NEW ACS PROGRAM
ACCREDITS
EDUCATION INSTITUTES
FEATURES

Accreditation of education institutes by the American College of Surgeons: A new program following an old tradition 8
Carlos A. Pellegrini, MD, FACS, Ajit K. Sachdeva, MD, FACS, FRCSC, and Kathleen A. Johnson, EdM

A new tool for professional development: The ACS Case Log System 13
Karen Sandrick

ACS and AMA: Different organizations working together 18
Jon H. Sutton

In their own words:
Serving as an ACS delegate to the AMA 22
LaMar S. McGinnis, Jr., MD, FACS

Surgical lifestyles:
Cross-country cancer advocacy on a bicycle 25
Karen Stein

Ten specialty boards report accomplishments and plans: Part I 29

DEPARTMENTS

From my perspective 4
Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director

Dateline: Washington 6
Division of Advocacy and Health Policy

Socioeconomic tips 40
New Medicare appeals process
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Future meetings

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

On the cover: The College introduces a new program to accredit education institutes (see article, page 8). Photo courtesy of Punchstock.
NEWS

In memoriam:
Remembering Oliver H. Beahrs
Thomas R. Russell, MD, FACS

FLS recognizes donor contributions to the College’s Foundation

ACS German Traveling Fellowship available for 2007

Trauma meetings calendar

ACOSOG news: ACS surgical trial accrual campaign: Get involved, make a difference

Trauma and Critical Care–Point/Counterpoint to be held in June

A look at the Joint Commission: Shared visions—new pathways

ABS elects three Fellows as at-large directors

NTDB™ data points:
For whom the bell tolls?
Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

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

**Objectives**
At the end of the course, the participants will be able to describe:
- The essentials of personal financial management as they relate to young surgeons in practice and residents and their families.
- The impact of interest rates and time upon loans, compound interest, and the implications for debt management.
- The building blocks necessary for the surgeons to invest successfully.
- The importance of time in reducing the risk of investing.
- The basics of mutual funds, stocks, bonds, and other investment vehicles.
- How to evaluate and choose a financial advisor.

**Intended Audience:**
- Surgical residents and surgeons recently in practice.

**Intended Audience:**
- Surgical residents and surgeons recently in practice.

Orders may be placed through ACS Customer Service at 312/202-5474 or via the College’s Web site at: www.acs-resource.org
For more information contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354
From my perspective

Many of you share your views with me on the College’s response to your evolving needs through e-mails, letters, phone calls, or face-to-face contact at meetings. While you sometimes disagree with the organization’s position on certain issues, the general consensus is that we are moving forward, and overall, the College does an admirable job of providing appropriate services to surgeons.

The staff’s role
The reality of how the College works is that all of you suggest through your representatives on the Board of Governors how we can improve our programs and services, and, as our policymaking body, the Board of Regents determines which of your ideas should be implemented. It is my responsibility, then, to ensure that the Regents’ directives are carried out. Ultimately, though, it is the staff of the College who do much of the actual work in terms of developing advocacy strategies, communicating with the public, planning educational programs, processing membership applications, and carrying out the policies established by the Board.

The College is structured around four key divisions—Education, Advocacy and Health Policy, Member Services, and Research and Optimal Care—as well as several support areas, including Communications, Executive Services, Convention and Meetings, Finance and Facilities, Human Resources, and Information Technology. Each of these areas comprises individuals who are highly competent in fulfilling their responsibilities and dedicated to this organization. Many of our nearly 200 employees have sought further education and training in their fields to help them do their jobs better. Some are willing to work late into the night or on the weekends to complete an assignment. Their commitment to a job well done is unquestionable.

Dedication
Quite a few of the College’s employees have devoted most of their careers to serving this organization’s members and to carrying out our mission of improving care for the surgical patient. In fact, several staff members have been here for more than a quarter of a century. Even so, the College continues to develop new positions that appeal to young people. Hence, we have a nice balance of employees who have an in-depth familiarity with the organization and of new staff who can provide a fresh perspective.

Fortunately, the College has developed a track record of staff stability. In the last year, we hired 30 new employees and had 17 terminations, making the turnover rate about 8 percent.

Morale appears to be high, with employees expressing enthusiasm about their work and their environment. And what amazes and pleases me most is that this staff exhibits an esprit de corps not found in many workplaces. Although each area has its own projects and expertise, there is considerable overlap, and our employees demonstrate remarkable cooperation in getting the job done. Many of our employees don’t just “do a job”—they embrace and believe in the programs they work to support, such as the Advanced Trauma Life Support® course and the National Cancer Data Base, among others, because they believe they are contributing to improvements in patient care.

Compassion
The individuals who work for the American College of Surgeons are committed to doing good deeds not only for the College but for other not-for-profit organizations as well. We have had food and clothing drives as well as collections of eyeglasses for the Lions Club and cell phones for victims of
domestic violence. Several employees have participated in walks, runs, and bicycle rides to raise money for medical research programs.

Our employees have continually shown compassion for their colleagues and associates, as well. For example, when one of our employees became quite ill last year, some of his coworkers coordinated a raffle to raise money to cover some of his expenses. When he lost his fight against cancer, this young man’s family was overwhelmed with the outpouring of support the staff offered.

Likewise, many of the College employees were saddened to learn of the devastating effects of Hurricane Katrina on New Orleans, LA—a city they’ve enjoyed visiting and working in during Clinical Congresses. To help with relief efforts, the College’s employee organization, the Career and Personal Development Program (CPDP), decided to donate some of the funds that are normally used for the annual employee holiday luncheon to the New Orleans Convention Bureau and Habitat for Humanity.

**Enriching their lives**

In addition to expecting our staff to be knowledgeable about their own areas of expertise here at the College, we also want them to be familiar with all the programs the College has in place for its members and the public. We also encourage our employees to expand their own personal knowledge base on topics that will assist them in their jobs and personal lives. As a result, CPDP sponsors a number of educational programs on topics such as financial management, working with others, and the arts, to name just a few, and also plans some social events for staff during the year.

To remain viable in the Chicago and Washington, DC, marketplace, the College offers our employees competitive salaries and retirement savings plans, and strong medical, dental, and life insurance policies. In addition, we encourage the staff to lead healthy lifestyles by offering them the opportunity to participate in nutrition, Weight Watchers, and other physical fitness programs sponsored at nearby facilities. And, we have instituted an Employee Recognition Award program to recognize those individuals who go above and beyond the call of duty to complete a task or to develop a more efficient or cost-effective way of handling a project.

**A great team**

Over the course of my six-plus years as Executive Director of the College, it has been my great pleasure to work with the staff, and I wanted to take this opportunity to let all of you know about the fine individuals who work for this organization. They make my job so much easier. We should all take great pride in their efforts and their willingness to come together as a team to help provide us with the services we need to better care for our patients. They are the reason why the College works and works well.

As we look to the future, it is important to note that our job is not done. The surgical profession and the American College of Surgeons are facing incredible challenges. We must continue to change with the times and to implement new programs, interact with new groups, and participate in the process of assessing and evaluating the quality of care. In other words, the College must continue to evolve and change so that we as an organization can continue to better serve our members and their patients. A recent example of a new and important endeavor the College is undertaking is the development of a building in Washington, DC, so that a united physical presence for all of surgery can be established near Capitol Hill. A related activity will be the creation of a Health Policy Institute in cooperation with all of the surgical specialty societies that will endeavor to proactively and positively address the many perplexing issues facing the surgical profession today.

We are fortunate indeed that as we move into the future, our strong staff of dedicated professionals will ensure that we will be able to succeed in achieving our goals. If you have comments about our staff or the work they are doing on your behalf, please don’t hesitate to let me know.

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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.
In a January 6 letter to Bill Thomas (R-CA), Chair of the House Ways and Means Committee, the Centers for Medicare & Medicaid Services (CMS) outlined steps for implementing a new fee schedule update for 2006, if and when Congress takes final action on the Deficit Reduction Act. That legislation, which did not obtain final passage before Congress adjourned for the holidays in December 2005, includes a proposal to replace the current 4.4 percent payment reduction with a freeze at 2005 payment levels.

According to CMS, Medicare contractors should be able to process claims at the higher 2005 rates starting within two days of enactment of legislation. In addition, Medicare contractors will be instructed to automatically reprocess claims already paid under the −4.4 percent update that took effect January 1. Because of the potentially large backlog of claims that will require reprocessing, CMS anticipates that this procedure may take until July 1 to complete.

Because patient deductibles and copayments also would be affected by a change in the update, CMS consulted with the Office of the Inspector General (OIG) about potential implications of federal fraud and abuse laws related to improper beneficiary inducements if physicians waive additional cost-sharing amounts resulting from a retroactively applied payment increase. The OIG determined that such waivers should not pose a problem. Finally, CMS announced a second 45-day enrollment period following enactment of legislation to allow physicians to reconsider their Medicare participation status for 2006.

At press time, it was anticipated that Congress would reconsider the massive Deficit Reduction Act after reconvening January 31.

Despite a payment cut followed by largely flat Medicare reimbursement rates, the proportion of U.S. physicians willing to treat Medicare patients stabilized in 2004-2005. Moreover, nearly three-quarters of the nation’s physicians reported that their practices were open to all new Medicare patients, according to a national study conducted by the Center for Studying Health System Change (HSC).

More specifically, the HSC reports that in 2004-2005, 72.9 percent of physicians said they accepted all new Medicare patients, a statistically insignificant increase from 71.1 percent in 2000-2001. Physicians’ willingness to treat Medicare patients remained high, despite a 5.4 percent payment cut in 2002 that was not fully offset by smaller increases in subsequent years. Only 3.4 percent of physicians reported that their practices were completely closed to new Medicare patients in 2004-2005, also statistically unchanged from 2000-2001. The proportion of primary care physicians accepting new Medicare patients increased from 61.7 percent in 2000-2001 to 65.3 percent in 2004-2005; surgeons’ numbers remained unchanged at approximately 73 percent in both years. Of those physicians who turned away new Medicare patients in 2004-2005, 69.2 percent cited inadequate reimbursement as a moderately or very important reason. For details, please view the report, Physician Acceptance of New Medicare Patients Stabilizes in 2004-05, online at http://www.hschange.org/CONTENT/811/.
Members of Congress call for surgeon on MedPAC

In late December 2005, Reps. Charles Boustany, MD, FACS (R-LA), and Mike Thompson (D-CA) sent a letter to David Walker, the Comptroller General and head of the Government Accountability Office (GAO), asking him to appoint a surgeon to the Medicare Payment Advisory Commission (MedPAC). Only two surgeons have served on MedPAC since its inception in 1997, and no surgeon has had a seat on the commission since 2002. MedPAC studies Medicare payment issues and makes recommendations to Congress regarding legislative solutions to problems. A total of 31 other members of the House of Representatives signed the letter.

The Comptroller General will announce his appointments for 2006 this spring. Given the many challenges facing surgeons under Medicare and the unique nature of surgery relative to other physician services, the College is working with members of Congress, the GAO, and the surgical specialty societies to ensure that surgery’s perspective is both represented on and understood by MedPAC. For a copy of the letter, please contact Shawn Friesen, Division of Advocacy and Health Policy, at sfriesen@facs.org.

Georgia General Assembly to consider CON amendment

The Georgia General Assembly is poised to consider legislation during its 2006 legislative session that would amend the state’s certificate of need (CON) law. Under the current statute, general surgery is defined as a multispecialty and, as such, is ineligible for an exemption that single specialties have from obtaining a CON when building ambulatory surgery centers.

For years, the College and the Georgia Chapter have disputed this aspect of the law through the courts and regulatory channels, filing amicus briefs, contacting elected state officials, and testifying at state hearings. In October 2005, Thomas Gadacz, MD, FACS, Georgia ACS Governor, testified before the state’s Study Commission on the Efficacy of the CON Program, and the College followed up with letters to every commissioner emphasizing the single-specialty definition of general surgery. A copy of this testimony is available at http://www.facs.org/ahp/testimony/state.html.

As part of its continuing advocacy efforts in this area, the ACS notified the governor and the state chamber of commerce that “it would be inappropriate for the College to consider Georgia as a location for any future meetings until this egregious policy is changed. If the State of Georgia cannot support surgery in this regard, then surgery simply cannot support bringing business into the state.” In addition, the College and the Georgia Chapter strongly support legislative efforts to amend the CON law to correctly define general surgery as a single specialty. Throughout the next few months, all Georgia surgeons will be asked to contact their state legislators through the Surgery State Legislative Action Center to support this legislation, which had not yet been introduced at press time. For more information, contact jsutton@facs.org.
Accreditation of Education Institutes
by the American College of Surgeons:
A New Program Following an Old Tradition

by Carlos A. Pellegrini, MD, FACS,
Seattle, WA,

Ajit K. Sachdeva, MD, FACS, FRCSC,
Director, Division of Education

and Kathleen A. Johnson, EdM,
Manager, Program for the Accreditation
of Education Institutes
and Experiential Learning Programs
The American College of Surgeons has had a rich tradition in leading major national efforts to enhance the care of surgical patients. Accreditation of clinical programs has been key to such efforts. The ACS played a pivotal role in establishing minimum standards for hospitals in 1917, which led to the creation of the Joint Commission on Accreditation of Hospitals. More recently, the College established programs to accredit trauma and cancer centers, which resulted in a major positive impact on surgical care and outcomes. However, until now, the ACS has not played a role in educational accreditation.

Major forces continue to exert an impact on the field of surgery and the professional activities of surgeons, surgical residents, and members of the surgical team. These forces include significant advances in science and technology, intense focus on patient safety and accountability, definition of the core competencies that all physicians must acquire and demonstrate throughout their careers, implementation of the program for maintenance of certification, and restrictions on resident duty hours. In addition, the pivotal role of education in changing physician performance and improving patient outcomes has received considerable attention. Other considerations have included the venues in which educational programs need to be offered, and the formats that result in optimum outcomes. State-of-the-art educational opportunities should be made available close to surgeons’ practices to facilitate participation and need to be just-in-time and clinically relevant. Facilities should be established and accredited to offer such education.

To address the aforementioned needs, the ACS Division of Education proposed to the Board of Regents in 2003 the concept of accreditation of education institutes, which would serve as regional sites where learners could acquire and maintain their skills—especially in new procedures, emerging technologies, and infrequently performed procedures—and would allow verification of knowledge and skills to confirm achievement of predetermined standards. Such institutes would offer College-sponsored and locally designed courses, and some institutes might pursue post-course preceptoring. The accreditation program would be voluntary. The ACS would accredit the institutes but would not own or manage these facilities.

The ACS Board of Regents received this concept very favorably and in October 2003 approved the appointment of an ad hoc committee to develop the model for accreditation of education institutes, which would be implemented by the Division of Education. The committee included individuals with expertise in establishing surgical skills centers and in surgical education. (See page 10 for a roster of committee members.)

Development of the accreditation program

The committee held its first meeting in March 2004. The members agreed that the goal of the accreditation program would be to establish a network of education institutes that would offer educational opportunities to practicing surgeons, surgical residents, medical students, and other members of the surgical team to address the spectrum of surgical skills and the core competencies and support efforts of surgeons to maintain their certification. The institutes would specifically address teaching, learning, and assessment of technical skills using state-of-the-art educational methods and cutting-edge technology.

