist in such situations.

Equally compelling was the difficulty experienced by those willing to volunteer and the barriers they encountered, which negatively affected the delivery of care. It is hoped that issues such as the portability of medical licenses over state lines, credentialing of volunteers, and the provision of tort liability coverage to medical volunteers will be examined in a new light and with renewed importance in the aftermath of these disasters.

There remains much to be done. Operation Giving Back will continue to adhere to its mission of facilitating volunteerism on both the domestic and international fronts.

A look at the Joint Commission

Patient safety

Welcome to the second installment in a series of monthly articles on the Joint Commission on Accreditation of Healthcare Organizations. Each month, we 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.jcaho.org.

For more than a decade, the Joint Commission has been a leader in improving patient safety. The Joint Commission supports this mission through its standards; survey process; Sentinel Event Policy; sentinel event database; *Sentinel Event Alert* newsletters that share lessons learned from and recommendations to prevent

adverse events; the Speak Up™ patient safety awareness campaign that encourages patients to become active, involved, and informed members of the health care team; and its National Patient Safety Goals. The 2006 National Patient Safety Goals focus on the following:

- Improve accuracy of patient identification
- Improve effectiveness of communication among caregivers
- Improve safety of using medications
- Reduce risk of infections associated with health care
- Accurately and completely reconcile medications across the continuum of care
- Reduce the risk of patient harm resulting from falls

In May 2003, the Joint Com-

mission hosted a Wrong Site Surgery Summit that led to the adoption of the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™. The Universal Protocol earned the endorsements of more than 50 professional medical societies, including the American College of Surgeons.

In March 2005, the Joint Commission and Joint Commission Resources created the Joint Commission International Center for Patient Safety (www.jcipatientsafety.org). In August 2005, the World Health Organization designated the Joint Commission and Joint Commission International as the world's first collaborating center for patient safety solutions.

VOLUNTARY QUALITY REPORTING PROGRAM, from page 18

Benefits of participation

Although the system is imperfect, reporting could benefit surgeons in several ways. First, data collected from physicians will provide Medicare with information on the quality of care that beneficiaries currently receive. Second, participating physicians can receive feedback on their performance and will have the opportunity to comment on how quality reporting could be streamlined and improved. Another advantage of participating is the opportunity to use the PVRP as a trial run. Many health policy experts believe that a mandatory physician reporting program or a pay-for-performance system is imminent.

Participating in the PVRP allows physicians to improve the ease and accuracy of data submission in a voluntary setting.

Interested physicians began reporting measures to CMS on January 3. New participants may begin submitting G-codes at any time. To receive feedback, however, physicians must register with their state's quality improvement organization. At press time, registration was scheduled to become available in February. Feedback may be available as early as July or August 2006.

For more information, including a full set of instructions and measures, visit www.cms.hhs.gov/quality/pfqi. 

AMERICAN COLLEGE OF SURGEONS

• DIVISION OF EDUCATION •



□ **NEW! PROFESSIONALISM IN SURGERY: CHALLENGES AND CHOICES:**

Professionalism is an essential component of surgical practice, and one of the six core competencies defined by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education. This CD-ROM presents 12 case vignettes, each including a scenario followed by multiple choice questions relating to professional responsibilities of the surgeon within the context of the case. The program provides the opportunity to earn online CME credit, with a printable certificate upon successful completion.

□ **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.acs-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.

For purchase and pricing information, call ACS Customer Service at 312/202-5474 or visit our **E-LEARNING RESOURCE CENTER** at www.acs-resource.org

For more information contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354.



Ideas for protocols sought

It has been four months since this column was initiated to provide communication from the American College of Surgeons Oncology Group (ACOSOG) to the College membership. In that time, major emphasis has been placed on broadening our communication and focusing our scientific efforts. We hope the communication efforts have delivered useful information.

As we gain experience and feedback, we hope to create dialogue among all stakeholders. We are opening the dialogue in this issue's column in the form of a "call for concepts" that encourages all members of the College to send us ideas for protocols. We need to hear from you. Thank you in advance to those of you who are sending ideas.