Contemporary educational approaches would be used to ensure achievement of competence and development of expertise. The education institutes would use a variety of methods to achieve specific educational outcomes. These methods may include bench models, simulations, simulators, and virtual reality. The faculty at these institutes would ensure that participants achieve predetermined levels of knowledge and skills at the completion of various courses. Collaborative educational research would be pursued by the accredited institutes to advance the science of surgical education. Thus, the accreditation process would provide a unique opportunity to enhance the existing activities of skills centers that, at present, focus principally on minimally invasive surgery, and would create a national network of education facilities that would provide cutting-edge education under the aegis of the ACS Division of Education.

The committee also undertook the process of developing standards and criteria for accredita-
tion of education institutes. A key consideration was that the accreditation program should enhance educational opportunities without becoming cumbersome or onerous. The committee initially performed a thorough needs assessment. Information was obtained from the surgical education literature and existing surgical skills centers. In addition, background information was gathered from established educational accreditation programs, including those of the Accreditation Council for Graduate Medical Education, Accreditation Council for Continuing Medical Education, Joint Commission on Accreditation of Healthcare Organizations, and other professional societies, as well as from the Trauma and Cancer Programs of the College. The ACS general counsel provided input in the design of the accreditation program to address various legal issues proactively. The committee deliberated about a variety of educational and administrative issues. Based on the discussions, three standards for accreditation were defined by the committee:

- Standard I: Learners
- Standard II: Curriculum
- Standard III: Technological support and resources.

Furthermore, two levels of accreditation were proposed—Level I (Comprehensive) and Level II (Basic)—which would be based on these aforementioned standards and criteria. Institutes may apply for either level of accreditation.

Once the committee developed the draft of the standards and criteria, Richard Reznick, MD, FACS, FRCSC, chair of the department of surgery at the University of Toronto, and Helen M. MacRae, MD, FACS, FRCSC, invited the committee to visit the University of Toronto’s Skills Centre in November 2004 to develop benchmarks and further refine the standards and criteria. Additional benchmarking was made possible at a later date when Mark W. Bowyer, MD, FACS, extended an invitation to the committee to visit the National Capital Area Medical Simulation Center of the Uniformed Services University in May 2005. Both visits were very productive and helped to define the specific accreditation standards and criteria.

**Approval of the ACS program**

The accreditation model, including the standards and criteria, was presented to the Board of Regents in October 2004 for information and input. The Regents were enthusiastic about the...
A progress report was presented to the Regents in February 2005 and the program was formally approved by the Board in June 2005 for launch in fiscal year 2005-2006.

A mock survey was conducted in July 2005 to assess the operational aspects of the accreditation model and make final changes in the accreditation process. The University of British Columbia’s Centre of Excellence for Surgical Education and Innovation—under the direction of Richard J. Finley, MD, FACS, FRCS—was selected as the test site for the mock survey. The center’s staff completed the requisite forms and the center underwent a formal review using the established standards and criteria. Robert V. Rege, MD, FACS, and Lelan F. Sillin III, MD, MSEd, FACS, were asked to play the role of the surveyors. The survey process was conducted openly, with the entire committee in attendance. The committee observed each step of the process, and extensive debriefings were conducted between the committee members, the surveyors, ACS Division of Education staff, and the staff of the center. At the completion of the exercise, the accreditation model and process were deemed to be sound. Minor changes were made in the accreditation documents based on this experience. The accreditation model is depicted in the figure on this page.

Launch of the ACS program

The ACS Program for the Accreditation of Education Institutes was officially launched during the 2005 Clinical Congress in San Francisco, CA. A special general session was held October 17 to share key features of the program. Ajit K. Sachdeva, MD, FACS, FRCS, Director of the Division of Education, presented background information and discussed the educational underpinnings of the program. Carlos A. Pellegrini, MD, FACS, a member of the Board of Regents and Chair of the ad hoc committee, outlined the activities of the committee and highlighted key components of the accreditation model. He underscored the speed with which the model had been developed over a short period of 18 months. Dr. Pellegrini complimented the committee members and the Division of Education staff for their expertise and tireless efforts. C. Daniel Smith, MD, FACS, Dr. Rege, Dr. Sillin, and Daniel B. Jones, MD, FACS, who served as chairs for the subcommittees that addressed the specific standards and criteria, presented the rationale for these standards and criteria and described their use in accrediting institutions at Level I or Level II. Thomas R. Russell, MD, FACS, Executive Director of the College, was the invited discussant at this session. He emphasized the critical role of the College in accreditation activities and expressed his strong support for this new program, emphasizing its relevance and significance. The response from the attendees of this session was extremely positive.

In addition, Dr. Sachdeva was invited by the Board of Governors to present, during their meeting at Clinical Congress, an outline of the educational accreditation activities of the ACS, including this program and the new program for verification of knowledge and skills. The response from the Governors was also very positive.

Surveyors were recruited before the 2005 Clinical Congress and were invited to a half-day training session at the Congress. Fourteen surveyors from across the U.S. and Canada participated in this session. The training was conducted by Kathleen A. Johnson, EdM, Manager of the Program for the Accreditation of Education Institutes and Experiential Learning Programs, and Drs. Pellegrini, Rege, Sillin, and Qayumi. The goal of the training was to educate the new surveyors about the accreditation requirements, the roles of the
surveyors, and the documents that would be used by both the institution applying for accreditation and the survey teams.

The committee was dissolved following completion of its charge, which involved creation of the accreditation model. Two smaller review committees were subsequently appointed in February 2006 with approval of the Board of Regents. These committees are responsible for making the accreditation decisions. Dr. Pellegrini chairs both review committees and both are staffed by the same members of the Division of Education to ensure consistency in the accreditation decisions.

The applications for accreditation and the informational materials have been mailed to institutes that have requested these documents. In addition, these documents have been posted on the ACS Web site, www.facs.org, and can be accessed through the Web page of the Division of Education. With support from Communications and Information Technology Services, an interactive Web page is being developed to facilitate dissemination and collection of accreditation materials and information on the ACS accredited institutes’ activities.

**Applying for ACS accreditation**

There are many reasons for education institutes to apply for ACS accreditation. The institutes will play a pivotal role in the Division of Education’s efforts to offer regional and local educational support to practicing surgeons, surgical residents, medical students, and members of the surgical team. The institutes would be involved in the development and implementation of innovative, cutting-edge educational programs to address the core competencies and would support surgeons in their efforts to acquire and maintain their surgical skills and meet the requirements for maintenance of certification. The institutes would also be involved in collaborative educational research and development conducted under the aegis of the College. They may serve as demonstration sites for certain new educational technologies, including simulators and simulations. Thus, the ACS Accredited Education Institutes would have the potential to dramatically change the way surgical education is delivered in the U.S. and Canada.

With the creation of this educational program of accreditation, the American College of Surgeons has reaffirmed its commitment to the education of surgeons from all specialties, following a long-standing tradition of establishing and monitoring standards that result in enhancement of the care of the surgical patient.

For further information about the ACS Program for the Accreditation of Education Institutes, please contact Dr. Sachdeva at asachdeva@facs.org, or Ms. Johnson at kjohnson@facs.org.

**Dr. Pellegrini** is Henry N. Harkins Professor and chair, department of surgery, University of Washington, Seattle, and a member of the Board of Regents.
A new tool for professional development:

The ACS Case Log System

by Karen Sandrick, Chicago, IL
or busy surgeons, maintaining an up-to-date case log system is frustrating and time-consuming. Electronic practice-based systems for logging case data tend to be designed for internists to keep track of the medical care of patients, so the software does not include fields for reporting details about surgical procedures. Electronic medical record systems for hospitals tally procedure and complication rates, but they focus on the institution, not individual practitioners, and they collect data for purposes of peer review in a confidential, protected environment that does not easily allow surgeons to access and track their own data.

Surgeons, therefore, are left to fend for themselves. Many surgeons are relegated to conducting paper chases of hard copies of patient records, scanning scores of entries to find and extract relevant data items, and tabulating procedure, morbidity, and mortality rates by hand. Or, they are forced to engage programmers to generate their own database management systems.

After all that effort, surgeons often still have no clear picture of their clinical outcomes, how their outcomes compare with those of other surgeons, and where and how they may take advantage of educational opportunities to improve the surgical care of patients within the framework of their specific day-to-day practices—not to mention how they may meet new certification requirements of the American Board of Medical Specialties.

But these challenges are about to be made simpler. At the 2005 Clinical Congress, Fellows were introduced to the American College of Surgeons Case Log System, which will help them uncover clinical practice data now buried in office paper-based files and coalesce information that is scattered in several hospital information systems. Since that time, more than 200 surgeons have accessed the system, entering more than 6,500 cases. By providing a quick and easy mechanism for collecting patient and outcomes information, the Case Log System will allow surgeons to gather practice data in an ongoing and systematic way so they can begin to accurately monitor their treatment patterns, identify clinical and knowledge-related areas for improvement, and choose educational programs best suited for honing the skills they believe they need to acquire.

**A mechanism to compare clinical outcomes**

The Case Log System will be a mechanism for addressing the first and last steps of the quality improvement cycle: discovering possible areas for improvement and how educational activities have led to improvement. “The Case Log System is groundbreaking,” said M. Michael Shabot, MD, FACS, vice-chief of staff, director of the Surgical Intensive Care Unit, and director of Enterprise Information Services at Cedars-Sinai Medical Center, Los Angeles, CA, and member of the ACS Committee on Education. “All surgeons can do nowadays is compare their clinical outcomes to results from a study in the literature, but studies are different from normal surgical practice. This system will provide masses of de-identified data for individual surgeons to use to assess their outcomes in comparison with other surgeons in a pooled database,” he added.

The system will capture information on a surgeon’s patients and upload them into the surgeon’s own private data store. The data will be processed to remove any information that may identify the patient or the surgeon, and they will be gathered in a central database that can be mined to analyze outcomes for a large group of surgeons. The system can be used by individual surgeons to discover how their practice or outcomes may differ from those of their anonymous peers.

The system will streamline the process of case log reporting for surgeons by generating simple reports about mortality and complication rates, including the percentage of deaths or cases that had complications organized by procedure and a breakdown of the procedures a surgeon performs by category.

“If half of our 25,000 to 30,000 general surgeons enter data about their gallbladder surgeries in the Case Log System, the College in a short period of time might accumulate data on 50,000 or 60,000 procedures,” Dr. Shabot said. “Then, a surgeon who does 30 gallbladder operations in a year could compare his or her outcomes, such as the number of wound infections or the rate of complications adjusted for risk factors like cardiac disease, against a very large distribution of
de-identified patients in the College’s database. They could also compare their mortality rates after cholecystectomy for all patients between the ages of 50 and 60 who had no cardiac disease. There is no other way to do that today.”

Surgeons also may compare their caseloads against national trends. “Surgeons may look at their case logs and find they’ve done 100 colon resections in the past six months and many were open procedures, whereas nationally the trend is toward laparoscopic colon resection. They may then decide they don’t have the skills or the confidence or both to do laparoscopic colon resection and feel the need to seek educational opportunities to fill that gap,” Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the Division of Education, said.

The system also can be used to determine changes in level of performance before and after participating in an educational program, Dr. Sachdeva explained: “Once surgeons apply new knowledge and skills to their practice, they could check for improvement with the Case Log System as part of the practice-based learning and improvement cycle. Surgeons would look at outcomes using the Case Log and determine whether they have improved, or, in the case of a new skill, what their new performance level is in comparison with national data.”

A new type of education

The Case Log System is the cornerstone of a four-part, practice-based learning and improvement cycle that supports the concept of just-in-time learning in the actual practice environment by (1) identifying areas for improvement, (2) engaging in learning, (3) applying new knowledge and skills to practice, and (4) checking for improvement.

“The key to all future surgical education for practicing surgeons is education in context, and the context is the clinical care they are providing their patients in their practice,” Dr. Sachdeva said. “Learning for practicing surgeons begins and ends at the bedside with the patient. That is where the educational opportunities are identified and where new knowledge and skills are applied—at the front lines.”

Rather than standard continuing medical education (CME)—which is episodic, directed at groups of individuals, and driven by teachers—continuous practice-based learning and improvement is a lifelong exercise that addresses the specific needs of each learner, and it is centered on and controlled by the learner, as explained by Dr. Sachdeva in an article in the Archives of Surgery.* Whereas CME focuses on clinical topics in formal lectures or conferences, continuous professional development covers issues in practice management, leadership, administration, and education as well as clinical concerns. Continuous professional development also makes use of a wide variety of educational media, including interactive large and small group exercises, discussions of actual cases in surgical care, and role-playing exercises. Instead of a single didactic CME course, continuous professional development engages in sequenced learning that continually applies and builds on new knowledge and skills. Practice-based learning and improvement

also offer academic detailing in which experts work individually with surgeons to promote desired changes in practice, meetings and discussions with opinion leaders in surgery, and audits of a surgeon’s practice with feedback.

**Directed by surgeons**

The Case Log System is wholly surgeon-directed. Each surgeon will own his or her data. The participation agreement that a surgeon signs to become involved in the Case Log System clearly specifies that the surgeon controls all data that contain identifying information, in the same way every surgeon controls the data accumulated in his or her office. “The Case Log System has no identifying information to provide any legal agency or court; it has only bulk de-identified data from many surgeons,” Dr. Shabot said.

Each surgeon will determine how he or she will use the information the Case Log System provides. “Following the principles of continuous professional development, we want the onus to be on the surgeon himself or herself,” said Dr. Sachdeva. “Learning has to originate at the surgeon’s level, so the surgeon has to decide where gaps may lie and what he or she needs to do to close them,” he added.

Once surgeons identify an area for improvement, they will be able to seek out learning activities that match their personal practice concerns with targeted educational modules, including electronic learning programs on the Web, CD-

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**Using the Case Log System**

The Case Log System technology is straightforward, so it will be simple and easy to use. There are two options for entering cases: through a personal digital assistant (PDA), or through a Web site. Cases entered on a PDA are transmitted to the Web site during a “hot sync.” Surgeons who don’t have PDAs can use the Case Log System solely as a Web-based program.

With software or Internet access, surgeons will be ready to begin entering data elements, such as diagnoses, procedures, preoperative risk factors, comorbidities, complications, and outcomes.

The most difficult aspect of data entry—coding each case—has been simplified. As Howard Tanzman, Director of ACS Information Technology, pointed out, there are approximately 15,000 procedure codes and more than 10,000 diagnosis codes. “Although surgeons deal with only a small subset of diagnosis codes, each one deals with a different subset; we had to design a system that would be generic for everyone but didn’t require any given surgeon to peruse 15,000 codes to find the one that’s appropriate for a particular case,” Mr. Tanzman said.

To address the problem, the Case Log System remembers the codes as the surgeon submits them. “After a surgeon enters 15 or 20 cases, the system will present a list of those codes as choices. That will make the initial processing of entering cases much easier,” Mr. Tanzman said.

Case Log System software also allows surgeons to enter their own descriptions, or nicknames, along with specific codes. For example, if a particular Current Procedural Terminology (CPT)* code has a six-word technical description, Mr. Tanzman added, “The surgeon can just replace that description with user-friendly words, such as ‘breast biopsy.’”

The actual data-entry process should take only a matter of minutes in the operating room, the recovery room, or the office. “Surgeons have a lot of waiting time in the operating room while cases turn over and patients are going under anesthesia. With the PDA they carry around in their pocket, surgeons can enter case data before they are ready to scrub or in the five to 10 minutes at the end of a case [while] waiting for the patient to wake up,” Dr. Shabot explained. Or, they can enter the data from any computer with Internet access.

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*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2005 American Medical Association. All rights reserved.
ROMs, hands-on courses, proctoring and preceptoring, symposia, and self-study programs. “We are going to offer surgeons a range of educational options that would tie in with identified gaps in knowledge and skills and make them easily accessible, especially over the Web,” Dr. Sachdeva said.

Proof of participation in these educational activities may be used by surgeons to maintain their certification with the American Board of Medical Specialties, which, as of July 1, 2005, now requires surgeons to demonstrate a commitment to lifelong learning and self-assessment by participating in CME and self-assessment evaluation through the Surgical Education and Self-Assessment Program (SESAP) and to evaluate their performance in practice. It is up to the individual surgeons to initiate the process, but the College will assist and facilitate surgeons toward that end. According to Dr. Sachdeva, “The American Board of Medical Specialties’ role is to certify; our [ACS’] role is to support and encourage people to get to that level. Therefore, we will not funnel information directly to the board. We will provide surgeons with information and tools they can use for the maintenance of certification process as they deem appropriate.”

Future applications

Down the road, the College will work to identify databases that may be suitable for statistically significant benchmarking. Many of the current databases are not risk-adjusted, so even though they have outcomes information, they do not indicate the risk status of the patient and therefore cannot provide accurate benchmarking information. Databases that do adjust for patient risks are statistically valid only at the institutional or departmental level, not for individual surgeons. “We are going to explore a number of different databases that may provide benchmarking information, and some seem more promising than others. But a lot of work has to be done in the benchmarking area,” Dr. Sachdeva said.

The College also will continue to build its repertoire of electronic learning programs. Over the last several years, the College has created a host of educational products. In about a year, it will be able to give surgeons more guidance about finding these products and other external educational opportunities and building them into their effort to improve knowledge and skills. The objective is to link surgeons with educational programs to address their specific practice concerns when they feel the need to learn. “The Case Log System technological platform and educational products are integrated; they cannot be separated. And they are designed to support surgeon’s practice improvement efforts, not to set rules or regulations,” Dr. Sachdeva said.

Further information about the ACS Case Log System may be obtained via e-mail at caselog@facs.org.

Karen Sandrick is a freelance writer in Chicago, IL.
For almost 160 years, two Chicago-based physician organizations have significantly affected the medical landscape and developed standards for the provision of quality medical care. Not surprisingly, the American College of Surgeons has been more focused on surgical issues, whereas the American Medical Association (AMA) has addressed broader concerns. For the most part, they have maintained a collegial and collaborative relationship, most recently advocating together for legislation related to patient safety, medical liability reform, and physician reimbursement and value-based purchasing.

**College overview**

The American College of Surgeons was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The College was an outgrowth of a Clinical Congress originally convened in 1910 by Franklin H. Martin, MD, FACS, the founder and editor of Surgery, Gynecology & Obstetrics. An organizing committee of 11 stalwarts of surgery was appointed at a Clinical Congress in 1912 with the enthusiastic support
of the 2,500 surgeons in attendance, resulting in the official formation of the American College of Surgeons in 1913. John M. T. Finney, MD, FACS, was elected the first President of this organization.

The ACS currently is governed by a 22-member Board of Regents (including the President) that is elected by the geographically balanced and specialty-representative 265-member Board of Governors. The Board of Regents, which is composed of volunteer surgeons in active practice, meets three times a year and is responsible for the management and control of the College’s business affairs. As such, it is also the policymaking body of the organization (with input from the Board of Governors and 12 surgical specialty Advisory Councils).

The Governors act as a liaison between the Board of Regents and the Fellows, and as a clearinghouse for the Regents on general assigned subjects and on local problems. Every ACS chapter has at least one Governor, and the Board of Governors meets annually at the Clinical Congress.

**AMA policymaking process**

In contrast to the ACS, the AMA is governed by a Board of Trustees (BOT) elected by the House of Delegates (HOD). Thirteen trustees and eight officers comprise the membership of the financially compensated BOT, which is responsible for the broad oversight and management of the AMA, such as implementing policies and directives adopted by the HOD, as well as hiring an executive vice-president. Michael Maves, MD, MBA, FACS, currently serves in this capacity, and Fellows of the College who are on the Board of Trustees include Duane Cady, MD, FACS (chair of the board); John Armstrong, MD, FACS (Young Physicians Section trustee); Peter Carmel, MD, FACS; William Hazel, Jr., MD, FACS; and William Plested III, MD, FACS (president-elect).

AMA policy is determined by the HOD, which is composed of state medical society and national specialty society representatives. A total of 541 delegates are in the HOD (with a corresponding number of alternate delegates if filled by their respective societies). Delegates meet twice yearly to adopt resolutions and reports and conduct elections for officers, trustees, and council members. Reference committees provide a forum for hearings on resolutions and reports, giving any AMA member the opportunity to voice opinions about the issues facing medicine. Once reference committees complete their hearings, they write a report that the HOD acts on that includes recommendations reflecting testimony from the hearings.

**Review of the past**

The AMA was conceived on May 7, 1847, when 250 delegates from 28 states attended a founding meeting. At that time, they elected Nathaniel Brewer, MD, to serve as the first president. The organization was initially founded to address issues related to medical education, ethics, and the standardization of medical practice.
Chapman, MD, to serve as the organization’s first president. Present at this meeting was Nathan Davis, MD, a 30-year-old Illinois physician who went on to be AMA president (1864-1866) and the first editor of the *Journal of the American Medical Association* when it was founded in 1883. Business at the founding meeting included adoption of the first code of medical ethics and the first standards for both preliminary medical education and medical degrees.

With a growth in membership and an increase in activities affecting the medical profession and public health, the AMA reorganized in 1901 and officially created the HOD. In the ensuing years, delegates from state medical associations continued to meet to address myriad issues. To help with specialty-specific issues, 23 specialty section councils were formed in 1971. Seven years later, the AMA reorganized once again, and specialty societies were granted delegate representation in the HOD.

**Role of surgery**

Since the organization’s establishment, surgeons have provided critical leadership to the AMA. Leaders of the surgical profession and ACS Fellows who made their mark on the AMA include John B. Murphy, MD, FACS; Hunter McGuire, MD, FACS; Charles Mayo, MD, FACS; William Mayo, MD, FACS; Frank Lahey, MD, FACS; E. Starr Judd, MD, FACS; James Mason, MD, FACS; and Fred Rankin, MD, FACS. After the College was formally founded, both the ACS and the AMA sought to develop a collaborative relationship in addressing issues of interest to the profession, fully recognizing that they would “agree to disagree” on matters on which they had divergent opinions.

However, after each specialty society was granted a delegate in 1978, the College participated

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### ACS representation at the AMA HOD

- **Richard Reiling, MD, FACS, Charlotte, NC**, delegation chair
- **Charles Logan, MD, FACS, Little Rock, AR**, delegate
- **Amilu Rothhammer, MD, FACS, Colorado Springs, CO**, delegate
- **Chad Rubin, MD, FACS, Columbia, SC**, alternate delegate
- **Thomas Whalen, MD, FACS, New Brunswick, NJ**, delegate
- **Patricia Turner, MD, Washington, DC**, Young Physicians Section delegate
- **Jacob Moalem, MD, North Brunswick, NJ**, Resident and Fellow Section delegate

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**VOLUME 91, NUMBER 3, BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS**
for only one year. John Beal, MD, FACS, served as the College’s delegate, and Hiram Langston, MD, FACS, as the alternate. After one year of service, Dr. Beal resigned from his position, and in February 1980, the Board of Regents declined to nominate an ACS delegate.

At the Board of Governors’ request, G. Tom Shires, MD, FACS, then-Chair of the Board of Regents, provided an informational report to the Governors at their October 22, 1980, meeting. In this report, Dr. Shires described the factors that went into the Board of Regents’ decision that the “arrangement served no useful purpose and had serious disadvantages.” In part, these factors reflected a clash of organizational cultures and a sense of the “organizational inappropriateness of a single token representation for a group of more than 40,000 surgeons worldwide in an administrative component of a national general medical association to which at least 10,000 Fellows of the College and a full half of the U.S. physicians do not belong.” AMA’s increased focus on socioeconomic issues and differing views on efforts to restructure the Medicare physician payment system widened the distance between the two organizations during this period.

Although the College did not return to the HOD until 1992, surgeons continued to participate in the group, serving as delegates from their state medical associations or their respective surgical specialty societies. To provide a forum at each session of the HOD for discussion and recommendations concerning professional and socioeconomic issues of particular interest to surgeons, the Surgical Caucus of the AMA (SCAMA) was formed by a core group of surgeon delegates in 1989.

ACS returns to the HOD

During the College’s absence from the HOD, members of the Board of Governors would occasionally recommend that the College return to the HOD. Finally, in late 1991 the Board of Governors recommended, and in 1992 the Board of Regents approved, the College’s resumption of its seat on the HOD. Thus, in 1992, George Block, MD, FACS, was nominated to serve as the College’s delegate. LaMar S. McGinnis, Jr., MD, FACS, participated as alternate delegate, and moved into the delegate slot in 1994 upon Dr. Block’s death. Richard Reiling, MD, FACS, joined

Dr. McGinnis as the new alternate delegate, with Dr. McGinnis chairing the College’s delegation until the November 2005 meeting of the HOD. Since returning to the HOD, the College’s delegation has grown to four delegates and one alternate. In addition, the College sends a delegate to the Young Physicians Section and to the Resident and Fellow Section. As the College’s influence has continued to grow, it has been able to successfully represent surgical concerns. To that end, the ACS took on the responsibility of staffing the Surgical Caucus in 2004, and, more recently, the College achieved a first in sponsoring a candidate for election to the AMA Council on Medical Education. Dr. Reiling was elected in June 2005 to this important council and serves as the only surgeon member.

November 2005 interim meeting of the HOD

During the interim meeting of the AMA’s HOD in November 2005, the College’s delegation represented surgery’s perspective on a host of issues and policy decisions. At the top of the agenda was pay for performance/value-based purchasing, with the HOD strongly supporting previously adopted AMA principles for these programs and opposing legislative or other related initiatives that continued on page 49

AMA pay-for-performance principles

Pay-for-performance programs must:

- Ensure quality of care
- Foster the patient/physician relationship
- Offer voluntary physician participation
- Use accurate data and fair reporting
- Provide fair and equitable program incentives

Resources for further information

ACS:
http://www.facs.org/about/about.html

AMA:

MARCH 2006 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
Serving as an ACS delegate to the AMA

by LaMar S. McGinnis, Jr., MD, FACS, Atlanta, GA

For the past 13 years, I have had the privilege of serving as one of the American College of Surgeons’ delegates to the American Medical Association (AMA). As the article by Jon Sutton on page 18 notes, the College and the AMA had a troubled relationship in the latter part of the twentieth century.

Background
The AMA first began to recognize medical specialties in 1971 with the formation of 23 specialty section counsels. In 1978, specialty society delegates were requested, and the College was represented by John Beal, MD, FACS, of Chicago, IL. For a variety of reasons, as mentioned in Mr. Sutton’s article, our relationship with the AMA became tenuous, and, in 1980, the College withdrew from the AMA House of Delegates (HOD). As a result, surgery had no official representation in the politically powerful AMA, and the void was widely noted. In 1990, the ACS President, M.J. Jurkiewicz, MD, FACS, and Director, Paul A. Ebert, MD, FACS, met with the surgical caucus that had formed in the HOD, and in 1991, the Board of Governors recommended to the Board of Regents that the College resume representation in the HOD.

The Board of Regents looked favorably on this recommendation, and in 1992 appointed George Block, MD, FACS, of Chicago as delegate and me as alternate delegate. Thus, after more than
a decade of absence at the AMA, one might say that the house of surgery resumed a presence in the historic house of medicine.

**Welcome back**

As Dr. Block and I would soon discover, our College is a centrist organization, led most ably by our Board of Regents. The AMA, on the other hand, is a representational democracy (the HOD) led by an elected Board of Trustees; the organization’s political activity is supported by allegiances and alliances of byzantine complexity with activities rooted in a century and a half of evolved relationships, carefully monitored by delegates with long tenures and who deeply protect and treasure the entrenched system. Dr. Block and I were thrown into this cauldron with little preparation and low expectations. When we asked Dr. Ebert how we should represent our College, his instructions were straightforward: “Think and act like a surgeon.”

The first meeting we attended was the December 1992 AMA interim meeting at the Opryland Hotel in Nashville, TN. This vast hotel was extensively decorated for the holiday season and heavily visited by scores of elderly persons, effusing at length about each decoration, making transit through the venue most difficult. As I was checking into the hotel, there was a tap on my shoulder. As I turned, Dr. Block greeted me with a handshake and remarked, “Welcome to hell.” Our initial AMA meeting required patience, persistence, and understanding on a number of levels.

Our return to the AMA was greeted with warmth and cordiality. Surgeons were especially forthcoming with their support and made it evident that the College’s absence had been deeply felt. Although we sensed a high level of acceptance, familiarity with the complexity of the full scope of activities was slow in coming. Unfortunately, just as we were evolving a rhythm in the process of becoming reacclimated, Dr. Block became quite ill and ultimately passed away. His death resulted in surgery’s loss of a superb leader and my loss of a great friend.

After Dr. Block’s death, I was appointed to serve as the College’s delegate, and Richard Reiling, MD, FACS, then of Ohio, joined me as alternate delegate. We immersed ourselves into this furor of AMA activity with the goal of representing our College and surgical interests at the AMA in a way that would advance quality surgical care for patients and maintain a favorable environment for the practice of surgery. We early on disavowed any interest in enmeshing ourselves or this organization in the AMA’s political intricacies.

Over the years, the ACS delegation has worked to cement relationships with those of the surgical specialties and with surgeons-at-large in the HOD. In addition, we have actively sought collaboration with other surgery-related organizations, such as the American Society of Anesthesiologists. Colleagues working together may often achieve more success than one organization working in isolation.

**Accomplishments**

Under the structure of the HOD, each organization is allowed one delegate per 1,000 AMA members from the specialty group. Over the past 12 years, our delegation has grown to four delegates and one alternate delegate.

Our delegates are now elected through the Board of Governors in a process similar to that of other volunteer leadership positions. Delegates serve up to three terms of three years each.

The AMA continues to grapple with the idea of increasing specialty society representation in the HOD, but concerns regarding further increasing the size of the house (541), plus some opposition from state society delegates, have kept this proposal in limbo. If this plan does fall into place, it is conceivable that our College representation could grow to 15 to 17 delegates.

The ACS delegation is the vital link between surgery and the AMA, with responsibility to report to the Board of Governors and to the Board of Regents on a periodic basis.