Regarding the scientific interest of ACOSOG, progress has been made toward focusing the efforts of ACOSOG on a vision and three themes with an emphasis on novel therapies relevant to the surgical patient (please see the call for concepts that appears on the next page for more information). We are now starting to work specifically on writing the National Institutes of Health (NIH) grant and the NIH site visit, due in 13 and 18 months, respectively.

As a result of the need for grant and site visit planning, we regret that the January

2006 semi-annual ACOSOG meeting was not open to full member participation. The January meeting was conducted as a strategic planning session with ACOSOG leadership. We have little more than a year to address all concerns raised at the previous site visit, and we needed this opportunity to focus our efforts.

We fully recognize it would be most desirable to have a well-attended meeting, as the membership of ACOSOG is vital to the organization, but please be assured that we are working hard to bring forward the best surgical science and to meet your needs. Thank you for your patience and understanding. *The June semi-annual meeting will be open to full member participation.*

June semi-annual ACOSOG meeting:

When: June 22–24, 2006

Where: Chicago, IL

Who: All ACOSOG members welcome

Topics and guest speakers to be announced at a later date

New ACOSOG trials

Following are new ACOSOG trials posted to the Web site (www.acosog.org).

- **Z4032**—A Randomized Phase III Study of Sublobar Resection versus Sublobar Resection plus Brachytherapy in High-Risk Patients with Non-Small Cell Lung Cancer

(NSCLC), 3 cm or smaller

Primary investigator (PI):
Hiran C. Fernando, MD

- **Z6041**—A Phase II Trial of Neoadjuvant Chemoradiation and Local Excision for uT2uN0 Rectal Cancer

PI: Julio Garcia-Aguilar, MD

- **Z1031**—A Randomized Phase III Trial Comparing 16 Weeks of Neoadjuvant Exemestane (25 mg daily), Letrozole (2.5 mg daily) or Anastrozole (1 mg daily) in Postmenopausal Women with Clinical Stage II or III Estrogen Receptor Positive Breast Cancer

PI: Matthew Ellis, MD

ACOSOG—Call for concepts

ACOSOG's success rests on meeting the clinical research needs of its members. Please let us know your thoughts on where future ACOSOG research agendas should focus.

ACOSOG vision: To improve the care of the surgical oncology patient through innovation and research.

ACOSOG scientific themes (protocol-specific examples):

1. **Surgical innovations:**

Z6041—Local Excision and Neoadjuvant Chemoradiation for Early Rectal Cancer

0360—Sentinel Lymph Node Mapping and Lymphadenectomy for Oral Cavity SCCa

2. **Novel preoperative and postoperative adjuvant therapies:**

Z1031—Neoadjuvant Aromatase Inhibitors in Breast Cancer

Z9001—Adjuvant ST1571 vs. Placebo following Resection of Primary GIST

3. **Management of early stage disease and micro-metastases:**

Z4031—Proteomic Analysis for Detection of Non-Small Cell Lung Cancer

Please send your ideas on studies you would like us to consider. We will review your ideas and provide feedback. We will consider whether the idea fits ACOSOG's vision and themes, the vision of the Cancer Therapy Evaluation Program, and whether the proposed study would be feasible and original. The top 50 percent of ideas will be submitted to the organ site leadership and committees for consideration. Thank you and we look forward to hearing from you.

Contact information:

Name: _____ Institution: _____

Phone/fax: _____ E-mail: _____

Study concept: Please include the study question and disease group and describe the best match for one of the three themes above. Please keep your concept proposal limited to the space provided below.

Send to: Beth Martinez at marti025@surgerytrials.duke.edu, or fax 919/668-7156

NTDB™ data points

The National Sample Project: A new application of the NTDB

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

Last year, the American College of Surgeons was awarded a contract from the Centers for Disease Control and Prevention (CDC) to develop a nationally representative sample of U.S. trauma centers. This National Sample Project (NSP) will enhance the National Trauma Data Bank™ (NTDB) by providing population-based data that will be used to make statistically valid inferences about patients cared for in Level I and II trauma centers.