Delegates attend the HOD’s annual meeting in June and the interim meeting in November, spreading ourselves out among the various reference committees and offering testimony and comment, when appropriate, on as many as 300 resolutions plus council and Board of Trustees reports advanced for action before the HOD. We introduce resolutions on subjects of surgical interest and have been successful in gaining AMA action on items of relevance to surgery, such as defining expert witness qualifications, establishing principles for office-based surgery, instituting a study of specialty hospitals and their impact, forming a physician work group to develop solutions for the emergency/trauma care problems, and gaining...
consensus for appropriate reimbursement for the use of ultrasound technology.

College staff now provides support for the surgical caucus, which presents excellent, broad educational programs at each meeting on such subjects as pay for performance, disclosure of medical errors, professionalism, competency and surgical practice, and quality improvement.

The College’s delegation has become aware of the AMA’s significant sphere of influence. The organization’s reach is broad, affecting payment and coding through the AMA/Specialty Society RVS Update Committee and the Current Procedural Terminology Advisory Committee; accreditation through the Joint Commission on Accreditation of Healthcare Organizations, certification through the specialty boards, and graduate medical education through the resident review committees and the medical education boards. The AMA also has significant clout with governmental bodies, such as the Agency for Health Resources and Quality, the Centers for Medicare & Medicaid Services, and so on. Indeed, some analysts believe the AMA is the most influential medical advocacy group in Washington.

The AMA councils, such as those on education, science and public health, medical service, and ethical and judicial affairs, produce periodic reports of significant consequence and importance. The ACS delegation believes that surgical input into these activities is essential, and we support surgical candidates for these elective posts. Last spring, Dr. Reiling was elected to the AMA’s Council on Medical Education, our first College-sponsored candidate for election. His presence there will be most valuable.

Where we’re going

The AMA today, as managed by Michael Maves, MD, MBA, FACS, executive vice-president and chief operating officer, along with a most competent Board of Trustees, is a much improved, more streamlined, more focused, and more effective organization. It has embarked on a massive marketing campaign that is gaining traction by communicating with physicians and with the public. The AMA leadership has been making decisive, forceful moves that are changing and improving the face and the substance of the organization, while moving from an obsession with membership to one focused on accomplishment.

Our fractious past interaction is now dramatically more collegial, and this collaborative spirit bodes well for the future. ACS Executive Director Thomas R. Russell, MD, FACS, has been an influential advocate for collaboration and effecting this change. Surgical leadership at the AMA includes almost one-half of the past AMA presidents, including 11 of the 28 most recent top officers. These past-presidents include such noteworthy Fellows as John Warren, Samuel Gross, J. Marion Sims, Hunter McGuire, William and Charles Mayo, Frank Lahey, and Fred Rankin. This historic relationship deserves to be nurtured. Individually, the College and the AMA are potent, but, working together whenever possible, we have the potential to be a major force in ensuring the eminence of American medicine and surgery for the benefit of our patients.

Certainly the present times pose unique problems for surgical practice. These problems need solutions forged by medicine as a whole. The College’s AMA delegation is poised to represent surgical interests in a collaborative, effective manner and to help find solutions. Surgeons should consider carefully the significance of working with the AMA and should support both organizations through membership and active involvement. Both are powerful professional organizations with similar interests and commitments.

I am most grateful to our College for allowing me the privilege of serving as one of your delegates for these past 13 years and for your support in building a better relationship between the ACS and the AMA.
Surgical lifestyles:

Cross-country cancer advocacy on a bicycle

by Karen Stein, Associate Editor
The Tour of Hope—a 3,330-mile bicycle expedition across the country by a team of individuals who have been touched by cancer in some way—is organized through a partnership between Bristol-Myers Squibb and Lance Armstrong, a cancer survivor and the seven-time Tour de France winner. The Tour of Hope is meant to “invigorate and inform the public about the importance of participating in cancer clinical trials.”

Riding on the 2005 team was James Geiger, MD, FACS, of Toledo, OH, a pediatric surgeon at the University of Michigan Health System who has an academic interest in oncology and a research background in immunotherapy in cancer.

Before the Tour of Hope, which took place September 29 through October 8, Dr. Geiger had never biked in an event of similar scope. “I had done some road bike racing and a lot of recreational cycling,” Dr. Geiger explains, “but I’d never trained this intensely or done this amount of riding in a short time period.”

The 24 riders who participated this year were divided into four teams of six riders. According to the Tour of Hope Web site (www.tourofhope.org), during the nine days of the Tour of Hope, which began in San Diego and ended in Washington, DC, each team rode four to five hours per day.

Joining Dr. Geiger on his team were: Duke Browning, whose toddler daughter died seven months after being diagnosed with leukemia; Joan King, a cancer survivor and lecturer in the Vanderbilt University School of Nursing;
Becky Lamph, a survivor of thyroid cancer and whose daughter, now in first grade, is a leukemia survivor; Mona Patel, whose brother died of non-Hodgkins lymphoma and whose mother is currently battling breast cancer; and Jeff Tredup, a research scientist at Bristol-Myers Squibb who was diagnosed with thyroid cancer four years ago. Dr. Geiger says he learned a lot from each of his team members. “The thing that unites us all,” he says, “is an overwhelming desire to try to advance cancer research and clinical trials so that no one has to suffer from cancer.”

To train for this arduous ride, all participants on each team were assigned to work with a coach at Carmichael Training Systems. (The owner, Chris Carmichael, is Lance Armstrong’s coach.) According to Dr. Geiger, the training programs were based on individuals’ cycling backgrounds and strengths. “Being from Ohio, I had no mountains to train on,” Dr. Geiger says, “so I had to train for climbs by putting my bike on a stationary bike trainer at a 15-degree angle and the gears set at high resistance to simulate climbs.” Dr. Geiger says that this workout was very intense, with daily four-hour workouts and the expectation to reach target heart rate. Participants had to go online to see what they had to do each day. During his last few weeks of training, Dr. Geiger says, he was on the bike 18 hours each week. Although he sometimes worried if he was doing too much or not enough, he was heartened that his trainer had coached Tour of Hope participants previously. But Dr. Geiger also felt that through his surgical training, he was prepared for Tour of Hope training: “Surgeons are used to this—someone tells us to do something and we go do it, no questions.”

For Dr. Geiger, the roughest day was when the team rode through western Texas. “It wasn’t so much the terrain, but the road was very coarse concrete and really bumpy,” Dr. Geiger explains. “It was a killer stage. Temperatures hit highs of 110 degrees and winds were blowing at 25 miles per hour, right into our faces for the whole ride. Plus, we were behind in schedule and really trying to push it. We were drinking so much fluid.” But that was not the only stage that presented a challenge. “For the last three days, we had to ride at night through torrential rains from Tropical Storm Tammy. It was really scary to do this ride at night. But the roads on the route were picked very carefully for conditions such as traffic, so we couldn’t reroute. There was no avoiding the rain,” he says. On the flipside, the easiest riding was during the first stage, through the western part of the Arizona desert; although they rode for 110 miles, it didn’t feel like it for Dr. Geiger, who explains that they rode during the nighttime when it was cool, and everyone on the team was feeling fresh.

When each team finished a stage, participants would dismount at rally stops along the route, typically at a school or hospital. Each rally was different, Dr. Geiger says, and although his team rode the “midnight shift” and often arrived for rallies late into the night or early morning, there were always people there. “There were thousands of people at the rallies for other teams who arrived in the daytime,” he said, “but even at 1:00 or 3:00 am, we had a couple hundred people show up. It was nice, though, because at these smaller rallies, we had more interaction with the audience.” Dr. Geiger explains that the rallies often captured the local flavor, allowing riders to get a sense for the people and the area. “In El Paso, TX, our team had a really neat rally. Men dressed up in sheriff’s deputy outfits and the women wore western garb. But all the people were there to listen to us spread the word on cancer research.”

The rally audiences found out about events
through promotion by Bristol-Myers Squibb and its cancer partners—the American Society of Clinical Oncology Foundation, CancerCare, the Cancer Research and Prevention Foundation, C-Change, the Coalition of Cancer Cooperative Groups, the Lance Armstrong Foundation, the National Coalition for Cancer Survivorship, and the Oncology Nursing Society—and through the local facilities themselves. Riders were also tracked using global positioning system technology, so people visiting the Tour of Hope Web site could always know where riders were. “Some people would come out in their cars and watch us go by,” Dr. Geiger says. “And if we were riding through a town but not stopping, sometimes there would be electronic signs that welcomed us. It was a lot of fun to be acknowledged, and it was good encouragement.”

After each rally, buses would pick up the team and after receiving care from a massage therapist, team members would consume food and drink for recovery from the long ride and then try to sleep while being driven to the next spot. “We would often get into hotels and get three to six more hours of sleep,” Dr. Geiger says, “but within 20 hours, we were back on the bike.”

Aside from the terrain, Dr. Geiger’s biggest challenges were the sacrifices he had to make in his busy schedule because of the need to train so intensely for the event. He says that although the ride was much more difficult than he’d anticipated, it was worth the effort because the commitment of all who participated was obvious.

By the end of the tour, Dr. Geiger says, “Nobody could believe we would feel so good. We were exhausted, but we had gotten used to the routine of getting on the bike before the body had fully recovered.” As good as it felt, however, Dr. Geiger says, he was ready for it to be over. “At the final rally in Washington, DC, my immediate family—26 members—showed up. It was a really emotional experience because I hadn’t been in contact with too many people at that point.”

A member of the 2003 Tour of Hope team emceed the final rally. After introducing guests and partners, Lance Armstrong spoke about this year’s ride and Nine Days of Hope, a video that showed the riders on this year’s journey, was screened.

In lamenting the lack of investment in finding a cure for cancer, Dr. Geiger states that half a million people die of cancer each year, and funding for clinical trials at the National Cancer Institute is being cut. “It’s really short-sighted. This is an exciting time in cancer research. But if we don’t continue advocacy efforts, we lose the opportunity to bring the research to the patients.”

Thus, Dr. Geiger was particularly gratified by his participation in cancer advocacy, something he had never done previously. “I’ve certainly seen the magnitude of cancer on an individual basis—how cancer can take a patient’s life and how devastating it can be to a family,” he explains. “To interact with people like Lance Armstrong and to see survivors throughout the country reinforces even more what I’m doing in my professional life. I was able to have an impact on people in a new way other than as a cancer surgeon.”

Dr. Geiger was greeted on his arrival in Washington, DC, by his wife, Mary, along with two of his children, Catherine and Michael.
Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the Bulletin to keep Fellows and other interested readers abreast of any changes in the procedures of the various boards.

The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the Bulletin will feature the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Orthopaedic Surgery, the American Board of Plastic Surgery, and the American Board of Urology.

The April issue of the Bulletin will feature reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Surgery, and the American Board of Thoracic Surgery.
The American Board of Colon and Rectal Surgery

The American Board of Colon and Rectal Surgery (ABCRS) held its most recent annual meeting September 25, 2005, and its most recent interim meeting March 20, 2005, in Chicago, IL, at the Omni Hotel. Future meetings will take place at the same site through 2008. The schedule is as follows:


Officers/members of the board

The Board is now composed of 15 members. Nominations to fill vacancies come from the board and five other sponsoring organizations. The ABCRS nominates four members, the American Society of Colon & Rectal Surgeons nominates four, the American College of Surgeons nominates two, the Association of Program Directors for Colon and Rectal Surgery nominates two, and the American Board of Surgery nominates one. The ad hoc associate executive director is a board nominee who serves in a transitory capacity (without vote) and only in anticipation of the retirement of the executive director. Board members normally serve two four-year terms.

Herand Abcarian, MD, FACS, officially announced his plan to retire, as of September 2006, as the board’s secretary-treasurer/executive director, a position he has held since 1986. His successor, David J. Schoetz, Jr., MD, was formally elected at the March 20 interim meeting. Dr. Schoetz’s capabilities are well known through his past board service, his involvement with the society, and his numerous contributions to the specialty.

Board officers are Vendie H. Hooks, MD, FACS, president, and Richard P. Billingham, MD, FACS, vice-president.

Current board members are: E. Christopher Ellison, MD, FACS; Terry C. Hicks, MD, FACS; Martin A. Luchtefeld, MD, FACS; Robert D. Madoff, MD, FACS; Patricia L. Roberts, MD, FACS; John P. Roe, MD, FACS; Clifford L. Simmang, MD, FACS; Michael J. Stamos, MD, FACS; Steven D. Wexner, MD, FACS; Bruce G. Wolff, MD, FACS; and W. Douglas Wong, MD, FACS.

Membership matters

At its March 20, 2005, interim meeting, the board approved bylaws changes that affect the composition of sponsoring organizations and members. The first change affects Article IV, Election and Duties of Officers. It provides for the appointment of an ad hoc associate executive director who will serve in a transitional capacity when the executive director decides to retire. This change also established a mechanism that will give board members input into the selection process. Dr. Schoetz is the board’s first ad hoc associate executive director.

The second change refers to Article III, Section 1, Membership, which affects board membership and sponsorship. This will eliminate the American Medical Association (AMA) as a sponsoring organization of the board. Board members agreed that the AMA no longer has close ties to the ABCRS and should not serve as a nominating body. The AMA slot will be given to the ABCRS, increasing its sponsorship to four members instead of three. At the October 3, 2004, annual meeting, Steven Wexner, MD, FACS, an AMA nominee, was elected to the board and will be the last AMA representative. A provision was made to allow Dr. Wexner to serve a complete eight-year term.

Examination committee activities

The board’s examination committee is divided into three working groups consisting of the written, oral, and maintenance of certification (MOC) subcommittees; each is directed by its own chairperson. At the September 25, 2005, meeting, Dr. Wolff officially became the new examination committee chair and Dr. Roberts the written examination committee chair. Dr. Hicks
continues to serve as the oral examination chair and Dr. Hooks as the maintenance of certification chair.

Oral examination. The ABCRS oral examination committee continues to focus on standardizing the oral examination process. The ultimate goal is to build the oral examination pool with quality case scenarios. Dr. Hicks believes testing candidates on the same material has made the oral examination more objective and provides a method that better identifies the areas in which candidates fail.

Following the annual board meeting in October 2004, the following changes or refinements were made to the oral examination process:

• Written summaries replaced oral critiques.
• Candidate surveys were conducted.
• E-mail notification of oral examination results was approved.

Written examination. In addition to the four-hour written examination, a visual diagnostic exam is given to candidates. This component combines elements of radiology and pathology into 40 questions incorporating gross and endoscopic photos, various diagnostic studies, and histology. Overall, it covers the gamut of colon and rectal surgery ailments. Formerly, separate X-ray and pathology examinations (consisting of 25 questions each) were given, but the board believes that combining the two components has made that portion of the examination more relevant to the specialty. The images and corresponding cases more closely resemble “real life” scenarios and authentic practice settings germane to colon and rectal surgery.

The written examination committee is considering ways to improve the written exam. It has been suggested that in the future the separate visual diagnostic examination could be incorporated into the written examination. With current technology, photographs could easily be introduced into the exam. In addition, the committee has considered whether there is a better way to conduct future examinations more efficiently, more economically, and more effectively. For example, one approach would combine the written and oral examinations. Also, there have been discussions regarding use of a central examination facility that would enable the board to conduct computerized examinations. These and other ideas will continue to be explored.

Recertification examination. The last recertification examination was given April 29–30, 2005, in Philadelphia, PA. A total of 66 diplomates participated; 65 passed (98%) and one failed (2%). The next recertification examination will be given June 3, 2006, in Seattle, WA.

The recertification statistical summaries for the last 15 years are provided in Table 1 (see page 32).

Transition to MOC

The recertification committee was officially renamed the MOC committee in 2003, and over the past two years, the ABCRS has been working to develop MOC components.

The MOC process for colon and rectal surgery—for which each activity occurs every five years unless otherwise specified—is composed of the following four components:

• Professional standing
  —Full, unrestricted license to practice medicine in all jurisdictions in which the diplomate practices
  —Hospital privileges to practice colon and rectal surgery (every five years)
  —Recommendations from the chief of staff of the primary hospital
• Lifelong learning and self-assessment
  —150 hours of Category 1 CME credit
  —Colon and Rectal Surgical Education Program
• Cognitive knowledge
  —MOC cognitive examinations—taken during the eighth, ninth, or tenth year of the MOC process (every 10 years)
• Assessment of practice performance
  —Patient survey: 15 questions from 20 patients
  —Operative log consisting of cases performed six months before the end of the five-year cycle

Assessment of practice performance is the most challenging because it requires boards to establish a process for assessing physician practice performance. The purpose of the assessment is to demonstrate to patients, the public, and the profession that physicians provide safe, effective, and patient-centered health care. At the MOC

MARCH 2006 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
committee’s recent meeting, discussion continued as to what components will be required in the ABCRS Part IV MOC process. In addition, modifications were made to the already approved Parts I through III. Completion of Part IV is nearly final, and the board’s goal is to submit the draft to the American Board of Medical Specialties by March 2006.

Table 1: ABCRS recertification performance, 1991–2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Participants</th>
<th>Passed</th>
<th>%</th>
<th>Failed</th>
<th>%</th>
<th>Maximum (%)</th>
<th>Minimum (%)</th>
<th>Average (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>66</td>
<td>65</td>
<td>98</td>
<td>1</td>
<td>2</td>
<td>94</td>
<td>68</td>
<td>88</td>
</tr>
<tr>
<td>2004</td>
<td>46</td>
<td>33</td>
<td>72</td>
<td>13</td>
<td>28</td>
<td>94</td>
<td>59</td>
<td>75</td>
</tr>
<tr>
<td>2003</td>
<td>48</td>
<td>46</td>
<td>96</td>
<td>2</td>
<td>4</td>
<td>92</td>
<td>66</td>
<td>82</td>
</tr>
<tr>
<td>2002</td>
<td>43</td>
<td>42</td>
<td>98</td>
<td>1</td>
<td>2</td>
<td>94</td>
<td>59</td>
<td>82</td>
</tr>
<tr>
<td>2001</td>
<td>24</td>
<td>23</td>
<td>96</td>
<td>1</td>
<td>4</td>
<td>90</td>
<td>69</td>
<td>81</td>
</tr>
<tr>
<td>2000</td>
<td>16</td>
<td>13</td>
<td>81</td>
<td>3</td>
<td>19</td>
<td>90</td>
<td>59</td>
<td>80</td>
</tr>
<tr>
<td>1999</td>
<td>68</td>
<td>62</td>
<td>91</td>
<td>6</td>
<td>9</td>
<td>94</td>
<td>61</td>
<td>82</td>
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<tr>
<td>1998</td>
<td>46</td>
<td>44</td>
<td>96</td>
<td>2</td>
<td>4</td>
<td>93</td>
<td>57</td>
<td>81</td>
</tr>
<tr>
<td>1997</td>
<td>19</td>
<td>19</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>97</td>
<td>72</td>
<td>87</td>
</tr>
<tr>
<td>1996</td>
<td>5</td>
<td>5</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>94</td>
<td>85</td>
<td>90</td>
</tr>
<tr>
<td>1995</td>
<td>3</td>
<td>3</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>88</td>
<td>86</td>
<td>87</td>
</tr>
<tr>
<td>1994</td>
<td>11</td>
<td>11</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>98</td>
<td>79</td>
<td>90</td>
</tr>
<tr>
<td>1993</td>
<td>7</td>
<td>7</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>97</td>
<td>85</td>
<td>90</td>
</tr>
<tr>
<td>1992</td>
<td>8</td>
<td>8</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>96</td>
<td>78</td>
<td>90</td>
</tr>
<tr>
<td>1991</td>
<td>7</td>
<td>7</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>97</td>
<td>91</td>
<td>94</td>
</tr>
<tr>
<td>Totals</td>
<td>417</td>
<td>388</td>
<td>95</td>
<td>29</td>
<td>5</td>
<td>94</td>
<td>72</td>
<td>85</td>
</tr>
</tbody>
</table>

Passing score 70%

Table 2: Examination results: Pass/fail rates

<table>
<thead>
<tr>
<th>Written exam - March 19, 2005 (71 candidates)</th>
<th>Oral exam – September 24, 2005 (71 candidates)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td># Fail rates</td>
<td>11/71</td>
</tr>
<tr>
<td>Total candidates</td>
<td>71</td>
</tr>
<tr>
<td>First-time takers</td>
<td>61</td>
</tr>
<tr>
<td>Repeat candidates</td>
<td>10</td>
</tr>
</tbody>
</table>
Electronic operating log

An ad hoc committee headed by Robert Madoff, MD, FACS, has worked to develop an electronic operative log reporting system as a joint effort between the American Council of Graduate Medical Education (ACGME) and the ABCRS. The effort has progressed to the final stage. The plan will use preexisting ACGME Web-based software, which will be accessible to all colorectal residents. The ABCRS administrative office will also have access but will have to adapt it to suit its particular software and reporting needs. The procedure-based program concept is to have each procedure requiring documentation of diagnosis through the use of a drop-down menu. Thereafter, the collected data can generate reports geared to the specific needs of the ABCRS, the RRC, and the ACGME. At the March 20, 2005, interim meeting, Dr. Madoff briefly reviewed the program. He reported that the case log system is now being used by 26 specialties. In 2004, residents logged 6.5 million cases. The basic concept is the same for all specialties, but each specialty has its own unique features. The board decided to make the electronic process mandatory for all residents entering colon and rectal training programs beginning July 1, 2005, and completing by June 30, 2006.

Continuing toward the goal of electronic accessibility and exchange of information, the board certification application is now available online. The application can be accessed through the ABCRS Web site (www.abcrs.org) by clicking “On-line Application” on the sidebar. The procedure is user friendly and will help to expedite the application process. The MOC application will be available online in the near future. On a broader scale, the board’s objective is to develop a centralized software solution for the central office. The goal is to create a more efficient method to track surgeons through various stages of the certification process and to eliminate the need to copy data from one database to another. The plan will include reprogramming the current operative database so it is compatible with the new Web-based ACGME system. A reporting mechanism will be designed to incorporate the board’s category system and automate the process of preparing various reports.

Examination results

The most recent written examination (Part I) was given March 19, 2005; 71 candidates were examined. The most recent oral examination (Part II) was given September 24, 2005; 71 candidates were examined. The pass/fail rates are shown in Table 2 on page 32.

Geographic/gender distribution

As of October 2005, the board has a total of 1,565 diplomates: 1,346 are in active practice, 203 are retired, six of unknown address or status, and 10 have expired certificates. Table 3 on this page shows the distribution of male, female, and international diplomates.

<table>
<thead>
<tr>
<th>Status</th>
<th>Male</th>
<th>%</th>
<th>Female</th>
<th>%</th>
<th>All</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active U.S.</td>
<td>1,137</td>
<td>72.65</td>
<td>141</td>
<td>9.01</td>
<td>1,278</td>
<td>81.66</td>
</tr>
<tr>
<td>Active international</td>
<td>63</td>
<td>4.19</td>
<td>5</td>
<td>0.33</td>
<td>68</td>
<td>4.52</td>
</tr>
<tr>
<td>Retired U.S./inactive</td>
<td>194</td>
<td>12.90</td>
<td>4</td>
<td>0.27</td>
<td>198</td>
<td>13.16</td>
</tr>
<tr>
<td>Retired international</td>
<td>5</td>
<td>0.33</td>
<td>0</td>
<td>0.00</td>
<td>5</td>
<td>0.33</td>
</tr>
<tr>
<td>Status/address unknown</td>
<td>6</td>
<td>0.40</td>
<td>0</td>
<td>0.00</td>
<td>6</td>
<td>0.40</td>
</tr>
<tr>
<td>Inactive/expired certificate holders</td>
<td>9</td>
<td>0.60</td>
<td>1</td>
<td>0.07</td>
<td>10</td>
<td>0.66</td>
</tr>
<tr>
<td>Total</td>
<td>1,414</td>
<td>90.35</td>
<td>151</td>
<td>9.65</td>
<td>1,565</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Table 3: Geographic/gender distribution
Officers and directors

Officers of the American Board of Obstetrics and Gynecology (ABOG) are Philip J. DiSaia, MD, FACS, Orange, CA, president; Gerson Weiss, MD, Newark, NJ, chairman of the board; Mary C. Ciotti, MD, Sacramento, CA, vice-president; Larry C. Gilsstrap III, MD, Houston, TX, treasurer; William Drogemueler, MD, Chapel Hill, NC, director of evaluation; and Norman F. Gant, MD, Dallas, TX, executive director. Directors include Bruce R. Carr, MD, Dallas, TX; Larry J. Copeland, MD, FACS, Columbus, OH; Sherman Elias, MD, FACS, Chicago, IL; Diane M. Hartmann, MD, Rochester, NY; Nicolette S. Horbach, MD, Annandale, VA; Frank W. Ling, MD, Memphis, TN; Roy T. Nakayama, MD, Honolulu, HI; Valerie M. Parisi, MD, MPH, Galveston, TX; Stephen C. Rubin, MD, FACS, Philadelphia, PA; Nanette F. Santoro, MD, Bronx, NY; Robert S. Schenken, MD, San Antonio, TX; Russell R. Snyder, MD, Galveston, TX; Michael L. Socol, MD, Chicago, IL; Ralph K. Tamura, MD, Chicago, IL; and George D. Wendel, Jr., MD, Dallas, TX.

Programs and fellowships

The ABOG and the American Board of Urology continue to work jointly to insure the success of the combined Female-Pelvic Medicine and Reconstructive Surgery Fellowships. At press time, there are 22 accredited fellowship programs in this new subspecialty; among these programs, 21 are obstetrics and gynecology programs and one is a urology-sponsored program.

The board now has received applications from five additional urology programs, which are being site visited this fall. It appears this effort will be successful with both boards working together to ensure that with the increasing age of our population, women with these disorders can be managed medically as well as surgically.

Maintenance of certification

The ABOG continues to work in close association with the American College of Obstetricians and Gynecologists to complete Part IV of our maintenance of certification requirements for the American Board of Medical Specialties (ABMS). The first three parts of maintenance of certification for the ABOG have been approved through the first and second readings at the ABMS. These programs include professionalism, lifelong learning, and cognitive expertise.

What remains is the final approval of the board and College’s joint efforts to develop an acceptable program for Part IV, which will be for continuous quality improvement until methods are developed to assess a practitioner’s quality of clinical care.

New foundation started

The Foundation for Excellence in Women’s Health Care has been started by the ABOG. The first project will be a lifelong learning project for all residents in obstetrics and gynecology in the U.S.

The goals of the lifelong learning program are twofold: to assist program directors in habituating residents to the discipline of lifelong learning and in providing documentation of effective instruction in cognitive knowledge during a residency review committee site visit.

The foundation proposes to send a new package to each residency program director with different references approximately every two months. Each package will contain one book for the program director with a keyed answer sheet and one book and answer sheet for each resident. Each book will have six references: two in gynecology, two in obstetrics, and two in office practice. There will be 30 multiple choice questions composed of 10 questions from the two references in each of the three sections.

The keyed answers provided to the program directors will be derived from the references, but they are not intended to provide definitive clinical advice or instruction. The program directors will have the prerogative of modifying, correcting, or rejecting any suggested answer.
in reviewing the questions with residents. The board does not request that the residents’ answer sheets be returned to the ABOG. Program directors may also see fit not to use the answer sheet at all or may restructure it, in whole or in part, to meet specific training and teaching needs.

Happy anniversary
On November 5, the ABOG will celebrate its 75th anniversary. The ABOG was founded in 1930 as the third specialty board, preceded by the boards of ophthalmology and otolaryngology. It should also be noted that the ABOG was a founding member of the ABMS.

The American Board of Orthopaedic Surgery

by Peter J. Stern, MD, FACS, Cincinnati, OH

The purpose of the American Board of Orthopaedic Surgery (ABOS) is to serve and protect the public and the medical profession by testing and setting minimal educational standards for those individuals who after successful completion of an accredited residency seek certification in orthopaedic surgery.

Primary certification
Primary certification begins with a written, seven-hour examination to evaluate fund of knowledge and is taken annually in July, just following completion of residency. In 2004, it was administered to 645 individuals, and the passing rate overall was 88 percent. Approximately two years after the written exam, an oral examination is administered. Candidates electronically submit six-month case lists from which 12 cases are selected. Each candidate is evaluated by six examiners who assess nine clinical and surgical skills. Failure rates since 1986 have varied between 8 percent and 15 percent.

Recertification
Since 1986, certificates issued are time limited. To ensure this end, every 10 years, ABOS diplomates must recertify. The ABOS reviews the credentials and practices of volunteer candidates, verifies a commitment to lifelong learning (continuing medical education, or CME). In addition, a secure practice profile-based exam or an oral exam is administered to assure the public and profession of diplomates’ continuing qualifications and competence.

Maintenance of certification
Because of external regulatory pressure and public demand, the American Board of Medical Specialties (ABMS), the umbrella organization to which all 24 medical specialty boards belong, believes that its member boards should have a leadership role in improving quality of care through a process termed maintenance of certification (MOC). For the past several years, the ABOS has spent considerable time preparing for the transition from recertification to MOC.

The four components of MOC approved by the ABMS are evidence of professional standing (licensure and peer review), lifelong learning and self-assessment, evidence of cognitive expertise (examination), and evidence of performance in practice.

The first component, evidence of professional standing, is already in place for ABOS. Lifelong learning and self-assessment will be accomplished by diplomates completing two three-year cycles of 120 hours of Category 1 CME credits and two self-assessment exams.

Since the inception of the time-limited certificate, successful passage of a secure recertification examination has been required to demonstrate that the candidate has a sufficient knowledge base to continue to practice orthopaedic surgery. To this end, the ABOS has constructed multiple computer-based, practice-profile examinations to assess a diplomate’s knowledge base. Last year, 98.4 percent of those taking one of these examinations passed. If one prefers, he or she may be examined by an oral
pathway, which is similar to initial certification in which preselected cases from the examinee’s practice are presented. The passage rate using this pathway was 89 percent in 2004. Finally, the ABOS is deciding on the best methods to assess the fourth component of MOC, performance in practice. A joint task force of members from the ABOS and the American Academy of Orthopaedic Surgeons has suggested practice performance assessment by the following methods: Peer review, patient questionnaire assessing physician communication skills and patient satisfaction, and a three-month list to assess best practices. Currently, the task force is developing criteria for best practices including performance measures.

The first date for transition from recertification to MOC will be for those diplomates whose certificates expire in 2010.