The NSP data will be collected from 100 randomly selected Level I and II centers located throughout the four census regions in the Northeast, South, Midwest, and West (see figure on this page).

To do this, the ACS has contracted with Dr. Paul Levy and his colleagues at Research Triangle Institute in North Carolina to provide technical expertise on sampling methodology. Dr. Levy has authored publications on population sampling* in addition to contributing statistical methodology for trauma system evaluation and injury severity scoring.

The NSP will be used to

*Levy PS, Lemeshow S. *Sampling of Populations: Methods and Applications*. New York, NY: John Wiley & Sons; 1999.

NSP trauma centers by census region

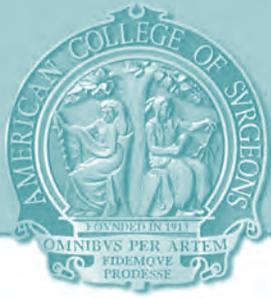


calculate important rates and incidence measures that describe trauma care and clinical outcomes. It will also provide baseline data and allow reliability in computing national estimates with high confidence.

Throughout the year, we will be highlighting the work of the NTDB 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.



The American College of Surgeons
presents

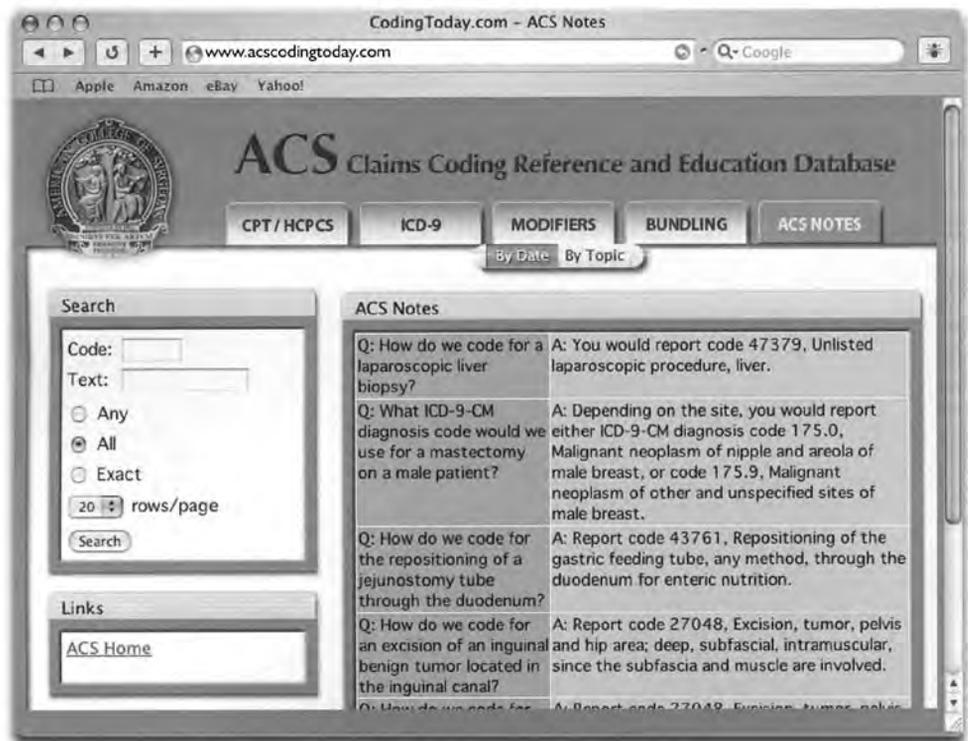
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Chapter news

by Rhonda Peebles, Division of Member Services

To report your chapter's news, contact Rhonda Peebles at 888/857-7545, or via e-mail at rpeebles@facs.org.