Other developments
Subspecialty certification has been available in hand surgery since 1989. In 2007, a second subspecialty certificate in sports medicine will be available.

Last fall, the board selected two director-elect, James R. Kasser, MD, from Boston, MA, and Daniel J. Berry, MD, from Rochester, MN. In keeping with its commitment to serve the best interests of the public, the board appointed its first public member, E. Thomas Sullivan, JD, senior vice-president and provost at the University of Minnesota.

Finally, the mission of the ABOS could not be accomplished without the more than 200 physician volunteers and the capable oversight of its executive director, G. Paul DeRosa, and his tireless staff. Transitioning from recertification to MOC has been the board’s major initiative over the past three years. Our academy has been most supportive and has been particularly helpful in the domains of assessment of practice performance and commitment to lifelong learning. Ultimately, our patients and the profession we serve will benefit from our insistence of maintenance of high standards so necessary in these changing times.

The American Board of Plastic Surgery
by John A. Persing, MD, FACS, New Haven, CT

Examinations
Oral examination: A total of 209 candidates sat for the oral examination November 11-13, 2004, in Phoenix, AZ. Among those candidates, 169 successfully completed the certification examination and 40 failed, with a failure rate of 19.1 percent. In November 2003, 206 candidates took the oral examination; 173 candidates passed and 33 (16%) failed. The usual failure rate has been 16 to 25 percent. There were 203 candidates for the 2005 oral examination. As of November 13, 2004, the ABPS had certified 6,841 plastic surgeons.

Written or qualifying examination: The computer-based test (CBT) written or qualifying examination was held October 18, 2004, for 214 candidates. Results of the 2004 written examination were distributed December 22, 2004: 178 of the total of 214 candidates successfully completed the written examination, with a failure rate of 23 percent. In 2003, 177 of 230 candidates passed the written examination, with a failure rate of 23 percent, which was consistent with previous years. The 2005 examinations were offered for the fourth time as a CBT and were held October 18, 2005, at test centers across the country. A total of 237 candidates sat for the 2005 written examination.

Subspecialty certification in surgery of the hand: ABPS administered the 2004 subspecialty certification in surgery of the hand (formerly known as the certificate of added qualifications in surgery of the hand) examination to 62 American Board of Plastic Surgery (ABPS) diplomates, 44 of whom were recertifying. Among 18 diplomates, 15 passed the hand surgery examination. The
total failure rate for all 15 examinees was 16.7 percent. A total of 44 diplomats sat for the 2004 hand surgery recertification examination; 35 passed, and 9 (20.5%) failed. The 2005 certification examination in surgery of the hand was administered as a CBT from August 6 through September 3, 2005.

Recertification/maintenance of certification: The third recertification examination was administered April 2005. In 2004, 159 took the examination and 151 passed; eight (9%) failed. Sixty-six candidates sat for the comprehensive surgery module, 82 examinees sat for the cosmetic surgery module, four candidates sat for the craniomaxillofacial module, and seven candidates sat for the hand surgery module. Among these candidates, two were lifetime certificate holders. In 2003, 122 diplomates took the examination and 118 (96.7%) passed and four failed. Among these diplomates, nine were lifetime certificate holders.

The cognitive examination continues to be offered as a CBT in four modules: Comprehensive plastic surgery, cosmetic/breast surgery, craniomaxillofacial surgery, and hand surgery. A subspecialty certificate in surgery of the hand was accepted in lieu of the hand surgery module cognitive examination component of the recertification program. The four key components of professionalism, knowledge, lifelong learning, and performance in practice are incorporated into the recertification program. Diplomates are required to collect an operative log for six months for assignment to an examination module in the areas of their practice profile. Maintenance of certification for plastic surgery is planned to start in 2007.

Evaluation of prerequisite training years: A task force for the evaluation of training pathways is currently evaluating the duration and content of the prerequisite years in training. A tripartite retreat was held in Chicago in September 2005—representatives from the Residency Review Committee for Plastic Surgery, the Academic Chairmen in Plastic Surgery, and the board reviewed the issues in depth.

Revocation of certification
The board is using the Federation of State Medical Boards Disciplinary Alert Notification System through the American Board of Medical Specialties to identify diplomats with state medical license sanctions. Plastic surgeons with revoked state medical licenses are referred to the ethics committee for revocation of certification. To date, the board has revoked certification for 44 diplomates. This information was also published in the board’s annual newsletter to diplomates in January 2005.

ABPS code of ethics
The board’s code of ethics continues to attract reporting and enforcing issues regarding advertising and expert witness testimony. Most recently, the ABPS code of ethics prohibition to participation in contests has drawn attention because of the proliferation of reality television programming. In January 2005, the board published a position statement on reality television in the annual newsletter. The board requires all examiners and directors to sign a statement attesting that they have not participated in reality television programming.

Subspecialty issues
The ABPS continues to be committed to the engagement, development, and recognition of subspecialty interests for the purpose of advancing the core of the entire specialty. The board’s four advisory councils have been working since May 2000 on contributing to the work of the recertification process and maintenance of certification program. The advisory councils reflect the four identified subspecialty modules for the recertification program. The members include board directors and nominees from plastic surgery subspecialty organizations. The board currently uses subspecialty expertise to develop journal review questions for self-learning for the Plastic and Reconstructive Surgery Journal.

In appreciation
At the May board meeting, the ABPS honored the following directors and expressed appreciation for their work: Lawrence L. Ketch, MD, director, 1998-2005, chair, 2004-2005; Gustavo A. Colon, MD, FACS, director, 1999-2005; Dennis J. Lynch, MD, FACS, director, 1999-2005; and Peter W. McKinney, MD, FACS, director, 1999-2005.
New officers and directors
The new directors elected to the ABPS on May 7, 2005, are: Gregory R. D. Evans, MD, Orange, CA; Bahman Guyuron, MD, Lyndhurst, OH; and Donald H. Lalonde, MD, Saint John, NB.

ABPS Officers for 2005-2006 are: John A. Persing, MD, FACS, chair; Thomas R. Stevenson, MD, FACS, chair-elect; Linda G. Phillips, MD, FACS, vice-chair; and Ronald E. Iverson, MD, FACS, secretary-treasurer.

The American Board of Urology

by Robert C. Flanigan, MD, FACS, Maywood, IL

Exams
The certification process of the American Board of Urology incorporates a qualifying examination (Part 1) and a subsequent certifying examination (Part 2). Admissibility to the qualifying examination requires that the applicants have completed or be within six months of satisfactorily completing an Accreditation Council on Graduate Medical Education (ACGME)-approved urology residency program. Admissibility to the certifying examination requires that the candidates have passed the qualifying examination, have 18 months of clinical practice experience in a single community, submit an acceptable practice log, and receive satisfactory peer reviews.

On August 6, 2004, 317 candidates completed the qualifying examination. In 2004, the examination was administered for the first time as a computer-based test. The exam was a cognitive, multiple-choice examination. The computer-based testing allows candidates to enter their responses directly into the computer and to view enhanced images on the screen. Of 317 candidates who sat for the qualifying examination, 263 passed and 54 failed. As has been true in other years, practitioners—educated in the U.S. or abroad—who have previously failed the examination had a high rate of re-examination failure. The 2005 qualifying examination took place August 5, 2005. A total of 299 candidates took the 2005 examination.

Since 1987, the qualifying examination has been scored using the principles of criterion-referenced testing, whereby the pass level is equated to a previous benchmark test using the Rasch model. The passing score will vary according to the difficulty of the examination for any year. Thus, although an examination may vary in difficulty from year to year, the probability of passing (pass rate) is based solely on the ability of the candidate pool in any given year. This is a fair and defensible methodology, which does not impose an arbitrary pass/fail point.

The 2005 certifying examination was a standardized oral examination that consisted of six protocols on which the candidate was tested. In February 2005, 262 candidates took the certifying examination; 249 (95%) passed and were certified, and 13 (5%) failed. The board uses a modified Rasch model for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. Consistent with the board’s commitment to continually improving its evaluation processes, in 1995 the board applied a dual-scoring system for the oral examination protocols. Separate grades are used for information gathering and diagnosis and for problem solving and patient management. This has resulted in a significant increase in statistical reliability. The board is pleased with this scoring technique for the oral examination.

Certification
The board requires completion of certification within five years of completion of an ACGME-approved residency program; extensions are granted for approved fellowship training. Failure to complete certification within the time allotted requires re-entry into the certification process at the qualifying examination level after first passing a preliminary examination.
In 1992, the board began its mandatory recertification process for all diplomates with 10-year, time-limited certificates, which have been issued since 1985. Currently, all trustees of the American Board of Urology recertify during their tenure on the board unless, because they were originally certified after 1985, they have already recertified to retain their certification. The process consists of multiple components. These various components provide the diplomate with different opportunities and ways to document his or her competence. A secure, computer-based, closed-book examination consists of five subject areas; the diplomate chooses the three subject areas with which he or she is most comfortable. Each module has 30 questions, for an individual examination of 90 questions.

Other components of recertification include peer review, a practice log review, and a continuing medical education requirement. In addition, at the board’s discretion, hospital/office chart reviews, an oral interview or examination, and/or a site visit may be required. Diplomates may enter the recertification process up to three years before expiration of the primary certificate. Upon successful recertification, the diplomate is issued a certificate valid for 10 years from the date of expiration of the original certificate. The 2002 recertification process was the first year that included diplomates recertifying for their second time. In November 2004, the last year for which this information was available at press time, 483 diplomates sat for recertification; 466 diplomates (96%) successfully completed the recertification process. The pass rate was consistent with that of previous years.

All of the boards with the American Board of Medical Specialties are developing a maintenance of certification (MOC) process that would supersede their existing recertification processes. The MOC will entail, among other things, ongoing monitoring of physicians by the certifying boards. The American Board of Urology is actively developing a MOC model. Currently the board is planning to implement MOC in 2006 or 2007. More information on the details of the MOC process will be widely disseminated to all candidates, diplomates, and societies when the process is in its final form and approved by the board and the American Board of Medical Specialties.

**Officers and trustees**

Current officers and trustees are: Robert C. Flanigan, MD, FACS, president; Mani Menon, MD, FACS, vice-president; Linda M. Shortliffe, MD, FACS, president-elect; Peter R. Carroll, MD, FACS, secretary-treasurer; Peter C. Albertsen, MD, FACS; David A. Bloom, MD, FACS; Ralph V. Clayman, MD, FACS; Michael O. Koch, MD, FACS; Paul H. Lange, MD, FACS; Howard M. Snyder III, MD, FACS; William D. Steers, MD, FACS; and W. Bedford Waters, MD, FACS.
A complete revision of the Medicare appeals process has been made in stages since December 2004. The last step, the revision of the carrier appeals process, took place on January 1, 2006. All claims initially adjudicated by carriers on or after that date will be subject to the new appeals process, as will all requests for the first level of appeal received by carriers after that date. Fiscal intermediary claims adjudicated on or after May 1, 2005, and requests for the first level of appeal received by fiscal intermediaries on or after May 1, 2005, went through the new appeals process.

The Medicare, Medicaid, and State Children’s Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated the changes. Together the two statutes required the following:

- Uniform appeal procedures for both Part A and Part B claims
- Reduced decision-making time frames for most appeal levels
- The right to raise the case to the next appeal level if it is not decided on time (for cases that are at the second level or higher)
- New entities, called qualified independent contractors (QIC), to handle the second level of appeal
- Generally additional evidence presented no later than the second appeal level
- Transfer of some of the administrative law judges (ALJ) to the U.S. Department of Health and Human Services
- The correction of minor errors without resorting to the appeals process (implemented in 2004)

There is much that has remained the same about the appeals process, such as the number of levels of appeals, the requirement that each level must be completed in sequence, the time limits for filing an appeal, the types of questions or issues that are subject to appeal, and who may file an appeal. (See Figure 1.)

Reform of the appeals process does not affect a physician’s right to appeal. The following material is provided in the interest of giving a comprehensive picture of the appeals process. Following are instances when a physician can file an appeal:

- The physician has accepted assignment of the claim. Participating physicians have agreed to always accept assignment.
- The physician has not accepted assignment of the claim and the claim is partially or wholly denied as not being medically necessary. This includes instances where the physician has collected payment from the beneficiary but failed to give an advanced beneficiary notice warning that the service might not be covered. The physician may be acting as a physician or a durable medical equipment supplier.
- The beneficiary has died and there is no one else available to appeal.

Remember that a beneficiary always has the right to appeal, unless he or she has assigned his or her appeal rights to the physician.
Figure 1 on page 40 for an explanation of when a physician may file an appeal.)

But there is also much that has changed. Each step in the appeals process (except for federal court review) must be completed in 60 or 90 days. (See Figure 2 on this page for an overview of the new appeals process.) There are specific requirements that the notice of the appeal determination must contain; the most important requirement is that if the appeal deals with the medical necessity of a service, the notice must give an explanation of the medical and scientific rationale for the decision.

Redetermination

- **First level of appeal or redetermination.** The first level of appeal is called a redetermination—rather than “review,” the term used previously—and must be completed in 60 days. The request for a redetermination cannot be made by telephone; it must now be made in writing to the carrier. The requirement that the redetermination be processed by someone who was not involved in the initial determination remains. If the redetermination is adverse to the appellant, the notice of the redetermination action must explain how to request the next level of appeal and it must also specify any additional documentation that should be furnished at the next level of appeal. (Simple clerical corrections or additions to the original claim, which some carriers required at the first level of appeal, may be handled by “reopening” the claim. That process is discussed later in this article.)

- **Second level of appeal or reconsideration.** The most important changes to this process have been made in the second level of review, which has been termed a “reconsideration.” The first and most important change is that the reconsideration has been moved away from the carrier that initially processed the claim to a QIC. Because the QICs are under an entirely different management structure than the local carriers, there will no longer be grounds for suspecting that a carrier was acting to protect itself rather than giving a truly fair hearing.

The reconsideration, which replaces a carrier’s fair hearing with a paper review, must be completed within 60 days. The dollar amount in controversy threshold of $100 has been eliminated,

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**Figure 2. The revised Medicare appeals process**

<table>
<thead>
<tr>
<th>Appeal level</th>
<th>Time limit for filing request for appeal</th>
<th>Monetary threshold to be met</th>
<th>Time limit for completing appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redetermination by carrier</td>
<td>120 days from receipt of the notice of initial determination</td>
<td>None</td>
<td>60 days</td>
</tr>
<tr>
<td>Reconsideration by qualified independent contractor</td>
<td>180 days from receipt of the notice of redetermination</td>
<td>None</td>
<td>60 days</td>
</tr>
<tr>
<td>Administrative law judge hearing</td>
<td>60 days from receipt of the notice of reconsideration</td>
<td>For requests filed in 2006, $110 or more in controversy. Updated annually.</td>
<td>90 days</td>
</tr>
<tr>
<td>Medicare appeals council (MAC) review</td>
<td>60 days from receipt of the notice of ALJ hearing decision</td>
<td>None, but in reality there must be $110 or more in controversy.</td>
<td>90 days</td>
</tr>
<tr>
<td>Federal court review</td>
<td>60 days from receipt of MAC decision or declination of review by MAC</td>
<td>For requests filed in 2006, $1,090 or more in controversy. Updated annually.</td>
<td>No time limit</td>
</tr>
</tbody>
</table>
so any denied claim can reach the reconsideration level. Generally any additional evidence must be submitted by the doctor at the reconsideration level.

If the case involves the medical necessity of a service, the reconsideration is carried out by a panel of health care professionals. The Centers for Medicare & Medicaid Services (CMS) makes it clear that for physicians’ services, the panel must include at least one physician. However, CMS does not specify the physician’s specialty. The QIC can decide not to follow national and local coverage and payment policies in a case but the notice of the reconsideration must provide a rationale for the decision and the case must not set a precedent.

- **Third level of appeal, or ALJ hearing.** A change in the amount in controversy threshold that must be met for the third level of review, an ALJ hearing, has been made and is discussed later in this article.

The ALJs are no longer employed by the Social Security Administration (SSA); they now report to the U.S. Department of Health and Human Services (DHHS). Readers may remember that the Medicare program started out as a part of SSA but was moved to DHHS. Medicare was moved administratively to the Health Care Financing Agency, the predecessor of CMS, in 1978. In 1995, pursuant to legislation, the SSA became an independent agency. The legislation called for moving the ALJs and their workload, which included Medicare cases, from DHHS to the new independent agency. Establishing an ALJ structure under DHHS to handle Medicare cases was not done until the passage of the MMA in 2003. The transfer was actually made in the late summer of 2005.

**Fourth and fifth levels of appeal**

Some very technical changes were made in the fourth level of appeal, the Medicare appeals council (MAC) review. The only change in the fifth level of appeal, the federal court review, is in the amount in controversy threshold (see next section).

**Monetary thresholds for further reviews**

For two steps in the appeals process, there continues to be a monetary threshold that must be met. Through 2005, the amounts had remained constant. However, starting this year, the amounts must be updated annually to reflect the medical care component of the consumer price index for urban consumers. In 2006, the amount in controversy must be equal to or exceed $110 for the ALJ hearing and be equal to or exceed $1,090 for a federal court review. As in the past, appeals may be consolidated if there are common issues of law and fact and similar services were delivered. One common reason for consolidating appeals is to reach the amount in controversy threshold.

**Escalating an appeal to a higher level**

Appellants have the right to escalate a case to an ALJ if a QIC fails to make a timely reconsideration and to the MAC if an ALJ fails to make a timely hearing decision. If a case is escalated to the next level, the ALJ or MAC has 180 days to make a decision. Note that the amounts in controversy thresholds do not apply for cases escalated to an ALJ. If the appellant decides not to escalate the appeal, the case remains with the QIC or MAC to make a decision.

The appellant should carefully consider whether to escalate a case because the requirements are different at each appeal level. For example, escalating a case to the MAC if an ALJ has failed to act in a timely manner may mean that the appellant does not get to present the case in oral argument at an ALJ hearing. (There is no oral presentation as part of the MAC review.)

**Reopenings**

The provision of MMA on reopenings clarified a long-standing area of confusion for the Medicare community when it was implemented in December 2004. Carriers differed in how they treated claims denied for clerical errors or omissions, with some—following the letter of the law—requiring the expense and complexity of submitting a request for a redetermination and others accepting the changes much less formally.

**Conclusion**

Congress had neglected the Medicare appeals process for a long time. Some aspects, such as leaving the ALJs in the SSA, were the result of Congress’ failure to take appropriate action when there was an opportunity. Other components, such
In memoriam

Remembering Oliver H. Beahrs

by Thomas R. Russell, MD, FACS, Chicago, IL

Oliver H. Beahrs, MD, FACS, a Past-Chair of the Board of Regents and Past-President of the American College of Surgeons, died January 7 in Rochester, MN, at age 91. Although it is with great sadness that I write this tribute to Ollie, it is important to remember that he truly led a full, rich, complete life. He touched the lives of countless patients and trained and influenced several generations of surgeons. He will hold a revered place in the history of American surgery for many, many years to come.

Thirst for adventure

Ollie was born September 19, 1914, in Eufaula, AL. Born to Elmer Charles Beahrs and Elsa Katherine (Smith) Beahrs, he was the second of four children. His parents met when they were living in Ohio and traveling on a river steamer that was cruising down the Ohio River.

Elmer Beahrs was a journalist and published the local newspaper in Eufaula. When Ollie was four years old, his father moved west at the advice of his physician, who thought the climate would be better for his health. A year later, Ollie, his mother, and his three siblings joined Elmer in Pomona, CA, where he had established a real estate insurance business and was a partner in a mortgage company.

After his father died of tuberculosis in September 1924, Ollie’s mother went to work, and so did the children. Ollie held several positions throughout his youth, including breeding and raising rabbits.

At age 11, Ollie witnessed his first magic show, and he was hooked. Performing magic would bring him much pleasure in life and provide a source of revenue toward his college and medical educations.

To add to his educational coffers, Ollie took a job the summer after high school as a steward on the steamer Yukon, which traveled through Alaska’s gold mining country. Ultimately, he would spend eight summers in Alaska.

Education, military service

Ollie began his higher education at the well-respected Chaffey Junior College in Ontario, CA, where he studied the sciences and became an active member of the premedical club. He did well academically, and in the fall of 1934, he entered the University of California–Berkeley as a junior. He spent the 1935-1936 school year in the Arctic, assisting Grafton Burke, MD, at Hudson-Struck Memorial Hospital in Fort Yukon. Ollie returned to Berkeley in the fall of 1936 and graduated in spring 1937.

He pursued his medical degree at Northwestern University Medical School, Chicago, IL. Throughout medical school, he continued to hone his skills as a magician and became so in demand that he actually had a booking agent, Mrs. Edith Davis. Mrs. Davis was married to Loyal Davis, MD, FACS, a neurosurgeon and professor of surgery at Northwestern and then-editor of the College’s journal, Surgery, Gynecology, & Obstetrics. Mrs. Davis also was the mother of Ms. Nancy Davis—the future wife of Ronald Reagan. As a result of these
connections, Ollie would form a lifelong friendship with the former president.

After receiving his medical degree from Northwestern, Dr. Beahrs began his surgical training in 1941 at the University of Minnesota, the Mayo Clinic, Rochester. Soon thereafter, the Japanese bombed Pearl Harbor, and Ollie immediately applied for active duty in the medical corps of U.S. Navy. He served with distinction from April 1942 to February 1946 and rose to the rank of captain in the U.S. Naval Reserve.

Once the war ended, Ollie returned to the Mayo Clinic to resume his surgical training. During his residency—and while he was performing a magic show—he met Helen Taylor. The two married in 1947 and remained together for the next 58 years. Ollie completed his postgraduate work in 1950.

**Devotion to the Mayo Clinic**

Dr. Beahrs would devote his surgical career to the Mayo Clinic, where he garnered a reputation as a consummate general surgeon with special interests in surgery of the head and neck and the gastrointestinal tract. He started at Mayo as a consultant in the department of surgery and an instructor. He ascended to the position of professor of surgery in 1973, was named the Joe M. and Ruth Roberts Professor of Surgery in 1978, and became professor of surgery emeritus in 1979. He was named teacher of the year in surgery at the Mayo Clinic in 1976.

Ollie took great pride in the Mayo Clinic’s ethics, principles, culture, and efforts to place the patient at the center of all its activities, including service, education, and research. He often stated that he could think of no other institution where he would rather work.

Dr. Beahrs was appointed to several prestigious positions related to the Mayo Clinic’s governance. He served on the Mayo Clinic board of governors and was vice-chairman of the board from 1964 to 1973. He also chaired the Mayo Clinic Council and was a member of the board of trustees of the Mayo Foundation.

In addition, Ollie was highly instrumental in the founding of the Methodist Hospital on the Mayo Campus. He served on that facility’s medical advisory committee, board of directors, and executive committee.

**Leader in organized surgery**

In addition to the American College of Surgeons, Dr. Beahrs was an active member of multiple medical and surgical organizations, including the American Cancer Society, the American Medical Association, the Society for Surgery of the Alimentary Tract, the Society of Surgical Oncology, the Southern Surgical Association, and the American Society of Colon and Rectal Surgeons, to name just a few. He was elected president of several professional associations, including the American Surgical Association (1978-1979), the American Association of Clinical Anatomists, the Society of Pelvic Surgeons, the Society of Head and Neck Surgeons, and, of course, the American College of Surgeons (1988-1989).

His commitment to the American College of Surgeons is legendary. After becoming a Fellow in 1951, he served on the Committee on Patient Care and Research and Education, chaired the Governors’ Committee on Chapter Activities, and was Vice-Chair and Chair of the Board of Governors (1976 and 1977-1979, respectively). Ollie served on the Executive Committee, was the longtime Chair of the Central Judiciary Committee, and chaired the Board of Regents from 1984 to 1987. He was first appointed to the Board of Regents in 1980.

Ollie played a key role in the College’s fundraising activities. His last great contribution to this important aspect of the organization’s operations was the establishment of the American College of Surgeons’ Foundation, which will help the College to develop resources for continued funding of scholarships and awards.

Recognized as a first-class surgeon and scholar throughout much of the world, Ollie was an honorary member of the Royal College of Surgeons (Ireland) and was active in a number of international surgical societies. He lectured extensively throughout the U.S. and in numerous foreign countries.

**Other achievements**

Among his many other honors, Dr. Beahrs was accorded the Distinguished Alumnus Award of the Mayo Medical School in 1986 and the Northwestern Medical School Merit Award in 1992.
Ollie wrote or contributed to more than 400 articles and six books on surgical topics. He served as the editor of a number of journals and was the editor of the third and fourth editions of the *Manual for Staging of Cancer*. In 1996, Mayo Publishing printed his memoirs, *The Odyssey and Reflections of One Surgeon*.

His infectious optimism and natural charisma served Ollie well throughout his career, especially when he worked on government-related panels. From 1986 to 1988, he served on the Physician Payment Review Commission, a predecessor of the Medicare Payment Advisory Committee. In addition, he was active with the National Institutes of Health.

In his Presidential Address to the American Surgical Association and the American College of Surgeons, Ollie stressed topics that still are of considerable relevance decades later. He highlighted surgeons’ profound obligation to their patients and stressed that we need to be a positive force in controlling health care spending. He also expressed grave concerns about growing government interference with medical practice. Obviously, these remain key issues in surgery today.

**Giant in the field**

Ollie Beahrs is survived by Helen; four children—Gean Beahrs Landry, wife of former race car driver Dick Landry; John “Randy” Beahrs, a urologist; David Howard Beahrs, a real estate broker; and Nancy Ann Beahrs, a registered nurse; and several grandchildren.

He will be remembered as a loving husband and father and as a giant in American surgery. Ollie had an enduring zest for life and had the rare ability to bring a little magic into the lives of everyone he knew—patients, friends, and colleagues.

*Dr. Russell* is Executive Director of the College, Chicago, IL.

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**Residency Assist Page**

American College of Surgeons

Division of Education

The Residency Assist Page of the American College of Surgeons offers a medium for program directors to acquire updates and advice on topics relevant to their needs as administrators and teachers.

Our goals are to offer practical information and approaches from summaries of published articles, invited editorials, and specific descriptions of lessons learned from program directors’ successful and not-so-successful strategies. Through the development of the Residency Assist Page, the ACS intends to support program directors and faculty by providing helpful information for addressing the challenges associated with administering state-of-the-art residency education.

[www.facs.org/education/rap/index.html](http://www.facs.org/education/rap/index.html)

For additional information, please contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354.
Established in 1988, the Fellows Leadership Society (FLS) is the distinguished donor recognition organization of the American College of Surgeons Foundation. The objectives of the FLS are to improve the quality of care for surgical patients and to encourage leadership and philanthropic support for initiatives important to the future of surgeons and the practice of modern surgery.

Since 1988, the College has received more than $18 million in contributions supporting its resident research scholarships and faculty fellowships. In addition, the College currently provides annual International Guest Scholarships, enabling surgeons from other countries to visit the U.S. to obtain the latest in surgical training.

FLS life membership is granted for outright gifts of at least $10,000 or a pledge to contribute a minimum of $10,000 within a period of 10 years.

At the Clinical Congress in October 2005, the ACS Foundation welcomed 36 new Life Members to the FLS (see box, right).

<table>
<thead>
<tr>
<th>2005 Life Members</th>
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<tbody>
<tr>
<td>Dr. and Mrs. H. Vaughan Belcher, FACS</td>
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<td>Dr. and Mrs. Reginald A. Burton, FACS</td>
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<td>Dr. and Mrs. John L. Cameron, FACS</td>
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<td>Dr. Francisco Cardenas, FACS</td>
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<td>Drs. William G. Cioffi and Theresa A. Graves, FACS</td>
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<td>Dr. and Mrs. Scott A. Duhachek, FACS</td>
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<tr>
<td>Dr. and Mrs. David L. Dunn, FACS</td>
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<tr>
<td>Drs. A. Brent and Sarita Eastman, FACS</td>
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<tr>
<td>Dr. and Mrs. Norman C. Estes, FACS</td>
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<td>Dr. Robert E. Falcone, FACS</td>
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<td>Dr. and Mrs. Steven L. Floerchinger, FACS</td>
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<td>Dr. and Mrs. Frank A. Folk, FACS</td>
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<td>Dr. and Mrs. Richard L. Gamelli, FACS</td>
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<td>Dr. Kirby R. Gross, FACS</td>
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<td>Dr. Barrett G. Haik, FACS</td>
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<td>Dr. Eugene T. Hansbrough, FACS</td>
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<td>Dr. Jay K. Harness, FACS</td>
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<td>Dr. and Mrs. Milnor Jones, FACS</td>
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<tr>
<td>Dr. and Mrs. Christoph R. Kaufmann, FACS</td>
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<td>Dr. and Mrs. Thomas D. Kimbrough, FACS</td>
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<td>Dr. and Mrs. G. Edward Kimm, Jr., FACS</td>
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<tr>
<td>Dr. and Mrs. René Lafrenière, FACS</td>
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<td>Drs. Max and Sue Langham, FACS</td>
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<td>Dr. and Mrs. William E. Matory, FACS</td>
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<td>Dr. and Mrs. Kenneth L. Mattox, FACS</td>
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<td>Dr. and Mrs. John E. Moenning, FACS</td>
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<td>Dr. and Mrs. Hisashi Nikaidoh, FACS</td>
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<td>Dr. and Mrs. Terry O. Norton, FACS</td>
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<td>Dr. and Mrs. William P. Reed, Jr., FACS</td>
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<td>Dr. and Mrs. James H. Ritter, FACS</td>
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<td>Dr. and Mrs. Hilario Robledo, FACS</td>
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<td>Dr. Valerie W. Ruschel, FACS</td>
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<td>Dr. and Mrs. Gerald W. Shaftan, FACS</td>
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<tr>
<td>Dr. and Mrs. Philip T. Siegert, FACS</td>
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<tr>
<td>Dr. and Mrs. Courtney M. Townsend, Jr., FACS</td>
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<tr>
<td>Dr. and Mrs. Larry P. Weinstein, FACS</td>
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ACS German Traveling Fellowship available for 2007

The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Germany.

**Purpose**

The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Germany, and a German Traveling Fellow will visit North America.