Chapters continue support for the College's funds

During 2005, 26 chapters contributed a total of \$38,665 to the College's endowment funds. The chapters' commitments to the various funds support the College's pledge to surgical research and education. Chapters can contribute to several different funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Fund. The chapters that contributed during 2005 include:

*R. Gordon Holcombe, MD, FACS, Chapter Award**: Louisiana

*Life Members of the Fellows Leadership Society (FLS)***: Arizona, Southern California, Florida, Illinois, Maryland, Nebraska, Brooklyn-Long Island (NY), Ohio, South Carolina, and North Texas

Annual Members of the Fellows Leadership Society: Alabama, South Florida, Georgia, Metropolitan Chicago, Indiana, Massachusetts, Michigan, North Carolina, North Dakota, Metropolitan Philadelphia, Southwestern Pennsylvania, South Dakota, and Virginia

Contributors: Southwest Missouri, Montana-Wyoming

Lebanon Chapter hosts 11th Clinical Congress

During the week of September 8, 2005, the Lebanon Chapter hosted the country's 11th Clinical Congress, which was held in Beirut at the Mövenpick Hotel and Resort. The education program also was sponsored by the Lebanese Society for General Surgery, the Lebanese Society of Urology, and the Lebanese Society of Vascular

*The R. Gordon Holcombe, MD, FACS, Chapter Award was established in 2004 for chapters that have contributed \$100,000.

**The FLS is the distinguished donor organization of the College. Chapters that contribute at least \$1,000 annually are FLS members. Chapters that have contributed \$25,000 are FLS Life Members.



Lebanon Chapter, left to right: Chahine Abousleiman, MD, FACS, Past-President; Wihbi Shuayb, MD, FACS, Governor; Mario Aoun, MD, president, Lebanese Order of Physicians; Mohamad Khalifeh, MD, FACS, Ministry of Public Health of Lebanon; Michel Daher, MD, FACS, President; and Wassim Wazzan, MD, president, Lebanese Society of Urology.



Connecticut Chapter, left to right: Bob Pirokowski, MD, FACS, Chair, Commission on Cancer; Scott Kurtzman, MD, FACS, President; Christopher Tasik, Executive Director; Orlando Kirton, MD, FACS, Secretary; Gary Bloomgarden, MD, FACS, Immediate Past-President; Philip Corvo, MD, FACS, Vice-President; Kathy LaVorgna, MD, FACS, Chair, Legislative Committee; Dr. Longo, Treasurer; Ken Ciardiello, MD, FACS, Chair, Awards Committee; and Carlos Barba, MD, FACS, Co-Chair, Bariatric Committee.

Surgery. More than 340 participants attended the Congress, which featured speakers from Europe and the U.S. In addition, a Residents Competition was held and the winning paper by Ghassan Slelati, MD, was presented at this meeting. (See photo, page 46.)

Connecticut approves changes

At its annual meeting in November 2005, members of the Connecticut Chapter agreed to form a

new tax-exempt organization in order to further the chapter's advocacy mission. During the annual meeting, new officers were elected (see photo, page 46) and a new leadership position, Chapter Historian, was created. An extensive Residents Competition was held, which featured papers on trauma, general surgery, bariatric surgery, and other surgical specialties. In addition, for the first time, a large group of physician assistants also conducted a paper competition.

Before concluding the annual meeting, a

Chapter meetings

For a complete listing of all of the ACS chapter education programs and meetings, please visit the ACS Web site at <http://www.facs.org/about/chapters/index.html>.

(CS) following the chapter name indicates a program cosponsored with the College for Category 1 CME credit.