**Basic requirements**

The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:

- Has a major interest and accomplishment in clinical and basic science related to surgery
- Holds a current full-time academic appointment in Canada or the U.S.
- Is younger than 45 years on the date the application is filed
- Is enthusiastic, personable, and possesses good communication skills

**Activities**

The Fellow is required to spend a minimum of two weeks in Germany and to achieve the following:

- Attend and participate in the annual meeting of the German Surgical Society, which will be held in Munich, Germany, May 1–4, 2007
- Attend the German ACS Chapter meeting during that meeting
- Visit at least two medical centers (other than the site of the annual meeting) in Germany before or after the annual meeting of the German Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons

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

A spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction in addition to professional activities.

**Financial support**

The College will provide the sum of U.S. $6,000 to the successful applicant, who will also be exempted from registration fees for the annual meeting of the German Surgical Society. The Traveling Fellow must meet all travel and living expenses. Senior German Surgical Society and ACS German Chapter representatives will consult with the Fellow about the centers to be visited in Germany, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his or her own travel arrangements in North America, as this makes available reduced fares and travel packages for travel in Germany.

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

Applications for this traveling fellowship may be obtained from the College’s Web site (www.facs.org), or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is **April 1, 2006**.

The successful applicant and an alternate will be selected and notified by June 30, 2006.
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.
ACS AND AMA, from page 21

contradict these concepts. It also took a strong stand on payment for care mandated by the Emergency Medical Treatment and Active Labor Act (EMTALA), calling on the AMA to incorporate language into any existing or future legislative efforts regarding EMTALA that will require all insurers to assign payments directly to any health care provider who has provided these services regardless of network participation.

Future interactions

The current relationship between the College and the AMA is built on a foundation of mutual respect and common goals. Although the two organizations still find that they “agree to disagree” on occasion, opportunities to work together to solve the difficult issues facing medicine and surgery—such as physician reimbursement, patient safety and quality improvement, and professional liability reform—are strengthening their collaborative spirit. The College will continue to support its delegation to the AMA HOD and will expand its involvement in this policymaking process as appropriate.

Fellows with questions, comments, or suggestions relating to ACS participation in the AMA House of Delegates should contact Jon Sutton, jsutton@facs.org

SOCIOECONOMIC TIPS, from page 42

as leaving the second level of appeal at the carrier, were doubtless appropriate at the time of initial enactment of the Medicare program but the weaknesses became apparent over time.

The major changes were made at the second level of appeal, or the reconsideration. Three of the changes are especially noteworthy: moving the second level of appeal out of the carrier, dropping the $100 amount in controversy requirement, and requiring that at least one physician be present on the QIC panel to make medical necessity decisions for physicians services. Given the volume of reconsiderations that the four QICs will receive, there is a potential for the practitioners within major specialties to see one or more of their own serving on the panels. Those changes, coupled with a separate management structure for QICs, make it appear that anyone can receive a truly fair reconsideration.

Moving some of the ALJs from the SSA to the DHHS will also serve both the Medicare and Social Security programs well. The ALJs for both programs will be able to specialize in only one complex program and, more importantly, people responsible for the Medicare program will manage the Medicare ALJs.

When members of Congress finally got around to reforming the Medicare appeals process, they did a remarkably good job of correcting all of the shortcomings in a complicated process.

Trauma meetings calendar

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

- **Trauma and Critical Care 2006**, March 20–22, Las Vegas, NV.
- **Trauma and Critical Care 2006—Point/Counterpoint XXV**, June 5–7, Williamsburg, VA.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: [http://www.facs.org/trauma/cme/traumtgs.html](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312/202-5342.
Announcing
THE BASIC ULTRASOUND COURSE
now on CD-ROM

The American College of Surgeons and the National Ultrasound Faculty have developed “Ultrasound for Surgeons: The Basic Course” for surgeons and surgical residents on CD-ROM.

The objective of the course is 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.

- Replaces the basic course offered by the American College of Surgeons.
- A printable CME certificate is available upon successful completion.
- CD will install the necessary software (PC or Mac).
- The learner is offered two attempts to pass a multiple-choice exam with a minimum score of 80% at the completion of the program.
- Residents must submit a letter from their director/chair to document residency status.
- Only one user per CD is allowed. Online access is needed to register the CD and to take the exam.
- $300 for nonmembers
- $225 for Fellows of the College
- $125 for residents with letter proving status*
- $90 for Resident and Associate Society (RAS) members (Additional $16 for shipping and handling of international orders)

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

The CD can be purchased online at http://www.acs-resource.org or by calling Customer Service at 312/202-5474.

For additional information, contact Linda Stewart, tel. 312/202-5354, e-mail lstewart@facs.org

The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this educational activity for a maximum of four Category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity. The American Medical Association has determined that physicians not licensed in the U.S. who participate in this CME activity are also eligible for AMA PRA Category 1 credit.
ACOSOG news

ACS surgical trial accrual campaign: Get involved, make a difference

The American College of Surgeons Oncology Group (ACOSOG) leadership met January 12–14 to discuss strategies to ensure successful grant renewal in 2006. Key deliverables for 2006 are (1) patient accrual to ACOSOG trials and (2) published reports from completed trials. ACOSOG leadership is promoting a campaign to enhance patient recruitment to ACOSOG and ACOSOG-endorsed trials. We need your help.

ACOSOG is dedicated to involving ACS Fellows in the research agenda of the National Cancer Institute (NCI). We will work closely with the ACS, Commission on Cancer, and Cancer Liaison Program to recruit surgeons to enroll patients in clinical trials.

Each month we will deliver the information you need to help engage you in this important enterprise. In past columns, we have provided a short primer on joining a cooperative group and provided lists of clinical trials available to surgeons. In the coming months, we will deliver in-depth descriptions of important new surgical trials and help surgeons with points on how to participate. Tomorrow’s practice comes from today’s research. Get involved and make a difference!

This month’s featured clinical trial is Z1031: Neoadjuvant Aromatase Inhibitors in Breast Cancers.

- What is the study? This study is a phase III trial that compares three aromatase inhibitors in the preoperative setting. Tumor tissue and blood samples will be collected for correlative science studies and surgical, radiologic, and pathologic endpoints will be compared. (See box on next page.)
  - Who can participate? Participation is open to postmenopausal women with stage II or III estrogen receptor (ER) positive breast cancer.
  - Why is this study being done? Chemotherapy is sometimes given before surgery to shrink breast tumors to allow breast-conserving surgery or to improve the chance that the tumor can be removed adequately by mastectomy. Recent studies have shown that estrogen-lowering drugs called “aromatase inhibitors” are an effective and less toxic alternative for postmenopausal women with hormone-dependent tumors. This study is designed to further investigate this treatment approach.

<table>
<thead>
<tr>
<th>ACOSOG-led and ACOSOG-endorsed (CTSU*) protocols open to accrual</th>
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<tr>
<td>For a more complete list, please visit the ACOSOG Web site at <a href="http://www.acosog.org">www.acosog.org</a></td>
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<tr>
<th>Category</th>
<th>Trial Number</th>
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<tr>
<td>Breast</td>
<td>Z1031</td>
<td>Neoadjuvant aromatase inhibitors in breast cancer</td>
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<tr>
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<td>NSABP B-35*</td>
<td>Anastrozole with tamoxifen in patients with DCIS undergoing lumpectomy with radiation</td>
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<td>NSABP B-39*</td>
<td>Whole breast radiation vs. partial breast radiation for breast cancer</td>
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<td>Head and Neck</td>
<td>Z0360</td>
<td>Sentinel lymph node mapping and lymphadenectomy for oral cavity SCCa</td>
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<td>Gastrointestinal</td>
<td>Z6041</td>
<td>Local excision and neoadjuvant chemoradiation for early rectal cancer</td>
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<td>Sarcoma</td>
<td>Z9001</td>
<td>Adjuvant ST1571 vs. placebo following resection of primary GIST</td>
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<td></td>
<td>Z9031</td>
<td>Preoperative radiation plus surgery vs. surgery alone for RPS</td>
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<tr>
<td>Thoracic</td>
<td>Z4031</td>
<td>Proteomic analysis for detection of non-small cell lung cancer</td>
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<tr>
<td></td>
<td>Z4032</td>
<td>Brachytherapy and sublobar resection in non-small cell lung cancer</td>
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</table>
Patients will be randomized at the start of the study.

- Patients will receive:
  - **Group 1: Exemestane**
    Patients randomized to Group 1 will take 1 tablet (25 mg) of exemestane once per day for 16 weeks, OR
  - **Group 2: Letrozole**
    Patients randomized to Group 2 will take 1 tablet (2.5 mg) of letrozole once per day for 16 weeks, OR
  - **Group 3: Anastrozole**
    Patients randomized to Group 3 will take 1 tablet (1 mg) of anastrozole once per day for 16 weeks

- Patients will have surgery.

- Patients will see their physician 30 days after completing the study drug and the outcome will be recorded every two years for 10 years. The physician may recommend that patients continue taking an estrogen-lowering drug or tamoxifen for five or more years, and patients may also receive other therapies such as chemoradiation or radiation therapy.

The primary purpose of the Z1031 study is to find out which aromatase inhibitor is the best one to use for future ACOSOG studies. All three aromatase inhibitors under investigation have been shown to shrink breast cancers and to improve the chances of breast conservation. Patients will be treated with 16 weeks of daily oral doses of either exemestane, letrozole, or anastrozole. Another aim is to develop new tests that can be used to predict which patient will do well with this form of treatment. For this reason, patient consent will be requested for extra tumor biopsies and for access to tumor samples taken at surgery.

- **How may surgeons get involved?** Surgeons who treat women with breast cancer should go to [www.acosog.org](http://www.acosog.org) for information on membership. For more information, call the NCI’s Cancer Information Service at 800/4-CANCER (800/422-6237), or TTY 800/332-8615, or visit the Web site at [http://www.cancer.gov](http://www.cancer.gov).


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**Trauma and Critical Care–Point/Counterpoint to be held in June**


The theme of this year’s meeting is “What’s New in Trauma/ Critical Care” and includes sessions on resuscitation beyond the basics; an exciting video session on technical advances; difficult case management panels (including the challenging and fun *Survivor* game for faculty); a thorough look at liver injuries and their operative management; a review of penetrating trauma to the chest, abdomen, neck, and central nervous system; pelvic fractures from the standpoint of the surgeon, orthopaedist, and interventionalist; and an in-depth look at results of recent multicenter studies and how they have changed our approach to patient care. There are breakfast and lunch sessions on disaster preparation and analysis and on system problems–system solutions, including Level I overload, the role of the Level IIIIs, telemedicine in rural trauma care, and economics.

This program is directed to the surgeon and surgical specialist but should also be of interest to practitioners of critical care and emergency medicine.
A look at the Joint Commission

Shared visions—New pathways

Welcome to the third 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.

In 2004, the Joint Commission launched Shared Visions—New Pathways®, its new accreditation process. The Joint Commission developed this initiative to create a more continuous accreditation process that eliminates the focus on scores and survey ramp-up activities. Shared Visions—New Pathways’ innovations extend far beyond the on-site survey itself. The Joint Commission implemented the following enhancements to the program:

• Eliminated overall evaluation scores
• Established the periodic performance review, whereby organizations annually self-assess their standards compliance and correct deficiencies
• Revised the accreditation standards to sharpen the focus on patient safety and reduce documentation burdens
• Increased the use of data and information to identify the priority focus areas unique to the safety and quality of care provided within each organization
• Replaced the on-site survey’s previous focus on documentation review with the new patient-centered tracer methodology, which evaluates care systems and processes as they were experienced by randomly selected patients
• Increased opportunities for physician and staff engagement via the periodic performance review and tracer methodology
• Enhanced surveyor education and training to improve surveyor consistency
• Implemented unannounced surveys in January, thereby transforming accreditation from an event into an ongoing process
• Introduced quality reports at www.QualityCheck.org to provide the public with valuable performance information about accredited organizations and stimulate performance improvement

As a result of these changes, Joint Commission accreditation is woven into a health care organization’s daily operations, and organizations prepare for the next patient, not the next survey.

ABS elects three Fellows as at-large directors

The American Board of Surgery (ABS) has elected three distinguished community surgeons to newly created at-large director positions: Thomas H. Cogbill, MD, FACS (La Crosse, WI); Nathalie M. Johnson, MD, FACS (Portland, OR); and J. Patrick Walker, MD, FACS (Crockett, TX). The three surgeons were chosen from more than 100 nominations received through an open nomination process that took place last summer.

The ABS added these at-large positions as part of an effort to better reflect the diversity of the U.S. surgeon community and specifically to increase the representation of surgeons in community or group practice. The overwhelming response to the call for nominations resulted in applications from many highly qualified surgeons from a wide range of backgrounds and practice environments. While the selection of three candidates from such an outstanding group was challenging, the ABS focused on experienced community-based surgeons with unusual records of achievement.

The three new directors will begin their terms as of July 1. For more information, visit http://home.absurgery.org/default.jsp?newselectatlarge.
The American College of Surgeons presents

ACS Coding Today

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ACS Coding Today features:

– Complete CPT, HCPCS Level II, and ICD-9 codes.

– Current Medicare Correct Coding Initiative bundling edits, national and local fee schedules, and Medicare policy information.

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For whom the bell tolls?

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

After an entire season of football, playoffs, college bowl games, hockey, wrestling, boxing, and the like, do you ever wonder what happens to all the athletes who have their bell rung? Did you wonder why helmet-to-helmet contact in the National Football League is no longer tolerated? Did you know that the force of a professional boxer’s fist is equivalent to being hit with a 13-pound bowling ball traveling at 20 miles per hour, or 52 Gs?

Although sports injury fatalities are infrequent, the leading cause of death from sports-related injuries is traumatic brain injury (TBI). TBI is defined as a blow or jolt to the head or a penetrating head injury that disrupts normal brain function.

Symptoms of TBI are categorized as mild, moderate, or severe. Mild TBI may result in a brief change in consciousness whereas a severe injury may result in prolonged unconsciousness, coma, or death. According to the U.S. Consumer Product Safety Commission’s National Injury Information Clearinghouse, there were more than 311,000 sports-related head injuries that ended up in U.S. emergency rooms in 2004. This number does not include those injuries that were treated in physician offices or urgent care centers or that were self-treated.

In order to examine the occurrence of these injuries in the National Trauma Data Bank™ Dataset 5.0, we used cause of injury codes (E codes) E917.0 for striking or struck accidentally by objects or persons in sports without subsequent fall, E917.6 in sports with subsequent fall (for example, boxing), and E886.0 fall in sports (for example, tackles). We then queried those records for any that contained a diagnosis in the head injury range of the International Classification of Diseases, Ninth Revision (ICD-9-CM) codes 850–854. There were 11,655 records, with 8,651 being discharged to home; 1,378 to acute care/rehab; 849 to nursing homes; 132 other; and 645 deaths. These data are depicted in the figure on this page. These patients were, on average, 38 years of age, had an average length of stay of almost five and one-third days, an intensive care unit length of stay of just more than one and one-half days, and an average injury severity score of 10. It is not surprising that there is an older average age of injury since Baby Boomers are taking to the bicycle paths and basketball courts and represent more than one-third of Americans...
The American College of Surgeons’ online job bank

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

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

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