February 2006		
Date	Event	Location/contact information
February 11	Utah (CS)	Location: Park City, UT Contact: Teresa Holdaway, 801/355-7477
February 23–25	South Texas (CS)	Location: Hilton Houston Plaza, Houston, TX Contact: Christine S. Cocanour, MD, FACS, 713/500-7194
February 24–25	North Texas (CS)	Location: Cityplace Conference Center, Dallas, TX Contact: Joseph Kuhn, MD, FACS, 214/824-9963
April 2006		
April 7	New York (CS)	Location: Rye Town Hilton, Westchester, NY Contact: Heather Bennett, JD, 518/433-0397
April 21–22	North and South Dakota (CS)	Location: Mitchell Holiday Inn, Mitchell, SD Contact: Terry Marks, 605/336-1965
April 28–30	Virginia (CS)	Location: Kingsmill Resort, Williamsburg, VA Contact: Susan McConnell, 804/643-6631
May 2006		
May 3–6	Chile	Location: Hotel Sheraton, Santiago, Chile Contact: Pedro Uribe Jackson, MD, FACS, 562/264-1878
May 6	Northern California (CS)	Location: Crown Plaza Hotel, San Francisco, CA Contact: Annette Bronstein, 650/992-1387
May 8	Metropolitan Philadelphia (CS)	Location: Union League of Philadelphia, Philadelphia, PA Contact: Lauren Brinjac, 888/633-5784
May 11–13	West Virginia (CS)	Location: The Greenbrier, White Sulphur Springs, WV Contact: Sharon Bartholomew, 304/598-3710
May 26–29	Florida (CS)	Location: Gasparilla Inn & Cottages, Boca Grande, FL Contact: Robert Harvey, 904/384-8239

Residents' "Jeopardy" was conducted; it was moderated by Walter Longo, MD, FACS, who also served as the Continuing Medical Education (CME) Program Chair for the chapter.

The paper competition and Jeopardy winners included the following

Physician Assistants Competition: Andrea Forgione, PA-C, Clinical Assessment and Diagnosis of Acute Pulmonary Embolism

Bariatric Surgery: Syed Ali, MD, A Technique for Preventing Port Site Complications in Laparoscopic Adjustable Gastric Banding

General Surgery: Suma Magge, MD, A Prospective Evaluation of the Utility of Computed Tomography Scans in Patients with Abdominal Pain in the Emergency Department

Surgical Specialties: Reynold I. Lopez-Soler, MD, PhD,* Development of a Mouse Model for Evaluation of Tissue Engineered Human Vascular Grafts

Trauma: Jeremiah T. Martin, MD,* "Normal" Vital Signs Belie Occult Hypoperfusion in Geriatric Trauma

Brief Clinical Reports: Stacie Perlman, MD,* Management of the Negative Frozen/Positive Permanent Sentinel Lymph Node in Breast Cancer Patients

Case Reports: Jared C Frattini, MD,* Sclerosing Epithelioid Fibrosarcoma of the Cecum: A Case Report

Resident Jeopardy Winners: Bolanie Asiyanbola, MD,* Jeremiah Martin, MD,* Fuad Alkhoury, MD*

*Special Five-Year Award**:* Fadi Abou Nukta, MD

During the annual luncheon, members were entertained by the musical presentation "Damaged Care," written and presented by Greg LaGana, MD, and Barry Levy, MD.

Surgeons (aged 45 years or younger), and their Chapter Administrator or Executive Director. The College's office in Washington, DC, will schedule Capitol Hill visits for Tuesday, June 13, for all chapters that participate.

Correction

In the December 2005 Chapter News column, the name of one of the winning residents from the Michigan Chapter was omitted. In addition to Dr. Arora, Almaas Shaikh, MD,* also won the Frederick A. Collier Award. This winning paper was entitled "Stress-Induced Regulation of Circulating Ghrelin Levels in Rats: Role in Gastric Motility."

Chapter anniversaries

Month	Chapter	Years
January	Northern California	54
	Louisiana	54
February	Arizona	54
	Australia–New Zealand	21
	South Florida	52
	Iowa	38
	Italy	20
	Lebanon	43
	Eastern Long Island, NY	38
	Montana–Wyoming	41
Peru	29	
South Korea	19	
Washington State	54	

2006 Leadership Conference: *Save the dates!*

The 2006 Leadership Conference will be held June 11–13 at the Washington Court Hotel in Washington, DC. Chapters are encouraged to send their Chapter Officers, two to three Young

*Denotes Resident Member of the College.

**An award given to a resident who has presented a winning paper for five consecutive years.